Live surgery telecast – surgery teaching tool or sensationalism?

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Live telecasts of surgery is on a dramatic rise. We got various invitations for live surgery workshops, to learn new operative techniques, and even ask questions during the procedure. Ease of transmitting video images live, supplemented by cheap technology, surgical industry and hospitals have enthusiastically subsidized these media events, trying to “Highlight and capture eyes” in the latest information age.

The value of video images in disseminating surgical knowledge is immense, but we question the added value of “live” broadcasts. Supporters for these programs argue that a live telecast somehow brings energy, honesty and the drama. However, at the same time this brings sensationalism and thrill? and that is where we object. We submit that live broadcasts serve neither the patient nor the audience. Can we personally allow ourself for this type of adventure at the crucial moments of life or death? This is not a Live cricket match where maximum you can loose a game.

For several reasons, We believe, broadcast of live surgery or reality surgery should be rethought.

1. It is a pressure over surgeon to perform the promised operation and to do it as planned, without change in the script. This is definitely and distinctly at odds with the patient safety measures. I once viewed a live telecast *mitral* valve repair that resulted in an unacceptable outcome in postoperative phase, but it was tolerated because, I suspect, the surgeon did not want to publicly acknowledge the failure and replaced the valve. Who was being served by this telecast, and what was the message?

2. It is a patient safety hazard. The operating room should be a solemn, quiet environment focused on the patient and only on the patient’s operation. The presence of camera and microphone instead tend to divert attention to the surgeon, who becomes master of this ceremony, rather than the caretaker. Who wants to be operated by a surgeon talking to remote audiences, fielding questions, and trying to demonstrate rather than concentrate?
3. It is a self-indulgent, inefficient way to communicate and teach surgery. Too often, live surgery contains endless stretches of technical details that have little educational merit. Sometimes, it is the surgeon’s ego that makes this performance, but more often, it is just a poorly edited video. Technical difficulties, delays in the procedure itself, and problems with signal feed add to the chaos. Isn’t a well-edited surgical video, with narration and figures added later by the surgeon after thoughtful review, will be better for everyone’s time and attention?
4. Sensationalism is incompatible with professionalism. Nearly always at the end of the operation, the surgeon returned to the lecture hall, still in scrubs after his video presentation, and was met by questions from the attendees. This, We thought, was at its worst moments. Our thoughts turned to the patient, who was still in the operating theatre, lying live or dead or with some complication.

Therefore, it will be better to make a video of operation and after proper editing and reviewing, we can learn from it, narrate it, duplicate it and share it. Several other related cases can be added so that the important lessons can be learnt.

We must restate that there is tremendous value in videos of surgical procedures. In fact, as a profession we have under-utilized video as an education tool and share information. However, we should ask ourselves: with the possibilities of distractions to the surgeon and the hazard on patient care, these live surgery creates, surgery teaching tool or just sensationalism?.

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