We commend insightful comments offered by our respected reviewers to our view-point manuscript entitled "CHATTISGARH TRAGEDY: A MIRROR TO OUTCOME-BASED APPRAOCH TO COMMUNITY SURGERY CAMPS!". We have outlined and listed each of the comments (please see below) put forth by our reviewers (2 Nos.); and responded to them keeping in view our central contention, namely, Surgical Healthcare delivery system in community surgery camps settings and the surgical outcome ethical imperatives to improve the whole system to benefit the patients.

**Dutta Surgical outcomes in camps**

**Response to Comments of Reviewer 1:**

|  |  |  |
| --- | --- | --- |
|  | **Review comments** | **Authors’responses** |
| **1.** | The authors have presented a very good comment on the ethics of surgery camps and have drawn out important ethical implications for improving the outcomes of such camps. The presentation of the arguments is coherent. | **Thank you for your encouraging remarks on the relevance and importance of the issues affecting current day Govt. backed community surgery camps** |
| **2.** | I would like to know the thoughts of the authors on justice implications of the interventions suggested by the authors. Would the interventions deny free access to surgery to the masses? I am not justifying the poor-quality surgeries in the name of providing access. But how do the authors propose to strike a balance between taking the surgical treatment to remote corners of the country and at the same time ensuring quality? | **The primary contention of the authors through this viewpoint manuscript is to identify the whole surgical healthcare delivery continuum and its translatability in community surgery camp scenario, which are designed and programmed to provide surgical healthcare access to the needy poor in far-flung areas of the country. The aim of pointing out the grave issues in the systems is not to shoot down the option of access but to highlight what actually ails the system; and how improving on veritable surgery outcome assessment and reporting is likely to attract enhancement of care and improve diligence in functionality of the SHCD at community surgery camp settings.** |
| **3.** | The area of rural surgery is emerging globally in resource poor regions. Many rural surgeons have innovated with minimal resources and available technology to take high quality surgery to remote areas. How do the authors view this? A brief note on this and the issues of regulating innovations in remote resource poor areas would add value to this comment. | **I fully agree with this comment. Many a rural surgeons (both private and Govt. employed) continue to contribute to the cause of surgery access to the poor people, especially in the rural settings. Either they resort to simple 'open surgery' or if backed by CSR or advertorial initiatives of private institutions; they do take innovative technology (e.g. laparoscopic abdominal procedures; laser interventions of eye.) at the door-steps of the patients in resource poor settings.**  **Although we have touched this point in our revised manuscript as to how some Institutions are taking this forward for the rural poor; and how it can be included into the CSR initiatives of the corporate healthcare Institutions; we did not elaborate further in order to stay on course with the central themes of the comment, namely SCHD and Surgical outcome.** |

|  |  |
| --- | --- |
| 4. Is there a role for operations research / implementation research in Surgical Health Care Delivery? Is there an ethical imperative to conduct this? | **Definitely, there is a role for operation research in the area of Surgical Health Care Delivery; first to apprise the practicing surgeons of the exact expanse of healthcare they sub serve; second, how they need to look back on their work; and finally what to audit, and what to disseminate to others.**  **The overriding ethical imperatives can be: how to ground principle of beneficence, how to identify potential area of maleficence and mitigate them beforehand, and importantly, how to hoist the 'justice' component of community surgery camps to the highest without undermining patient’s autonomy, privacy, and confidentiality.** |

**Response to Comments of Reviewer 2:**

|  |  |  |
| --- | --- | --- |
| **1.** | This is a substantial comment and relevant to medical ethics. | **Thank you for your supporting comment** |
| **2** | It could influence practice and policy. | **Yes, I agree. This document could be a progenitor to policy changes, especially regarding safe practices in community surgery camps in the resource poor settings** |
| **3.** | The interpretation is warranted but needs to be developed. | **As per the reviewer's comments, we have expanded the content to improve clarity.** |
| **4.** | Jargon and flowery English usage detract from explaining to the reader the main ethical concerns. This should be modified | **Where ever possible, difficult to follow language has replaced to the best of our knowledge.** |
| **5.** | Detailed comments have been inserted into the text. | **Detailed Response and modification of the manuscript is undertaken in respect to the suggested comments inserted into the manuscript (Nos. 14).**  **Please see under the headings, Additional response to comments of the Reviewer 2** |

**Response to Additional Comments of Reviewer 2**

**(as Inserted into manuscript text)**

**Response to comment # [M 1]:** Agreed. ‘Mass’ surgery is now replaced with ‘community’ surgery camps.

**Response to comment # [M 2]:** While we agree fully to the comment, the Chhattisgarh tragedy was made ‘case-in-point’ not only because of the gravity of the mishap or the repercussions thereafter, but also: *One*, the surgery performed in the surgery camp, i.e. female sterilization by tubectomy under general anaesthesia (GA); involved and represented the complete range of surgery healthcare continuum (including, pre-operative evaluation→preparation→anaesthesia administration →tubectomy→post-operative recovery room care) and had a definitive expected surgical outcome in terms of uncomplicated recovery and successful sterilization.

*Two*, we discussed the relevant issues (ethical) and wider implications (surgical outcome) related to the conduct of surgery procedures in camp settings. Therefore, historical wrong-n-misses and policy matter notwithstanding, we focused specifically on highlighting the ethical issues and how addressing would bring clarity to the whole SHCD process and improve the job-at- hand (safe surgery→good outcome) in community surgery camp sites.

*Three*, though few other surgery camp mishaps occurred after the Chhattisgarh tragedy; none reflected the issues with greater suffering of the beneficiaries. Mishaps in eye surgery camps per se do not involve full SHCD, i.e, it is short and quick surgery under local anaesthesia, doesn’t require sustained post-operative care, and the surgery outcome can be assessed as early as a day after.

**Response to comment # [M 3]:** The sentences pointed out are now simplified for easy comprehension.

The ability to foresee and prevent post-surgery morbidity in a standardized OR is difficult to translate in community surgery camp settings. The reasons could be unfavorable/non- standardized environment (infrastructure issues, human resource deficiency) outside the OR hampering adequate pre-surgery patients preparation and comprehensive post-operative care or difficulty in identifying anticipating and articulating a team response to emergent problem en-course of the SHCD process. Therefore, felt depreciation of the adequate SHCD in community surgery settings makes it difficult to review and adjudicate surgical success based on merely achieving surgical procedure end-points. Rather, it’s the immediate patient outcome and final (long-term) surgical outcome that defines successful surgery.

**Response to comment # [M 4]:** We completely agree and endorse Reviewers opinion on this section. In order to serve our aim to propose the general and ethical issue riveting around the SHCD process of surgery in community surgery camps wherein a large number of surgery takes place in a very short duration (as rightly exemplified by you in cleft lip-palate surgeries Operation Smile Train centre and eye surgery in Arvind Eye Centre); we focused selectively on processes and care issues as a very relevant suggestion of the reviewer, the opening paragraph of this section is modified and expanded to bring greater clarity and connect.

***In Arvind Eye institute and Smile Train International are excellent proponents of mass surgery access to the very poor; have been able to sustain their successful run because of the absence of intent to advertise, endorse and disseminate. In their systems, each and every beneficiary patient becomes a champion in spreading the good work. On the contrary, the community surgery settings, the unnecessary premature media hype shifts the focus from the surgical contention such that it instills false confidence in operating surgeons and emboldens them to surgical adventurism.***

**Response to comment # [M 5]:** The incomplete sentence, which was an error due to wrong punctuation placement has been corrected now.

**Response to comment # [M 6]:** as per the reviewer’s suggestion: the essence of the paragraph is now moved to the ‘introductory’ section.

**Response to comment # [M 7]:** as per the suggestion the paragraph is now rewritten to enhance flow and comprehension.

**Response to comment # [M 8]:** ‘Complete internal healing’ means ‘internal tissue healing’ after surgical handling of the organ or tissues. (In this case the Fallopian tubes, peritoneal cavity)

**Response to comment # [M 9]:** Yes, I agree with the reviewer. Therefore, rather than representing whole SOP to cover a gap where SOP was virtually non-existent , we have presented salient features of what future SOP for surgical camps must contain (including but not limited to).

**Response to comment # [M 10]:** The suggestion to expand section with the adverse impact following Chhattisgarh mishap is not being undertaken to stay in focus of SHCD contention and how the final patient outcome is the key to preventing future catastrophe in mass community surgery camps.

**Response to comment # [M 11]:** Yes, in a resource constrained Government camp setting? The sentence has now been modified to add clarity.

**Response to comment # [M 12]:** In the key messages section we are proposing suggestive recommendation for considering ‘to-do’ or ‘not-to-do’ list. It is bound to be somewhat harsh, especially with delineating ‘what not-to-do.’ No changes are offered in respect key messages section.

**Response to comment # [M 13]:** We deliberately kept the key-messages section succinct and pertinent to convey the message directly. Therefore, any elaboration of the point would dilute the matter and veer the matter away from the central contention, i.e. the ethical imperative around SHCD in surgery camps to ‘policy-governance administrative implications’

**Response to comment # [M 14]:** The link is completed and now is getting actuated on clicking.