EDITORIAL

What is the role of “Live Surgical Demonstrations” at conferences?

Recently I attended an international meeting as a member of the faculty and had the pleasure of meeting with friends and colleagues from various parts of the world. In conjunction with this particular meeting, a workshop was held demonstrating a variety of surgical techniques. I had been invited by the organisers to participate in the workshop as one of the demonstrators of live surgery, but had declined as I have strong views on these events, which I wish to share with you. I did take part in another segment of the workshop and attended the live surgery demonstrations as a member of the audience. My bias against such events was illustrated to me as I sat in the darkened room of the conference venue watching one of my colleagues demonstrate a procedure which was beamed live from the local hospital.

Quite coincidentally I had previously seen my colleague do the same operation at his hospital and I learned a lot from him as he is an excellent technician and teacher. However, working in a foreign environment the story was quite different. He had met the patient on the evening prior to the surgery but, due to language difficulties, had very little chance of making a clinical assessment of the indication for the procedure. He had expressed his concerns to me but felt committed to the organisers. On the day of the surgery he met the staff in the operating room for the first time and went through the equipment to ensure that what he had requested was available. To his disappointment and dismay favoured instruments could not be delivered at the last moment and alternate instruments were to be used.

Of course none in the audience sitting with me in the auditorium were aware of any of these impediments. The operation commenced and it soon became apparent to me that my colleague was having difficulties as the instruments were unfamiliar and the ‘professor’ who was assisting was quite an inexperienced assistant for the complex procedure. A significant technical complication occurred during the procedure, but my colleague was able to retrieve the situation due to his skill and experience. However the patient’s chance of a postoperative complication significantly increased, both short and long-term.

My colleague was distressed at the end of the demonstration and reflected on his decision to participate in such an event; something he had done on a number of previous occasions. Two days later he flew home, never to see the patient again.

I take the opportunity of my editorial to relate this story as I know many of the readers of HPB would be familiar with the scenario. I raise the following issues:

- What are the ethical responsibilities of the surgeon demonstrator to the patient?
- Have they been fulfilled to a standard that would be acceptable in the surgeon’s own environment?
- What is the educational value of such an event to the audience?
- Did anyone learn anything from seeing Professor ‘famous’ get into trouble and thankfully get out of trouble?
- Faced with the same situation at some future date would the audience even remember this scenario and perform likewise?
- If it is a technique that we aim to teach would not a well constructed video fulfil the teaching objectives?

I believe that surgical education has come a long way since the days of ‘see one, do one, teach one’. We have learned that adults learn and learn well if a positive environment is created. Adults respond well to positive critique and in general the following four step approach is effective in teaching any procedure – from simple suturing to complex liver and pancreatic surgery.

Rodney Peyton [1] of the Royal College of Surgeons has popularised the four steps to effective learning of procedural skills:

- Demonstration: trainer demonstrates at normal speed, without commentary
- Deconstruction: trainer demonstrates while describing steps
- Comprehension: trainer demonstrates while learner describes steps
- Performance: learner demonstrates while learner describes steps
This four step approach ensures that the teacher breaks the process into manageable steps and progress is made from one stage to the next as each step is mastered.

What, you might ask, has Peyton’s ‘four steps’ have to do with the experience that I have related? The ethics of the situation aside (and I strongly believe that it cannot be put aside), educationally watching a master surgeon demonstrate his/her art is only one step in the process of learning. Divorcing the first step from the subsequent teacher/learning experience, whilst may be useful for the few experienced senior surgeons in the audience, can have disastrous consequences for the more junior inexperienced surgeons and their patients. It is time that we, the leaders in HPB took on roles as educators seriously, both for the benefits of our profession and, more importantly, for the benefit of our patients. In this issue of HPB the president of the IHPA, Henry Pitt, highlights what the association is trying to do in facilitating education in our specialty. I applaud his initiative and invite all our readers to contribute by accepting an invitation to assist – demonstrations of procedures at meetings need to be followed up by effective teaching and proctoring, otherwise they are at best only of entertainment value.

J Toouli
Editor-in-Chief

Reference