presenters and delegates alike, the only detraction being the lack of author/delegate discussion.

At some meetings, it is often possible to set aside time specifically for poster presentations to be 'presented' in shorter form.² At the European Plastic Surgery Research Council last August, this worked very well as an informal early evening social event. In the relaxed setting of an evening drinks reception each of the posters were briefly presented (three slides maximum) and discussion flourished (in some cases long into the evening).

e-Posters can be educationally and scientifically sound. They can allow the author and conference delegates the opportunity to discuss the science of surgery to the full with minimal organisational and transportation issues. e-Posters are green and portable – nowadays who doesn't travel with a USB-drive tucked in their pocket? Poster presentations are an essential element to scientific surgical meetings as they allow all members of the surgical team an opportunity to present their work. We should embrace them as an opportunity to present quality research, but they should evolve much like the science of surgery.

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***Clostridium difficile* knowledge in healthcare workers: conclusions in the absence of broader evaluation**

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COMMENT ON

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A validated, knowledge-based questionnaire tool could provide the means for identification of risk factors associated with poor levels of knowledge, assist in targeting educational interventions, and provide measurable data on the impact of educational interventions.

Unfortunately, Aroori *et al.* failed to examine if data resulting from the questionnaire could discriminate populations with known differing levels of knowledge or if conclusions were valid in repeated sampling of healthcare

worker populations elsewhere. Additionally, the questionnaire provides no clear conclusion/definition of what is an adequate level of knowledge, *i.e.* does anything less than 100% correct response deem a healthcare worker as possessing a lack of knowledge?

Previously, we assessed methicillin resistant *Staphylococcus aureus* knowledge in healthcare workers, both in a surgical trainee¹ and wider healthcare worker population in repeated sampling. We found questionnaire statements on policy could be UK-region specific and that knowledge levels needed to be judged against a broader healthcare worker population context. In addition, even populations with assumed high levels of knowledge (infection control nurses) did not achieve 100% correct answers.²

Until further validation, it is difficult to support the conclusions that the study findings are indeed 'valid' in reference to a presumed 'significant lack of knowledge' in wider consultant and nursing staff populations.³ This questionnaire can only ultimately comment on a local population, sampled at a specific time, and does not adequately define an appropriate level of knowledge.

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AUTHOR'S RESPONSE

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We would accept that any survey of this kind can only reflect the knowledge of those within the population which was sampled at the time the sample was taken. Indeed, it is very likely that awareness of *Clostridium difficile* is greater now than it was then. Nevertheless, it does give some insight into the understanding of these issues within different groups of healthcare workers.

No precise definition of 'adequate' levels of knowledge has been attempted. It would be a separate study to compare 'knowledge' with 'practice' (which is what really matters) to define the minimum level of knowledge for the delivery of good practice.