The ethics of live surgery: an ongoing debate

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The ethics of live surgery was first questioned in India in 2003, by N Ananthakrishnan (1) with responses from Sanjay Nagral (2) and Ramesh Ardhanari (3). The lay press in India discussed the issue in 2004 (4). Experts in western countries have also debated its possible ill effects as reports emerge of mishaps in workshops. Yet the concept is going live to reality television. Further discussion (5) has arisen, following the first live operation - open heart surgery - before a public audience (6). It is time to revisit the debate.

The hazards of live surgery have been elucidated by Duke E Cameron of Johns Hopkins Hospital, Baltimore, USA, who has pressed for a rethink on the practice (7), suggesting that the solemnity and focussed environment of an operating room should not be disrupted by the presence of a camera, microphone and the accompanying crew. The Society of Thoracic Surgeons' standards and ethics committee has recommended that "public live surgery broadcasts not be permitted, and that such broadcasts not be permitted at its annual meeting" (8). It has been noted that "several national surgical associations have banned the practice from some or all of their meetings, including the American College of Obstetricians and Gynaecologists and the American College of Surgeons" (8).

Medical ethics is now supposed to be part of the curriculum for MBBS students in India. It covers a number of core issues: autonomy or the right to arrive at one's own conclusions regarding treatment; beneficence; and, even more important, non-maleficence; justice, dignity and informed consent.

Autonomy

There is a constant tussle between the "autonomy" of two groups-- physicians and society at large. The former will hold that the aim of treatment is to do good to patients and also benefit from the knowledge disseminated by various teaching methods (in addition to financial and career advancement). Society presumes that physicians should work for the benefit of patients and society. The struggle of most ethicists is to find a balance between the welfare of the physician and that of society.

Live surgery is definitely beneficial to the profession. Attending surgeons learn at first hand, "seeing" the difficulties and mistakes as they occur and learning how to tackle them. It also serves as an advertising portal for the operating surgeon and the organising institute or society, and increases the attendance at any meeting, making it lucrative for organisers and advertisers.

Part of the excitement of live surgery is witnessing the real life management of complications. Live surgery satisfies a basic instinct, like watching gladiators fighting, with an audience watching in awe and cheering in the garb of learning. Are we actually waiting for something to go wrong in order to learn what to do in a crisis?

It would be better for the procedure to be recorded and replayed frame by frame. The surgeon will be in a better position to explain the procedure after it has been completed.

Non maleficence over beneficence

Talking while operating can divert the attention of the surgeon. The physician should avoid situations that put the patient at risk of harm. If multi-tasking is prohibited for mundane tasks like driving, why should it be allowed for more demanding tasks like surgery? It has already been proven that accidents are often caused while talking over a mobile phone. How is a microphone different from a mobile phone in this context?

Similarly, everyone would answer Duke Cameron's question similarly (7): one would not travel on a flight in which the pilot was conducting a live demonstration of the art of flying.

Would one ask a driver to drive on an unknown track on a vehicle which he is driving for the first time? That is sometimes the case in live surgery workshops. There are surgeons operating on patients in operating rooms unfamiliar to them, with instruments they are using for the first time.

Justice

Are all decisions in live surgery workshops taken in the best interests of the patient? It is possible that the operating surgeon feels compelled to continue with an operation as it has been advertised by the organisers. In some cases, implants or instruments of sponsoring companies may be used though they are not the best option. Some instruments may not even have that country's regulatory approval. Sometimes, the operating surgeon may not be sufficiently experienced in their use. Some patients may be especially vulnerable; in eye surgeries, for example, the eye to be operated may be a "precious" eye.

Dignity

In live surgeries, patient details are announced and patients seen by more people than they may be comfortable with. A person's grief or pain should not be telecast out of respect for their dignity even on reality shows. A surgical procedure is something much more serious.

Second, the operating surgeon's comfort is compromised. Further, observers are subjected unnecessarily to procedures like cleaning, draping, suction, and suturing. To add to it are "centration" issues with audience complaints about poor

reception or problems with signal feeds adding to the chaos and diversion of attention from the "centre of our universe"-- the patient.

What does the audience learn when a surgeon refuses to accept failure? And why should the audience be party to "crimes" if they occur? Time and again members of the audience have been threatened in India for raising an objection to something unethical. Some have had notes made in their confidential reports for having "opened their mouths". Others may have lost their jobs in corporate hospitals over similar issues.

Informed consent

Often, a patient may feel coerced to consent as otherwise a foreign surgeon/expert may not operate. And patients are unlikely to be informed that their surgeon's attention may be diverted while talking during surgery; it is impossible for the surgeon to concentrate totally on the patient, as some attention may be diverted to the audience.

Reality shows have invaded our lives and people behave in a manner they would not have if they were not on television to attract attention. It is time that conscientious surgeons voice their opinions fearlessly to prevent sensationalism overtaking professionalism and causing surgery to lose the respect and status that it has enjoyed for ages.

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Commentary: live telecast surgery on shaky ground

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I completely agree with the author's views and the reasons stated by him. Let me share my thoughts on some of the points discussed.

In our country, patients operated on in a live surgical workshop held at government hospitals are generally unable to bear the expenses of the surgery and have come to the public facility because they have no other choice. It is wrong in this situation for the consultant under whom the patient is admitted to subject him to a surgery to be broadcast to surgeons from all over the country or the world, without any intelligent informed consent. In many cases, "informed consent" has been given but the patient, being financially weak, is actually left without a choice. How often do we see patients giving consent only because the treatment is free, including the cost of medicines and disposables. This is too good an offer to be refused.

In other cases, the lure of an internationally/nationally renowned surgeon coming only to perform this surgery can drive patients to agree to the live surgery. Little do they know that:

1. The surgeon in question is not familiar with the hospital, operating room (OR) setup or surgical team with whom he will work;
2. The number of people inside the OR will be well beyond the prescribed guidelines for maintaining OR sterility and hospital infection committee guidelines;
3. The recording equipment itself will be unsterile and carry a potentially high microorganism load while being shifted from one hospital to the other;
4. The equipment being used by the operating surgeons will be new to them or may never have been used by them earlier, but must be used as the manufacturer is supporting the event;
5. In order to promote the event, more live cases are conducted than the setup can tackle, compromising the sterility of the instruments being used especially in minimally invasive surgery/ laparoscopy workshops.

A demonstration of a live procedure from the OR to an audience in a remote place is a direct violation of the principles of medical ethics as it is contradictory to the oath of non-maleficence. This, in turn, is a subject of medical litigation in today's testing times.

The crux of the matter has already been aptly explained by Dr. Morekar. The important issue is that we need to find a balance between the two points of view: one supporting the fact that live demonstration surgery is an important teaching aid for all surgeons, and the other opposing it on ethical grounds.