Dental Health: Current Research

Perspective A SCITECHNOL JOURNAL

Ethical Concerns in Dental Surgery

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Abstract

Ethical concerns involve not only the interests of patients, but also the interests of surgeons and society. Surgeons choose among the options available to them because they have particular opinions regarding what would be good (or bad) for their patients.

Ethics and surgical intervention must go hand in hand. In any other arena of public or private life, if someone deliberately cuts another person, draws blood, causes pain, leaves scars and disrupts everyday activity, then the likely result will be a criminal charge. If the person dies as a result, the charge could be manslaughter or even murder. Of course, it will be correctly argued that the difference between the criminal and the surgeon is that the latter causes harm only incidentally. The surgeon's intention is to cure or manage illness, and any bodily invasion that it incurs is only with the permission of the patient.

Medicine asks: "What can be done for the patient?"

Ethics asks: "What should be done for the patient?"

Keywords

Surgery, Ethics, Medical Ethics, Dentistry, Dental Surgery, Autonomy

Introduction

Biomedical ethics is the system of analysis and deliberation dedicated to guiding surgeons toward the "good" in the practice of surgery. One of the most influential ethical "systems" in the field of biomedical ethics is the principality approach [1].

In this approach to ethical issues, moral dilemmas are deliberated by using four guiding principles: autonomy, beneficence, no maleficence, and justice.

The main question in autonomy is "What does patient want?" The main question in beneficence is "What are the benefits?" The main question in no maleficence is "Will it harm the patient?" The main question in justice is "Are the patient's requests fair and able to be satisfied?"

The principle of autonomy respects the capacity of individuals to choose their own destiny, and it implies a right for individuals to make those choices. It also implies an obligation for physicians to permit patients to make autonomous choices about their medical care. Beneficence requires that proposed actions aim at and achieve something good whereas no maleficence aims at avoiding concrete harm: "premium non nocere" [2]. Justice requiresfairness where both the benefits and burdens of a particular action are distributed equitably [3].

Patients consent to surgery because they trust their surgeons; yet what should such consent entail in practice and what should surgeons do when patients need help but are unable or unwilling to agree to it? When patients do consent to treatment, surgeons wield enormous power over them, the power not just to cure, but to maim, disable and kill. How should such power be regulated to reinforce the trust of patients and to ensure that surgeons practice to an acceptable professional standard? Are there circumstances, in the public interest, in which it is acceptable to sacrifice the trust of individual patients through revealing information that was communicated in what patients believed to be conditions of strict privacy?

History of medical Ethics

Historically, Western medical ethics may be traced to guidelines on the duty of physicians in antiquity, such as the Hippocratic Oath, and early Christian teachings. The first code of medical ethics, Formula ComitisArchiatrorum, was published in the 5th century; during the reign of the Ostrogothic king Theodoric the Great. In the medieval and early modern period, the field is indebted to Islamic scholarship such as Ishaqibn Ali al-Ruhawi (who wrote the Conduct of a Physician, the first book dedicated to medical ethics), Avicenna's Canon of Medicine and Muhammad ibnZakariyaar-Razi (known as Rhazes in the West), Jewish thinkers such as Maimonides, Roman Catholic scholastic thinkers such as Thomas Aquinas, and the case-oriented analysis (casuistry) of Catholic moral theology. These intellectual traditions continue in Catholic, Islamic and Jewish medical ethics.

By the 18th and 19th centuries, medical ethics emerged as a more self-conscious discourse. In England, Thomas Percival, a physician and author, crafted the first modern code of medical ethics. He drew up a pamphlet with the code in 1794 and wrote an expanded version in 1803, in which he coined the expressions "medical ethics" and "medical jurisprudence" [4].

However, there are some who see Percival's guidelines that relate to physician consultations as being excessively protective of the home physician's reputation. Jeffrey Berlant is one such critic who considers Percival's codes of physician consultations as being an early example of the anti-competitive, "guild"-like nature of the physician community [5,6].

In 1815, the Apothecaries Act was passed by the Parliament of the United Kingdom. It introduced compulsory apprenticeship and formal qualifications for the apothecaries of the day under the license of the Society of Apothecaries. This was the beginning of regulation of the medical profession in the UK.

In 1847, the American Medical Association adopted its first code of ethics, with this being based in large part upon Percival's work [7]. While the secularized field borrowed largely from Catholic medical ethics, in the 20th century a distinctively liberal Protestant approach was articulated by thinkers such as Joseph Fletcher. In the 1960s and 1970s, building upon liberal theory and procedural justice, much of the discourse of medical ethics went through a dramatic shift and largely reconfigured itself into bioethics [7].

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Received: October 24, 2020 **Accepted:** March 09, 2021 **Published:** March 16, 2021

Main Concepts

Respect for Autonomy

Surgeons have a duty of care towards their human patients which goes beyond just protecting their life and health. Their additional duty of care is to respect the autonomy of their patients and their ability to make choices about their treatments, and to evaluate potential outcomes in light of other life plans. Such respect is particularly important for surgeons because, without it, the trust between them and their patients may be compromised, along with the success of the surgical care provided. We are careful enough at the best of times about whom we allow to touch us and to see us unclothed. It is hardly surprising that many people feel strongly about exercising the same discretion in circumstances in which someone is not only going to do these things but to inflict what may be very serious wounds on them as well.

For all these reasons, there is a wide moral and legal consensus that patients have the right to exercise choice over their surgical care. In this context, a right should be interpreted as a claim that can be made on others and that they believe that they have a strict duty to respect, regardless of their own preferences. Thus, to the degree that patients have a right to make choices about proposed surgical treatment, it then follows that they should be allowed to refuse treatments that they do not want, even when surgeons think that they are wrong. For example, patients can even refuse surgical treatment that will save their lives, either at present or in the future, through the formulation of advance directives specifying the types of life-saving treatments that they do not wish to have if they become incompetent to refuse those [3].

Informed Consent

In surgical practice, respect for autonomy translates into the clinical duty to obtain informed consent before the commencement of treatment. The word 'informed' is important here. Because of the extremity of their clinical need, patients might agree to surgery on the basis of no information at all. Agreement of this kind, however, does not constitute a form of consent that is morally or legally acceptable. Unless such patients have some understanding of what they are agreeing to, their choices may have nothing to do with planning their lives and thus do not count as expressions of their autonomy. Worse still, if patients are given no information, their subsequent choices may be based on misunderstanding and lead to plans and further decisions that they would not otherwise have made.

For agreement to count as consent to treatment, patients need to be given appropriate and accurate information. Such information should include:

-The condition and the reasons why it warrants surgery;

-The type of surgery proposed and how it might correct the condition;

-The anticipated prognosis and expected side-effects of the proposed surgery;

-The unexpected hazards of the proposed surgery;

-Any alternative and potentially successful treatments other than the proposed surgery;

-The consequences of no treatment at all.

With such information, patients can link their clinical prospects with the management of other aspects of their life and the lives of others for whom they may be morally and/or professionally responsible. Good professional practice dictates that obtaining informed consent should occur in circumstances that are designed to maximize the chances of patients understanding what is said about their condition and proposed treatment, as well as giving them an opportunity to ask questions and express anxieties [8].

Where possible:

-A quiet venue for discussion should be found;

-Written material in the patient's preferred language should be provided to supplement verbal communication;

-Patients should be given time and help to come to their own decision;

The person obtaining the consent should ideally be the surgeon who will carry out the treatment. It should not be – as is sometimes the case – a junior member of staff who has never conducted such a procedure and thus may not have enough understanding to counsel the patient properly [9].

Good communication skills go hand in hand with properly obtaining informed consent for surgery. It is not good enough just to go through the motions of providing patients with the information required for considered choice. Attention must be paid to:

-Whether or not the patient has understood what has been stated;

-Avoiding overly technical language in descriptions and explanations;

-The provision of translators for patients whose first language is not English;

-Asking patients if they have further questions.

When there is any doubt about their understanding, surgeons should ask patients questions about what has supposedly been communicated to see if they can explain the information in question for themselves [10].

Surgeons have a legal, as well as a moral, obligation to obtain consent for treatment based on appropriate levels of information. Failure to do so could result in one of two civil proceedings, assuming the absence of criminal intent. First, in law [11] intentionally to touch another person without their consent is a battery, remembering that we are usually touched by strangers as a consequence of accidental contact. Surgeons have a legal obligation to give the conscious and competent patient sufficient information 'in broad terms' about the surgical treatment being proposed and why. If the patient agrees to proceed, no other treatment should ordinarily be administered without further explicit consent.

Negligence is the second legal action that might be brought against a surgeon for not obtaining appropriate consent to treatment. Patients may have been given enough information about what is surgically proposed to agree to be touched in the ways suggested. However, surgeons may still be in breach of their professional duty if they do not provide sufficient information about the risks that patients will encounter through such treatment. Although standards of how much information should be provided about risks vary between nations, as a matter of good practice, surgeons should inform patients of the hazards that in their view any reasonable person in the position of

the patient would wish to know. In practice, surgeons should ask themselves what they or a close relative or friend should be entitled to know in similar circumstances.

Finally, surgeons now understand that, when they obtain consent to proceed with treatment, then patients are expected to sign a consent form of some kind. The detail of such forms can differ, but they often contain very little of the information supposedly communicated to the patient who signed it. Partly for this reason, the process of formally obtaining consent can become overly focused on obtaining the signature of patients rather than ensuring that appropriate types and amounts of information have been provided, and have been understood. Both professionally and legally, it is important for surgeons to understand that a signed consent form is not proof that valid consent has been properly obtained. It is simply a piece of evidence that consent may have been attempted. Even when they have provided their signature, patients can and do deny that appropriate information has been communicated or that the communication was effective. Surgeons are therefore well advised to make brief notes of what they have said to patients about their proposed treatments, especially information about significant risks. These notes should be placed in the patient's clinical record [12].

Practical Difficulties

Thus far, we have examined the moral and legal reasons why the duty of surgeons to respect the autonomy of patients translates into the specific responsibility to obtain informed consent to treatment. For consent to be valid, patients must:

-Be competent to give it – be able to understand, remember and deliberate about whatever information is provided to them about treatment choices, and to communicate those choices

-Not be coerced into decisions that reflect the preferences of others rather than themselves;

-Be given sufficient information for these choices to be based on an accurate understanding of reasons for and against proceeding with specific treatments.

Surgeons will face four key practical difficulties in aspiring to these goals [13].

First, surgical care will grind to a halt if it is always necessary to obtain explicit informed consent every time a patient is touched in the context of their care. Fortunately, such consent is unnecessary because patients will already have given their implied consent to whatever bodily contact is required in order to fulfill the therapeutic goals when they gave their explicit consent to treatment. Yet the fact that this is so underlines the importance of obtaining proper and explicit consent in the first place, along with taking care to note any sign of the patient withdrawing that consent or placing restrictions on it – for example, through verbally refusing or physically resisting specific aspects of care.

Second, some patients will not be able to give consent because of temporary unconsciousness. This might be a by-product of their illness or injury, or it could simply be the result of the administration of general anesthetic. The moral and legal rules that govern such situations are clear. Patients may be at risk of death or of serious and permanent disability if surgery is not immediately performed.

The situation is then one of medical necessity, and intervention can occur in their best interests without consent. The exception is when it is known that patients have made a legally valid advance decision refusing treatment of the specific kind required. In any case, surgery that is not immediately necessary because of such risks should be postponed until patients regain consciousness and are able to give informed consent or refusal for themselves.

Surgeons must take care to respect this distinction between procedures that are therapeutically necessary and those that are done merely out of convenience, even when, in the course of one operation, they discover problems unknown to the patient that they believe to require further surgical work. For example, a surgeon was successfully sued for battery by a female patient for performing a hysterectomy thought to be in her best interests when all that she had explicitly consented to was a dilatation and curettage.

Third, informed consent may be made impossible by incompetence of other kinds. In the case of children, parents or someone with parental responsibility are ordinarily required to give explicit written consent on their behalf. This said, surgeons should

-Take care to explain to children what is being surgically proposed and why;

-Always consult with children about their response;

-Where possible, take the child's views into account and note that even young children can be competent to consent to treatment provided that they too can understand, remember, deliberate about and believe information relevant to their clinical condition.

When such competence is present, under English law [14], children can provide their own consent to surgical care, although they cannot unconditionally refuse it until they are 18 years old. With the exception of the latter, these provisions illustrate the importance of respecting as much autonomy as is present among child patients and remembering that, for the purposes of consent to medical treatment, they may be just as autonomous as adults.

If competence is severely compromised by psychiatric illness or mental handicap, other moral and legal provisions hold. If patients lack the autonomy to choose how to protect themselves as regards the consequences of their illness, then others charged with protecting them must assume the responsibility. Yet care must be taken not to abuse this duty. Even when such patients have been legally detained for compulsory psychiatric care, it does not follow that such patients are unable to provide consent for surgical care.

Their competence should be assumed and consent should be sought. If it is established with the help of their careers that such patients are also incompetent to provide consent for surgery and that they are at risk of death or serious and permanent disability, then therapy can proceed in their best interests. However, if treatment can be postponed, then this should be done until, as a result of their psychiatric care, patients become able either to consent or to refuse. As with children, respect should always be shown for as much autonomy as is present. If, for whatever clinical reason, adult patients are permanently incompetent to consent to surgery, therapy can again proceed if it is necessary to save life, to prevent serious and permanent injury or, more electively, to alleviate discomfort and optimise care. The only exception is, again, when the patient has already formulated a legally valid advance decision refusing the specific treatments on offer and someone has been appropriately appointed by the patient as having appropriate power of lasting attorney (or possesses such power for any other judicial reason).

Otherwise, it is always a futile exercise to ask the relatives of incompetent patients to sign consent forms for surgery on adults who cannot do so for themselves. Indeed, to make such requests can be a disservice to relatives, who may feel an unjustified sense of responsibility if the surgery fails. This said, relatives should be treated

With politeness and consulted about issues that pertain to determining the best interests of patients [15].

Matters of Life and Death

It has been noted that the right of a competent adult to consent to and refuse treatment is unlimited, including the refusal of life sustaining treatment. Probably the example of this most familiar to surgeons is Jehovah's Witnesses, who refuse blood transfusions at the risk of their own lives [16]. There can be no more dramatic example of the potential tension between the duties of care to protect life and health and to respect autonomy. The tension does not stop here, however. For there will be some circumstances in which the protection of the life and health of patients is judged to be inappropriate; in which they are no longer able to be consulted; and in which they have not expressed a view about what their wishes would be in such circumstances.

Here, if possible after discussion and consensus with the next of kin, a decision may be made to withhold or to withdraw life sustaining treatment on behalf of the incompetent patient. The fact that such decisions can be seen as omissions to act does not excuse surgeons from morally and legally having to reconcile them with their ordinary duty of care. Ultimately, this can only be done through arguing that such omissions to sustain life are in the patient's best interests.

The determination of best interests in these circumstances will rely on one of three objective criteria, over and above the subjective perception by the surgeon that the quality of life of the patient is poor. There is no obligation to provide or to continue life-sustaining treatment;

-If doing so is futile – when clinical consensus dictates that it will not achieve the goal of extending life. Thought of in this way, judgments about futility should not be linked to evaluations of a patient's quality of life and thus can be difficult to justify as long as treatment might stand even a very small chance of success.

-If patients are imminently and irreversibly close to death – in such circumstances, it would not be in the patient's best interests to prolong life slightly (e.g. through the application of intensive care) [17]. When again, there is no hope of any sustained success. Not needlessly interfering with the process of a dignified death can be just as caring as the provision of curative therapy.

-If patients are so permanently and seriously brain damaged that, lacking awareness of themselves or others, they will never be able to engage in any form of self-directed activity. The argument here is backed up by morally and legally reasoning that further treatment other than effective palliation cannot be in the best interests of patients as it will provide them with no benefit.

When any of these principles are employed to justify an omission to provide or to continue life-sustaining treatment, the circumstances should be carefully recorded in the patient's medical record, along with a note of another senior clinician's agreement. Finally, surgeons will sometimes find themselves in charge of the palliative care of patients whose pain is increasingly difficult to control. There may come a point in the management of such pain when effective palliation is possible at the risk of life because of the respiratory effects of the palliative drugs [18]. In such circumstances, surgeons can with legal justification administer a dose that might be dangerous.

Although experts in palliative care are skeptical that this is very necessary with appropriate training. In any case, the argument employed to justify such action refers to its 'double effect': that both the relief of pain and death might follow from such an action. As intentional killing (active euthanasia) is rejected as professional and legal medical practice throughout most of the world, a potentially lethal dose is regarded as appropriate only when it is motivated by palliative intent and this motivation can be documented.

Care at the End of Life

The process of dying and the care of a patient at the time of death is a distinct clinical entity that demands specific skills from physicians. The issues specific to dying and the available tools for compassionate care at the end of life are addressed in this section.

The Syndrome of Imminent Demise in a patient who has progressed to the terminal stage of an advanced illness (e.g., cancer), a number of signs provides evidence of imminent death. As terminally ill patients progress toward death, they become increasingly bedbound, requiring assistance for all basic ADL. There is a steady decrease in desire and requests for food and fluids. More distressing to the dying patient is a progressively dry mouth that may be confused by the treating team as thirst. It is often exacerbated by anticholinergic medications, mouth breathing, and supplemental oxygen (O2) administered without humidification with progressive debility, fatigue, and weight loss, it is common for terminally ill patients to experience increasing difficulty swallowing. This may result in aspiration episodes and an inability to swallow tablets, requiring alternative routes for medication administration (e.g., IV, SC, PR, sublingual, buccal, or transdermal) [19].

In addition to the increased risk of aspiration, patients near death develop great difficulty clearing oropharyngeal and upper airway secretions, leading to noisy breathing or the so-called "death rattle." As death approaches, the respiratory pattern may change to increasingly frequent periods of apnea often following a Cheyne-Stokes pattern of rapid, progressively longer breaths leading up to an apneic period. As circulatory instability develops near death, patients may exhibit cool and mottled extremities. Periods of confusion are often accompanied by decreasing urine output and episodes of fecal and urinary incontinence [20].

A number of cognitive changes occur as death approaches. Patients who are in the last days of life may demonstrate some signs of confusion or delirium. Agitated delirium is a prominent feature of a difficult death. Other cognitive changes that may be seen include a decreased interest in social interactions, increased somnolence, reduced attention span, disorientation to time (often with altered sleep-wake cycles), and an altered dream life, including vivid "waking dreams" or visual hallucinations. Reduced hearing and visual acuity may be an issue for some patients; however, patients who appear comatose may still be aware of their surroundings. Severely cachectic patients may lose the ability to keep their eyes closed during sleep because of loss of the retro-orbital fat pad [21].

Pronouncing Death

If the body is hypothermic or has been hypothermic, such as a drowning victim pulled from the water in the winter, the physician

should not declare death until warming attempts have been made. In the hospital, hospice, or home setting, the declaration of death becomes part of the medical or legal record of the event [22]. There are a number of physical signs of death a physician should look for in confirming the patient's demise:

Complete lack of responsiveness to verbal or tactile stimuli, absence of heart beat and respirations, fixed pupils, skin color change to a waxen hue as blood settles, gradual poikilothermia, and sphincter relaxation with loss of urine and feces. For deaths in the home with patients who have been enrolled in hospice, the hospice nurse on call should be contacted immediately. In some states, deaths at home may require a brief police investigation and report. For deaths in the hospital, the family must be notified (in person, if possible). A coroner or medical examiner may need to be contacted under specific circumstances (e.g., deaths in the operating room), but most deaths do not require their services. However, the pronouncing physician will need to complete a death certificate according to local regulations. Survivors may also be approached, if appropriate, regarding potential autopsy and organ donation. Finally, it is important to accommodate religious rituals that may be important to the dying patient or the family. Bereavement is the experience of loss by death of a person to whom one is attached. Mourning is the process of adapting to such a loss in the thoughts, feelings, and behaviors that one experiences after the loss [23].

Although grief and mourning are accentuated in the immediate period around death, it is important to note that patients and families may begin the process of bereavement well before the time of death as patients and families grieve incremental losses of independence, vitality, and control. In addition to the surviving loved ones, it is important to acknowledge that caregivers also experience grief for the loss of their patients.

Confidentiality

Respect for autonomy does not entail only the right of competent patients to consent to treatment. Their entitlement to exercise control over their life and future corresponds to the duty of surgeons to respect their privacy – not to communicate information revealed in the course of treatment to anyone else without consent. Generally speaking, such respect means that surgeons must not discuss clinical matters with relatives, friends, employers and others unless the patient explicitly agrees. To do otherwise is regarded by all the regulatory bodies of medicine and surgery as a grave offence, incurring harsh penalties. For breaches of confidentiality are not only abuses of human dignity; they again undermine the trust between surgeon and patient on which successful surgery and the professional reputations of surgeons depend

Important as respect for confidentiality is, however, it is not absolute. Surgeons are allowed to communicate private information to other professionals who are part of the health-care team – provided that the information has a direct bearing on treatment. Here, the argument is that patients have given their implied consent to such communication when they explicitly consent to a treatment plan. Certainly, patients cannot expect strict adherence to the principle of confidentiality if it poses a serious threat to the health and safety of others. There will be some circumstances in which confidentiality either must or may be breached in the public interest. For example, it must be breached as a result of court orders or in relation to the requirements of public health legislation. It may be ignored in attempts to prevent serious crime or to protect the safety of other known individuals who are at risk of serious harm [24-27].

Research

As part of their duty to protect life and health to an acceptable professional standard, surgeons have a subsidiary responsibility to strive to improve operative techniques through research, to assure themselves and their patients that the care proposed is the best that is currently possible. Yet, there is moral tension between the duty to act in the best interests of individual patients and the duty to improve surgical standards through exposing patients to the unknown risks that any form of research inevitably entails [28]. The willingness to expose patients to such risks may be further increased by the professional and academic pressures on many surgeons to maintain a high research profile in their work. For this reason, surgeons (and physicians, who face the same dilemmas) now accept that their research must be externally regulated to ensure that patients give their informed consent, that any known risks to patients are far outweighed by the potential benefits, and that other forms of protection for the patient are in place (e.g. proper indemnity) in case they are unexpectedly harmed. The administration of such regulation is through research ethics committees, and surgeons should not participate in research that has not been approved by such bodies. Equally, special provisions will apply to research involving incompetent patients who cannot provide consent to participate and research ethics committees will evaluate specific proposals with great care

In practice, it is not always clear what is to count as surgical research that should be subjected to regulation and what constitutes a minor innovation dictated by the contingencies of a particular clinical situation. Surgeons must always ask themselves in such circumstances whether or not the innovation in question falls within the boundaries of standard procedures in which they are trained. If so, what may be a new technique for them will count not as research but as an incremental improvement in personal practice. Yet, if the improvement is to be thought of in this way, no conclusions can be drawn from it to alterations in standard practice or to an evaluation of their efficacy. Equally, there will be no consequences for surgical training, as the innovation in question should only have been attempted against the background of the already existing training and experience of the surgeon in question. If a proposed innovation exceeds these conditions, then it does count as research and should be approved by a research ethics committee. Such surgical research should also be subject to a clinical trial designed to ensure that findings about outcomes are systematically compared with the best available treatment and that favorable results are not the result of arbitrary factors (e.g. unusual surgical skill among researchers) that cannot be replicated.

Case Studies

The death of a patient who was operated upon by a Japanese surgeon as part of a live surgery workshop at the All India Institute of Medical Sciences (AIIMS) in Delhi has rekindled a debate on the ethics of organizing such workshops and the rights of patients on whom the procedures are carried out.

At the workshop on July 31,2015 part of the 23rd annual conference of the Indian National Association for Study of the Liver, hosted jointly by AIIMS and the Army Research & Referral Hospital, New Delhi, over a hundred surgeons watched as Dr Goro Honda, from Japan's Tokyo Metropolitan Cancer and Infectious Diseases Center, performed a laparoscopic liver resection at AIIMS. He was

assisted by an Indian team led by DrSujoy Pal, an associate professor in the gastrointestinal surgery department of AIIMS [27].

Laparoscopic liver resection involves the removal of the liver or a portion of it through three or four keyhole-sized incisions in the stomach.

The surgery, which started at 9am, was being broadcast live to a hall full of surgeons. Honda's patient was 62-year-old Shobha Ram — a labourer who had developed liver cirrhosis after a hepatitis B infection. Ram was transferred to AIIMS from GB Pant Hospital which has a reputed GI surgery facility headed by Dr Anil Agarwal. Sometime into the procedure, massive bleeding occurred and surgeons struggled to stanch the flow of blood.

Despite suggestions that the team resort to an open surgery, Honda continued with the laparoscopic technique, relenting only after seven hours of surgery. The live video feed to the audience was terminated and the patient shifted to the intensive care unit, where he died 90 minutes later.

Live surgery demonstrations have raised questions about the propriety of exposing a patient to a situation where the operating surgeons are intent on showcasing their skills live before an audience. In the United States, after the death of a patient in a similar workshop in 2006, some medical bodies have banned such operations.

This incident at AIIMS has only added to the controversy. Questions are now being raised about the ethical and procedural aspects of the fatal workshop. Did the organizers take permission from the Medical Council of India (MCI) to allow a foreigner to conduct surgery? Could Ram have been saved if the surgeon had not insisted on continuing with the laparoscopic technique despite the bleeding? Was a post-mortem audit of the laparoscopic procedure carried out?

Many questions relate to the pre-surgery diligence. Was Ram's assent sought to have him subjected to a demonstrative procedure carried out by a foreign surgeon and assisted by a team with little or no experience in the technique? (It is now learnt that given the inexperience of the AIIMS GI surgery department in laparoscopic liver resection, it would have been more prudent to have assembled an experienced team from outside the hospital for the workshop.)

Was the patient selection process done meticulously? Was laparoscopic resection the most suitable procedure for treating Ram's condition or did the need to find a patient for the workshop override patient interest?

When contacted, DrPeushSahni, head of the AIIMS GI surgery department, said that Ram's attending doctors had carried out a detailed preoperative assessment to ascertain the feasibility of removing the tumour surgically. Sahni said haemorrhage is a known complication of the procedure and that the mortality rate globally of laparoscopic resection in patients with cirrhosis is 5-10%. However, a questionnaire on the incident emailed to him remained unanswered. And until questions are asked and answered, perhaps the debate on live surgeries will only get more heated [25].

Maintaining Standards of Excellence

To optimize success in protecting life and health to an acceptable standard, surgeons must only offer specialized treatment in which they have been properly trained. To do so will entail sustained further education throughout a surgeon's career in the wake of new surgical procedures. While training, surgery should be practised only under appropriate supervision by someone who has appropriate levels of skill. Such skill can be demonstrated only through appropriate clinical audit, to which all surgeons should regularly submit their results. When these reveal unacceptable levels of success, no further surgical work of that kind should continue unless further training is undergone under the supervision of someone whose success rates are satisfactory. To do otherwise would be to place the interest of the surgeon above that of their patient, an imbalance that is never morally or professionally appropriate.

Surgeons also have a duty to monitor the performance of their colleagues. To know that a fellow surgeon is exposing patients to unacceptable levels of potential harm and to do nothing about it is to incur partial responsibility for such harm when it occurs [26].

Surgical teams and the institutions in which they function should have clear protocols for exposing unacceptable professional performance and helping colleagues to understand the danger to which they may expose patients. If necessary, offending surgeons must be stopped from practicing until they can undergo further appropriate training and counseling. Too often, such danger has had to be reported by individuals whose anxieties have not been properly heeded and who have been professionally pilloried rather than congratulated for their pains. Surgeons and anyone else discovered to have been participating in such 'cover up' and ostracism should share the blame and punishment for any resulting harm to patients.

Conclusion

The two general duties of surgical care are to protect life and health and to respect autonomy, both to an acceptable professional standard. The specific duties of surgeons are shown to follow from these: acceptable practice concerning informed consent, confidentiality, decisions not to provide, or to omit, life-sustaining care, surgical research and the maintenance of good professional standards. The final duty of surgical care is to exercise all these general and specific responsibilities with fairness and justice, and without arbitrary prejudice.

The conduct of ethical surgery illustrates good citizenship, protecting the vulnerable and respecting human dignity and equality. To the extent that the practice of individual surgeons is a reflection of such sustained conduct, they deserve the civil respect which they often receive. To the extent that it is not, they should not practice the honorable profession of surgery.

According to fundamental code of ethics, always consider first the well-being of the patient. The patient being treated at the time must be the physician's primary concern. Informed consent includes adequate information about the details of procedure, associated risks, benefits, and alternatives before any surgery. Performing unnecessary surgery violates rules of fundamental code of ethics. It may be a basis for malpractice in routine practices. However, it may be difficult to prove which cases are unnecessary.

In another hand "You cannot learn to play the piano by going to concerts." This favorite quotation is a not-so-subtle reference to the fact that young surgeons must carry out operations personally and under their own responsibility to learn this wonderful clinical art and manual skill. For this important learning experience to occur without jeopardy to the patient, certain key requirements should be met.

References

1. Beauchamp TL, Childress JF (1989) Principles of Biomedical Ethics. (3rd editon), Oxford University Press, New York.
2. Dharamsi S (2006) Building moral communities? First, do no harm. J Dent Edu 70: 1235-1240.
3. Schneider C, Schneider D (1999) The Practice of Autonomy: Patients, Doctors, and Medical Decisions.New York, Oxford University Press.
4. Codes of Ethics (1999) Some History Center for the Study of Ethics in the Professions at IIT Archived.
5. Berlant, Jeffrey (1975) The Professions and Their Prospects. American Sociological Association.
6. Percival, Thomas (1849) Medical ethics, John Henry Parker, Oxford Dictionary of National Biography.
7. Walters L (2004) The Birth of Bioethics.
8. Faden RR, Beauchamp TL (1988) A History and Theory of Informed Consent. The University of Chicago press.
9. Bernat JL, Peterson LM (2006) Patient-centered informed consent in surgical practice. Archives of Surgery 141:86.
10. Guadagnoli E, Soumerai SB, Gurwitz JH (2006) Improving discussion of surgical treatment options for patients with breast cancer 61:171-175.
11. Article 116 of the Russian Criminal Code(2015)Some Aspects of Criminal Responsibility for Cumulative Crime under Article 117 and other Articles of Criminal Code of the Russian Federation. Russian Justice.
12. Courtney MJ (2001) Information about surgery. What does the public want to know? ANZ J Surgery 71: 24-26.
13. Sulmasy DP, Lehmann LS, Levine DM, Faden RR (1994) Patients' perceptions of the quality of informed consent for common medical procedures. J Clinic Ethics 5: 189-194.
14. McK NK (1991) the Age of Legal Capacity (Scotland) Act 1991. J Law Society of Scotland 36: 434-439.
15. McCullough LB, Jones JW, Brody BA (1998) surgical ethics. Oxford University Press USA.
16. Packer JI (2008) Evangelism and the Sovereignty of God. InterVarsity Press.
17. Curtis JR, Rubenfeld GD (2001) Managing death in the intensive care unit. The transition from cure to comfort. Oxford University Press.
18. Dunn GP (2012) Surgical palliative care. Recent trends and developments. Anesthesiol Clin 30: 13-28.
19. Saunders CM (1976) The challenge of terminal care. Scientific Foundations of Oncology. London, England. Heinemann 85: 673-679.
20. Nuland SB (1995) how we die. Reflections on life's final chapter. Vintage.
21. Byock IR, Merriman MP (1998) Measuring quality of life for patients with terminal illness: the MissoulaVITAS quality of life index. Palliative Medicine 12: 231-244.
22. Kübler Ross E (2011) Questions and Answers on Death and Dying: a companion volume to on death and dying. Simon and Schuster.
23. Twycross R (2004) Anorexia, cachexia, nausea and vomiting Medicine32: 9-13.
24. Emanuel EJ, Wendler D, Grady C (2000) what makes clinical research ethical? JAMA 283: 2701-2711.
25. Platt MP, Grundfast KM (Eds-2) (2016) Scary Cases in Otolaryngology. Plural Publishing.
26. McKneally MF, Daar AS (2003) Introducing new technologies: protecting subjects of surgical innovation and research. World J surgery 27: 930-934.
27. Gillon R (1994) Medical ethics, four principles plus attention to scope. BMJ 309: 184-188.
28. Moore F D (1959) Metabolic care of the surgical patient. WB Saunders.