Occasional viewpoint

Video education and evidence in endoscopy

The need to document clinical activities has become a well recognised part of everyday medical practice. Careful clinical notes which record all interactions with patients are now the standard rather than the exception. Such notes will document patients' opinions, the results of investigations and treatment plans. With every significant advance in medical technology, we have seen the inclusion in notes of electrocardiograms, still photographs from echocardiograms and of course the results of many haematological and biochemical tests.

Doctors are encouraged to record any conversations about disease and prognosis with patients or their relatives and whether educational material has been given. In parallel with these developments, radiology departments have become concerned about the need for long term storage of vast quantities of information in an easily retrievable and concise format. It is consequently with some surprise that we find endoscopy records continue to be handwritten reports or computer printed summaries made by endoscopists. The advent of the video endoscope and the ease with which a permanent record can be made throws into question such an approach. Apart from providing a visual record of a procedure, it could be used to monitor the progress of a disease or the effect of treatment.

The use of video records in endoscopy has a number of potential advantages. The first would be for improving clinical practice and patient care. A video would allow a record of unusual endoscopic lesions to be made for later discussion and peer review. Such videos would be of particular value when deciding on the most appropriate management of difficult problems. Although photographs of pathology are helpful, a video puts the lesion into an anatomical perspective within its surroundings. Surgeons find such recordings helpful for planning the most appropriate procedure or operation, particularly when they have not conducted the endoscopy themselves. An example would be in deciding whether a large colonic polyp should be removed endoscopically or surgically. Surgeons would also benefit by having the facility to assess cancers prior to operation.

The second benefit would be to junior doctors' education and for monitoring the progress of trainees, including nurse practitioners. An on-going visual record of a trainee's performance has many advantages over the present log book system. The trainer can review on a weekly basis an individual's performance and identify areas of difficulty and concentrate subsequent training on those areas where skills are deficient. There is clearly a place for increasing independent practice by postgraduate students during their training years and the use of video records would ease the transition from supervised to totally independent practice. However, we all need our clinical activity to be monitored and the video record will permit peer review of endoscopic procedure by specialists in the field. Such peer review would provide evidence of continuing medical education and of on going audit of clinical practice.

Apart from their value in the training of medical students and junior doctors, a third potential use of endoscopy videos is in patient education and this is yet to be explored in any detail.

The reassurance of a normal procedure may reduce anxiety about cancer. We have good evidence that many endoscopies in younger people are done specifically because of anxiety about the underlying cause of symptoms. The visual image is the culture of the late 20th century and there is some hope that educational information imparted by videos is as effective as the written word. Indeed, there is increasing anecdotal evidence that it is more acceptable to patients than written information.

Of course there is an obvious disadvantage to recording the events of endoscopy. Once such an approach has been initiated it becomes impossible to go back to a less complete format of recording clinical activities. The introduction of video records will open up the possibility of litigation and professional comment on cases where something went wrong. There is the compensatory view that an adequate endoscopic investigation would protect endoscopists who are being criticised for their technique. When using videos to comment on individual endoscopies in specific cases, especially in the legal setting, it is important to comply with the Bolam Test which requires that the standard is that "of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill . . .".[1] The recording should satisfy the average rather than best practice and so comply with the Bolam Test. Only then should an expert truly criticise deficiencies in technique. If videos are being used to monitor training of individuals, then this should be done by review of many procedures and not of just a few endoscopies.

Although video recording could lead to problems, we believe that the standard of patient care and practitioner care will be increased by its use.

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1 Bolam *v* Friern Hospital Management Committee [1957] 2 All ER 118.