AMASI

GUIDELINES FOR CONDUCTING LIVE OPERATING WORKSHOPS

UNDER AEGIS OF ASSOCIATION OF MINIMAL ACCESS SURGEONS OF INDIA (AMASI) GUIDELINES FOR CONDUCTING LIVE OPERATING WORKSHOPS

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Introduction:

The Association of Minimal Access Surgeons of India (AMASI) has a mission to promote and inculcate excellence in minimal access surgery across the country. It recognizes that a vast majority of the surgical fraternity of India earnestly desires further training and information on surgical techniques in minimal access surgery. Many senior surgeons did not have the opportunity to train themselves in these techniques during their residency days. Many younger colleagues, though exposed to basics of laparoscopic surgery in their residency surgical units, desire to learn from the experts in the field. To this purpose, AMASI regularly conducts various educational activities in the form of symposia, didactic lecture series, certification examinations and operating workshops. These educational activities, in turn, translate into better surgical care of the Indian population.

Live operating workshops have emerged as a potent teaching technique to demonstrate standard surgeries and newer innovations to the surgical fraternity. Such workshops serve as forum for the sharing of techniques, promote discussion and knowledge dissemination, showcase innovations and potential improvement of interventions.

Over the years AMASI has conducted more than 300 workshops around the country and abroad where

AMASI designated faculty have operated in certified centers of excellence. When performed according to strictly enforced criteria, upholding ethics and patient safety criteria's as per this guideline, evidence have also showed that there is no difference in duration of procedure, complications, success rate, estimated blood loss, hospital stay, procedural and clinical outcomes.

In view of the mounting criticism against live operating workshop, AMASI is of the opinion that rather than banning such an essential tool in the continuing education of the surgical fraternity, it has the responsibility to share its guidelines to all and ensure that the patients' interests and well-being are given the highest priority while at the same time, maximum educational benefit is derived. With this objective in mind, the executive committee is sharing its guidelines which was formed earlier and revised later, considering all aspects of the matter.

These guidelines were formed after review of published literature, including the existing guidelines developed by various international physician societies for live operating workshops (literature reviewed in listed in the bibliography at the end). After consideration of all factors, including prevalent conditions in our country, a consensus was reached among members of the expert committee regarding the recommendations for conduction of live operative guidelines. In absence of a viable

alternative, for the purpose of allowing a vast majority of practicing surgeons an opportunity to continue enhancing, fine-tuning and improving their surgical abilities and knowledge, live operative workshops under the banner of AMASI are only being conducted as per the following guidelines.

I. GENERAL RULES:

1. Live transmission of surgery is meant for educational purposes of specialist's medical personnel only. It should not be done to the lay public or to press or to non-specialist doctors (MBBS and non-allopathy practitioners), for the purpose of any advertisement, publicity or creating records.
2. All steps must be taken to protect the privacy of the patient and always at all cost to preserve his/her anonymity.
3. Operations of greater educational value to the surgeons in the audience, relative to their clinical needs, should be chosen over operations of lesser educational value. Operations are inappropriate for live broadcast if intended to show that an operation can be done rather to demonstrate to others how to do it. Innovative operations and rare procedures that the surgeon has never or only occasionally performed previously should not be broadcast because they lack educational value and

increase the need for the surgeon's undivided attention.

4. Cases selected should be the simplest in terms of ease of operability for the specific indications. The aim of the workshop should be to demonstrate the standard technique of surgery for the particular indication and not to showcase the surgical skills of the operating surgeon. Thus, 'difficult' cases should be strictly avoided in workshop as they simply challenge the ingenuity and skills of the operating surgeon without adding any educational value for the audience.
5. Surgeries with high operative morbidity and mortality rates should be always avoided.

II. CENTER / HOSPITAL ORGANISING THE WORKSHOP:

1. The workshop should be organized in a hospital with adequate infrastructure for laparoscopic surgeries – minimum high quality digital / HD / 3 chip digital cameras, standard insufflators, xenon/LED light sources, multiple suction machines, multiple electrocautery machines, ultracision and vessel sealers.
2. Adequate anesthesia with trained anesthetist used to regularly inducing patients for laparoscopic surgeries should be available round-the-clock including ICU. The equipment should include an anesthesia workstation, multipara monitor

including $EtCO_2$ monitoring, defibrillator, syringe pumps, etc.

3. The center should have round-the-clock availability of surgeons (host team) who is used to laparoscopic surgeries as well as laparotomies, capable of managing any post-operative complications.
4. A member of the host team should be preferably a part of the operating team also, even if the operating surgeon brings his/her own team.

5. Certified blood bank inside hospital or near the hospital with facility to arrange blood in any emergency settings along with adequate ambulance service should be available in the hospital.

6. Surgeries like the one being demonstrated should be routinely done in the said hospital before.

III. OPERATING FACULTY SELECTION:

1. The operating faculty should be informed of patient details, including investigations, at least 48 hours before surgery.
2. The operating faculty should be well-rested and should not be suffering from jetlag or fatigue when entering the OT.

3. He/she should be holding operating privileges in a hospital in his or her country of origin.
4. He/she should be asked their preference of surgery.
5. He/she should have enough proficiency, with a high annual volume of cases, for the procedure allotted to him/her.
6. He/she should be given written permission from head of institution for operating privileges in the host unit.
7. He/she should be asked to submit their requirements for that surgery, including instruments, prosthesis like meshes and suture materials at least 48 hours before surgery.
8. The operating faculty/team should give written consent for live transmission of the procedure.
9. The operating faculty/team should give written consent for use of scientific material /snaps/ videos for educational purpose.
10. The operating faculty should be informed that the live transmission may be stopped at any time as per the patient advocate's decision for whatever reason. This point should be mentioned in the invitation letter.
11. The operating faculties personal and hospital indemnity insurance is arranged prior to the event.
12. The names of the operating faculty and under whom the patient is admitted should be mentioned in the patient's consent form.

13. The operating faculty cannot return from the venue on the same day of surgery and must ensure proper post operative follow-up of the patient. One of the team members must stay back till the patient is discharged from hospital.
14. The person under whom the patient is admitted is responsible for any liability, hence the respective person should submit their indemnity coverage and MCI registration at least a week before workshop.
15. The operating faculty should review the reports (which should be sent to him) at least 48 hours before surgery. Can also suggest additional reports if needed.
16. The operating faculty should see the patient and be introduced to the patient several hours prior to surgery and should formulate / discuss plan of management with patient (not necessary what is suggested by the organizer of workshop) based on his or her own expert assessment.
17. In case of conversion of a laparoscopic surgery to open laparotomy, the faculty should be ready to carry out the conventional surgery. In case, the faculty is not willing or unable to perform the conventional surgery, he/she should make it clear beforehand prior to embarking on the laparoscopic surgery.

IV. INFORMED CONSENT:

1. Patients should give specific consent to a live telecast during the operation, which should be separate from the operating consent.
2. Patients must be allowed to meet the visiting surgeon before consent for surgery.
3. Patient should know operating team members names by whom he/she is being operated in workshop, local care takers name and must also be written down in consent.
4. Patient should know that the operating faculty is coming from outside and might leave after surgery and that post-op care till discharge will be done by one member of team and local team.
5. Patient should know his/her financial liability: whether the entire hospitalization is completely free; pharmacy and/or lab to be paid for; hospital expenses free up to set no. of days etc. However, in no circumstances, operating charge should be collected from patient.
6. Informed consent must be taken from patient for using the scientific material / photographs /videos for educational purpose with / without revealing identity.
7. In case of post-op complications, the standard protocols should be spelled out in the consent form.

8. The patient should understand that his/her surgery is not hinged on the live broadcast of surgery and he/she can still get operated outside the workshop.

V. OPERATING THEATRE TEAM:

1. The operating surgeon must submit in advance a detailed list of preferences, including instruments, disposables, and devices; patient, surgeon, and scrub nurse positioning; and preferred assistants.
2. Any language difficulties should be foreseen and avoided.
3. Nominated assistants should be appropriately registered and suitably experienced.
4. Anaesthesiologists must be involved in planning the procedure in every step.
5. The visiting surgeon must be allowed the option of bringing his or her own assistant/team. The financial liability of the assistant/team should be clarified in writing beforehand to avoid dispute after the workshop.

VI. DURING WORKSHOP:

1. The WHO surgical checklist (or a local adaptation) must be used and involve all personnel in the operating room, who must also be briefed about the event.
2. Unnecessary personnel and equipment should not be present in the operating room.
3. Representatives from industry should be in the operating room only if their presence is mandatory, and they should be appropriately registered and certified by the host hospital.
4. The new equipment and devices used in live surgery must be strictly limited to those deemed essential from the viewpoint of scientific significance, and any usage for solely commercial purposes must be avoided.
5. The video crew should be clearly instructed not to interfere with the surgeon's work area nor disturbing him/her.
6. There should be at least one senior moderator in the OT (OT Workshop moderator) who is senior and well experienced to the procedure.
7. OT Workshop moderator should ensure that the operating faculty is not disturbed while he is performing the procedure. Preferably there should be only one-way direct communication, from the

operating surgeon to the audience if required and thought necessary by the operating surgeon. If the moderator or the audience wants to ask any technique related question while watching, that should be relayed to the OT moderator in the OT complex and who can then relay the same to the surgeon, when he/she is not involved in any critical step of the surgery. Operating Faculty should not be talking or arguing with someone in the hall while continuing surgery.

8. There should be a minimum number of personnel in the theatre and strict silence should be maintained.
9. The overall workshop in charge of the whole program (Organising secretary) should convene a meeting of all theatre personnel – nursing staff, sweepers, Anaesthesiologist, residents, audio visual people on day prior to explain correct protocols, assign duties and how to maintain decorum.
10. All personnel in operation theatre should follow standard sterile techniques.
11. OT Moderators should guide the discussion towards critical steps, learning points and interesting issues.
12. Hall Moderators should avoid irrelevant questions / discussions, avoid stoppage of operation for the purpose of discussion for longer time, should avoid lengthy theoretical discussions, should avoid

anything that distracts the operator from operation, should not disturb the operator during critical steps and also should himself recognize the difficult moments during surgery so as not to disturb the operating surgeon at anytime.

13. OT Moderator can stop the transmission to allow the surgeon to tackle any difficult step or complications and can be resumed as and when they feel that the surgeon is comfortable.
14. The OT moderators in operation theatre should take up the discussion in general unless the operating surgeon is very comfortable in doing the same.
15. The hall moderators should filter the questions from audience and should pass to the operating surgeon through OT moderator only if necessary.
16. The open surgery trolley should be kept ready so that delay can be avoided if conversion is considered.
17. The camera surgeon and the first assistant should be experienced in laparoscopic surgery.
18. The operating faculty may bring his own assistants if he so wishes, in which case he must bear the expenses of the assistants, including travel and accommodation. The organizers may provide local hospitality to the assistants (food coupons/access to exhibition area).

19. There should be a senior faculty, designated by AMASI who will be seeing the surgery & a Patient Advocate – to look after the interests of the patients. When such faculty determines that the surgery is not proceeding as planned, he/she can advocate stopping the transmission and/or surgery, which will be binding for the operating faculty as well as the organizers.
20. The operating faculty, after completing the surgery, should write (or get written) a brief operating note and post-op orders along with his signature.
21. All surgical procedures should be digitally recorded.
22. There should be maximum of two screens in a hall.
23. The transmission quality should be minimum of HD quality.

VII. AFTER THE WORKSHOP:

1. The local faculty incharge either him/herself or his/her nominee (senior resident) should update the operating surgeon daily about the patient till the patient is discharged. Any specific instructions of the operating surgeon may be considered in the management of the patient.
2. The outcome of all patients operated in the workshop should be sent to the AMASI headquarters within 30 days after the workshop so that the association may display the same on its website & for record.

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