



HAL
open science

What Is a Good Teaching Video? Results of an Online International Survey

Pauline Chauvet, Revaz Botchorishvili, Sandra Curinier, Anne-Sophie Gremeau, Sandrine Campagne-Loiseau, Céline Houlle, Michel Canis, Benoit Rabischong, Nicolas Bourdel

► **To cite this version:**

Pauline Chauvet, Revaz Botchorishvili, Sandra Curinier, Anne-Sophie Gremeau, Sandrine Campagne-Loiseau, et al.. What Is a Good Teaching Video? Results of an Online International Survey. *Journal of Minimally Invasive Gynecology*, 2020, 27, pp.738 - 747. 10.1016/j.jmig.2019.05.023 . hal-03489982

HAL Id: hal-03489982

<https://hal.science/hal-03489982v1>

Submitted on 22 Aug 2022

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.



Distributed under a Creative Commons Attribution - NonCommercial 4.0 International License

Title: **What is a good teaching video ? Results of an online international survey**

Author names and affiliations

Pauline CHAUVET, M.D ^{1,2}, Revaz BOTCHORISHVILI, M.D ¹, Sandra CURINIER, M.D¹,
Anne-Sophie GREMEAU, M.D¹ , Sandrine CAMPAGNE-LOISEAU, M.D ¹,
Céline HOULLE, M.D¹, Michel CANIS M.D Ph.D^{1,2}, Benoit RABISCHONG M.D Ph.D¹,
Nicolas BOURDEL M.D Ph.D ^{1,2}

⁽¹⁾ Department of Gynaecological Surgery, Clermont-Ferrand University Hospital Estaing,
place Lucie & Raymond Aubrac, Clermont-Ferrand, France

⁽²⁾ Faculty of Medecine, ISIT-University of Auvergne, place Henri Dunant, Clermont-Ferrand,
France

Corresponding author: Pauline CHAUVET pchauvet@chu-clermontferrand.fr

+33473755044 Department of Gynaecological Surgery, Clermont-Ferrand University
Hospital Estaing, place Lucie & Raymond Aubrac, Clermont-Ferrand, France

Disclosures: The authors have no conflicts of interest to disclose.

Précis: To optimize surgical teaching, the standardization, updating and ease-of-access of
surgical teaching videos should be promoted.

IRB approval was not required

1 **Abstract**

2 **Study Objective:** To analyze surgeon views on criteria for a good teaching video, with the
3 aim of determining guidelines.

4 **Design:** Online international survey, using a self-developped questionnaire

5 **Setting:** a French universitary tertiary care hospital

6 **Patients:** 388 participants answered an online questionnaire, with 154 women (40,53%) and
7 226 men (59,47%).

8 **Interventions:** A questionnaire on the criteria for a good quality teaching surgery video was
9 developed by our team and communicated via an online link.

10 **Measurements and Main Results:** The responses of 388 respondents were analyzed and
11 highlighted the pedagogical benefits of teaching videos. Video duration may vary according
12 to the type of media or surgical procedure but should not exceed 10 to 15 minutes for
13 complex procedures. Providing information on surgical set-up (BMI of the patient,
14 Trendelenbourg position degree, pressure of pneumoperitoneum...) is essential. Surgical
15 videos should be reviewed and divided into clearly defined steps, with continued access to
16 the entire non-modified video for reviewers, and be accessible on both educational and open
17 platforms. Patient consent and relevant information should be made available. Reviews
18 should include "bad procedure" videos which are highly appreciated, especially by young
19 surgeons.

20 **Conclusion**

21 The many advantages of the video format, including availability and rising popularity, provide
22 an opportunity to reinforce and complement current surgical teaching. To optimize use of this
23 surgical teaching tool, standardization, updating and ease-of-access of surgical videos
24 should be promoted.

25

26

27 **Keywords :** gynaecological surgery, teaching, surgical videos.

28 **Introduction**

29 Surgical education is a long learning process. Video is one of the most effective tools for
30 surgical learning (1,2) but current concerns over the technical quality of educational surgical
31 videos warrant further investigation. Inadequate technical quality and limited accessibility on
32 internet security of available online videos may create difficulties when using these videos in
33 a teaching context and potentially lead to serious errors regarding decision making and
34 safety.

35 While quality criteria are well defined for scientific publications, few objective criteria exist for
36 surgical videos, frequently made available by scientific journals or through websites such as
37 Youtube, Vimeo and Daily Motion. Even if there are available websites such Surgery U or
38 WebSurg, that have guidelines of publication/presentation, and that the scientific meetings in
39 minimally invasive surgery have video abstracts with guidelines to assess a surgical video, it
40 has been shown that YouTube remains the current preferred educational video resource for
41 surgical preparation (3), and that available surgical videos on open platforms may fail to
42 provide sufficient content or quality (4).

43 The objective of this study was to analyze surgeon views on criteria for a good teaching
44 video, with the aim of determining guidelines.

45

46 **Materials and methods**

47 **The questionnaire**

48 Due to the absence of relevant validated questionnaires, two gynecologist surgeons on our
49 team designed a questionnaire.

50 Question types included scaled response and open-ended questions and focused on
51 demographic data (age and experience in surgery, nationality, type of hospital), and the
52 *supposed quality criteria* of a teaching surgery video.

53 The questionnaire was first pilot-tested by the main investigator and supervisors, and
54 underwent revision before being made available via a REDCap platform online link .
55 REDCap (Research Electronic Data Capture) is a secure, web-based application designed to
56 support data capture for research studies (5) (**Figure 1**). REDCap (Research Electronic Data
57 Capture) is a secure, web-based application designed to support data capture for research
58 studies, providing: 1) an intuitive interface for validated data entry; 2) audit trails for tracking
59 data manipulation and export procedures; 3) automated export procedures for seamless data
60 downloads to common statistical packages; and 4) procedures for importing data from
61 external sources.

62

63 **Participants**

64 Following permission from the scientific committees of the following societies ESGE
65 (European Society for Gynaecological Endoscopy), AAGL (American Association of
66 Gynecologic Laparoscopists), and APAGE (Asia-Pacific association for
67 gynecologic endoscopic surgeons), the questionnaire was distributed via multiple mails to
68 participants, members of these three societies.

69 Participants were invited to participate by email and asked to submit their responses online,
70 via the REDCap platform. This online study was conducted between 1st February and 18th
71 March 2018 with data collected and managed using REDCap electronic data capture tools
72 hosted at Clermont-Ferrand University Hospital.

73 **Open comments**

74 Concerning “bad procedure” videos, respondents were first asked if there should be more
75 “How not to do” or “what should not be done” videos, and then given the opportunity to
76 comment. Comment analysis involved several phases, that can be synthesized in: (1) data
77 consultation, (2) systematic coding and categorization of data by theme, and (3)

78 interpretation of findings. The analysis was carried out according to the guidelines proposed
79 by Braun and Clarke (6). Detailed consultation of the comments, led to sorting by topic or
80 theme. Thematic analysis led to the identification of 4 different themes, following a similar
81 methodology to that of other open comments studies (7).

82 **Statistical Analysis**

83 Statistical analysis was performed with Stata 13 (StataCorp, College Station, TX). The tests
84 were two-sided with a type-I error set at 5%. Only categorical data were analyzed. The
85 relationships between parameters (notably concerning the comparisons of age groups) were
86 studied using Chi-Squared or Fisher's exact tests.

87

88 **Results (Table 1, Figure 2, Figure 3, Figure 4).**

89

90 Between the 1st February and the 18th March 2018, 388 participants answered our online
91 questionnaire, with 154 women (40,5%) and 226 men (59,5%). Participants, all of whom
92 were gynecologic surgeons, worked in 54 different countries, with the largest group (almost
93 40%) from the USA. Additional population characteristics are shown in **Table 1**.

94 82% of respondents qualified the pedagogical benefits of teaching videos as very or
95 extremely important (**Figure 2**). No significant differences were found for age, experience or
96 type of hospital groups.

97 The main results regarding quality criteria are presented in **Figures 3 and 4** including overall
98 results, and comparative analyses between age groups.

99 59.3 % of respondents considered teaching videos for surgery should be made available on
100 both specialized educational and open platforms. 65.3 % would have greater confidence in a
101 reviewed video produced using film editing software, than in an unedited free access video.
102 64.1% stated that reviewers should however have access to the original video, in its entirety
103 without modifications (n=246).

104 Video access costs were classed as important by 285 respondents (74.4%), particularly by
105 respondents aged 20-30 years, with 40% considering these costs as extremely important
106 versus 17% for respondents aged >50 years ($p < 0,001$). 62.4% strongly agreed that medical
107 professionals should have easy access to videos platforms or online revues
108 while 85.3% ($n=324$) agreed that surgical videos should as standard be divided into clearly
109 defined steps, with 89.5% ($n=342$) considering the latter as good didactic practice for
110 learning surgical procedures. Finally when asked if there should be more “How not to do” or
111 “what should not be done” videos, 68.2% ($n=260$) of respondents agreed.
112 Results concerning information and patient consent are provided in **Figure 4**.

113

114 **Analysis of open comments**

115 208 open comments were given as to why there should be more “How not to do” or “what
116 should not be done” videos, and emphasized the benefits of ‘bad procedure’ videos. 58
117 comments were considered uninformative and 150 were coded.
118 Uninformative comments were majoritarily in a language other than English or French, or
119 lacking detail (e.g “good”, or “important videos”).
120 Overall 3 themes were identified from the data.

121 - **Theme “Learn from mistakes”**: 55 respondents (36.7%) commented on the value of
122 learning from mistakes as in the following examples:

123 *“You can always learn by watching what is wrong”*

124 *“It is essential to learn from mistakes of others instead of making them yourself”*

125

126 - **Theme “Element of surgeon training”**: **86 comments** (57.3%) focused on the
127 positive role of such videos as a teaching tool, especially for young surgeons.

128 *“Would help in learning correct surgical technique”*

129 *“These resources complement surgical training provided by more expert surgeons”.*

130

131 - **Theme “true life” video:** in 9 comments (6%), respondents insisted on the
132 importance of showing “true life” videos.

133 *“Because only the best scenarios are reported”*

134 *“Complications happen, but are rarely recorded”.*

135

136 **Discussion**

137

138 **Where do we stand?**

139 For surgical trainees and practicing surgeons, online videos continue to be the primary
140 resource used in preparing for surgical cases (3). There is evidence that surgical videos have
141 led to improvement in the acquisition of surgical skills (6-10) and enable the surgical learning
142 curve (9)(10). Residents are mainly taught surgery by well-trained, experienced surgeons
143 but can complete their training in standard techniques from video-based education available
144 on a growing number of online platforms (dedicated online platforms like AAGL, or
145 WebSurg.com).

146 However it has been shown that available surgical videos on open platforms may fail to
147 provide sufficient content or quality, with no correlation between a number of views or “likes”
148 and the quality of the video (4). YouTube remains the current preferred educational video
149 resource for Surgical Preparation (3). Several studies focusing on the quality of Youtube
150 videos available for specific medical procedures, (11–14) revealed that the wide variety of
151 accessible videos vary considerably in quality, depending on the posting source. The strict
152 guidelines for publication that apply to medical written articles, fail to apply to surgical videos
153 that are published in the absence of guidelines or quality criteria.

154 Furthermore, open platforms are frequently used by health care consumers for dissemination
155 of health-related information which is often fraught with anecdotal or inaccurate information
156 (15). Thus surgical videos on open platforms may have detrimental effects on teaching of

157 surgery, particularly in the light of increasing trends to make video-based education easily
158 accessible. High priced and difficult access to reviewed surgical videos further opens the way
159 for non-reviewed, open-access videos.

160 Concerted efforts are required from experts in specialty fields, surgical education
161 organizations and from surgical education resource managers to improve educational
162 platforms and increase access to good video-based education. Future studies are required to
163 help promote high quality online videos through consensus methodology and peer review.

164

165 **What about steps?**

166 A large majority of respondents stated that a surgical video should be divided into clearly
167 defined steps. This is an effective way to facilitate surgical procedure training, making
168 content more understandable, easier to remember and the procedure easier to repeat. Good
169 examples of this include the 10 steps Academy videos (16–23) that demonstrate a didactic
170 approach to teaching difficult laparoscopic gynecological procedures.

171 In the literature, importance is given to both focusing on key steps (24), and allowing pauses
172 between steps, thus providing opportunities for drawing attention to difficulties or anatomical
173 elements with arrows and/or legends (24). Mota et al. (25), found that over and above the
174 surgeon's technical skill, videos were most appreciated for the presence of didactic
175 illustrations and practical tips.

176 Non-modified videos fail to provide the additional valuable information for viewers such as
177 focusing on anatomical landmarks, use of instruments and the particular skills required to
178 perform the surgery, to make the procedure easy to remember and repeat.

179 A majority of respondents (83,1%) agreed that acceptable guidelines for teaching videos
180 should be defined. Assuring surgical video quality is essential and can be facilitated by the
181 implementation of peer-review or similar screening processes, as applied to scientific
182 journals.

183

184 **What about bad procedure videos?**

185 Our results show that 68,2% (n=260) of respondents insist on the value of “how not to do” or
186 “what should not be done” videos. Despite this, too few studies have looked into the impact
187 of “bad procedure videos”. Analysis of respondent open comments lend support to the need
188 for such research and are known to be a key source of information (7). Finally videos require
189 clearly defined teaching purposes and critical reviewing. Though videos of poor operative
190 quality may attract a wide variety of views (26), these may lack crucial critical analyses.
191 The definition of a bad video is not always easy: a clean nice edited video of a bad technique
192 is a bad video a somewhat bloody procedure of a difficult operation may be an invaluable
193 teaching tool. This peer review process could be part of the teaching process in each
194 surgical department. So many videos are available that it could be the teacher’s duty to
195 review video selected or found by the residents and the fellow to help them to select the
196 good and or the informative ones.

197

198 **What information should surgical videos provide? What guidelines are needed?**

199 Video length should depend on the type of media and surgical procedure, not exceeding 10
200 to 15 minutes for more complex procedures. For highly complex procedures the operation
201 may be divided in steps, which are described in 10 minutes videos. Describing and or
202 teaching radical hysterectomy in 10 minutes is a challenge, but providing several 10 minutes
203 video to teach all the tricks and details which are used in daily practice appears as a valuable
204 alternative. We chose 10-15 min because into the literature there’s articles supporting the
205 conclusion that lectures should adhere to the 10- to 15-min attention span that is
206 characteristic of modern students (27,28). Furthermore, this time appeared to us long
207 enough to have a “serious” video presentation but short enough to hold a person’s attention.

208 Providing information on surgical set-up (BMI of the patient, Trendelenbourg position degree,
209 pressure of pneumoperitoneum...) is essential. Surgical videos should be reviewed, divided
210 into clearly defined steps, with continued access to the entire and non-modified video for
211 reviewers and be accessible on both educational and open platforms. Patient consent and

212 relevant data should be available. Videos article should include “ bad procedure“ videos,
213 which are highly appreciated especially by young surgeons.

214

215 The many advantages of the video format, including availability and rising popularity, provide
216 an opportunity to reinforce and complement current surgical teaching. To optimize use of this
217 surgical teaching tool, standardization, updating and ease-of-access of surgical videos
218 should be promoted.

219

220 **Limitations**

221 Study limitations involve the number of participants. An increased number of participants
222 would have given greater strength to the results. The use of a non-validated questionnaire in
223 this study is also a limitation, however we were able to create a pertinent tool that can be
224 adapted in any future studies.

225 This method of recruitment may include a selection bias, because surgeons with interest in
226 teaching concerns are more likely to participate to such a study, thereby leading to over-
227 representation of surgeon invested in teaching surgery. Furthermore, the majority of our
228 study population were working in teaching hospital. So participants included in the study
229 might not be representative of the entire surgeons population. However, it allowed a quick
230 and large collection of data.

231

232 **Conclusion**

233 There are clear pedagogical benefits to the use of teaching videos. A good surgical teaching
234 video should be structured, divided into clearly defined steps and have clear outcomes and
235 learning points. Future research is required to promote high quality online videos through
236 consensus, methodology and peer review.

237

238 **Acknowledgements:** We would like to thank Mr Bruno Pereira and Mrs Céline Lambert
239 (University Hospital Clermont-Ferrand, Biostatistics Unit (DRCI), Clermont-Ferrand, France)
240 for their assistance with statistical analysis.

241

242

243 **References**

- 244 1. Ahmet A, Gamze K, Rustem M, Sezen KA. Is Video-Based Education an Effective
245 Method in Surgical Education? A Systematic Review. *J Surg Educ* [Internet]. 2018 Feb [cited
246 2018 Mar 31]; Available from: <http://linkinghub.elsevier.com/retrieve/pii/S1931720417306803>
- 247 2. Yilmaz EM, Soyder A, Aksu M, Bozdog AD, Boylu S, Edizsoy A, et al. Contribution of
248 an educational video to surgical education in laparoscopic appendectomy. *Turk J Surg*. 2017
249 Dec 12;33(4):237–42.
- 250 3. Rapp AK, Healy MG, Charlton ME, Keith JN, Rosenbaum ME, Kapadia MR. YouTube
251 is the Most Frequently Used Educational Video Source for Surgical Preparation. *J Surg*
252 *Educ*. 2016 Nov;73(6):1072–6.
- 253 4. Lee JS. YouTube as a source of patient information on gallstone disease. *World J*
254 *Gastroenterol*. 2014;20(14):4066.
- 255 5. Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, Conde JG. Research electronic
256 data capture (REDCap)--a metadata-driven methodology and workflow process for providing
257 translational research informatics support. *J Biomed Inform*. 2009 Apr;42(2):377–81.
- 258 6. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006
259 Jan;3(2):77–101.
- 260 7. Chauvet P, Guiguet-Auclair C, Comptour A, Denouël A, Gerbaud L, Canis M, et al.
261 Feelings and expectations in endometriosis: Analysis of open comments from a cohort of
262 endometriosis patients. *J Gynecol Obstet Hum Reprod*. 2018 Sep;47(7):281–7.
- 263 8. Crawshaw BP, Steele SR, Lee EC, Delaney CP, Mustain WC, Russ AJ, et al. Failing
264 to Prepare Is Preparing to Fail: A Single-Blinded, Randomized Controlled Trial to Determine
265 the Impact of a Preoperative Instructional Video on the Ability of Residents to Perform
266 Laparoscopic Right Colectomy. *Dis Colon Rectum*. 2016 Jan;59(1):28–34.
- 267 9. van Det MJ, Meijerink WJHJ, Hoff C, Middel LJ, Koopal SA, Pierie JPEN. The
268 learning effect of intraoperative video-enhanced surgical procedure training. *Surg Endosc*.
269 2011 Jul;25(7):2261–7.
- 270 10. Carter SC, Chiang A, Shah G, Kwan L, Montgomery JS, Karam A, et al. Video-based
271 Peer Feedback Through Social Networking for Robotic Surgery Simulation: A Multicenter
272 Randomized Controlled Trial. *Ann Surg*. 2015 May;261(5):870–5.
- 273 11. Fischer J, Geurts J, Valderrabano V, Hügler T. Educational Quality of YouTube Videos
274 on Knee Arthrocentesis: *J Clin Rheumatol*. 2013 Oct;19(7):373–6.
- 275 12. Bezner SK, Hodgman EI, Diesen DL, Clayton JT, Minkes RK, Langer JC, et al.
276 Pediatric surgery on YouTube™: Is the truth out there? *J Pediatr Surg*. 2014 Apr;49(4):586–
277 9.
- 278 13. Rössler B, Lahner D, Schebesta K, Chiari A, Plöchl W. Medical information on the
279 Internet: Quality assessment of lumbar puncture and neuroaxial block techniques on
280 YouTube. *Clin Neurol Neurosurg*. 2012 Jul;114(6):655–8.
- 281 14. Larouche M, Geoffrion R, Lazare D, Clancy A, Lee T, Koenig NA, et al. Mid-urethral
282 slings on YouTube: quality information on the internet? *Int Urogynecology J*. 2016
283 Jun;27(6):903–8.
- 284 15. Madathil KC, Rivera-Rodriguez AJ, Greenstein JS, Gramopadhye AK. Healthcare
285 information on YouTube: A systematic review. *Health Informatics J*. 2015 Sep;21(3):173–94.
- 286 16. Acsinte OM, Rabischong B, Bourdel N, Canis M, Botchorishvili R. Laparoscopic

- 287 Promontofixation in 10 Steps. *J Minim Invasive Gynecol* [Internet]. 2017 Oct [cited 2018 Mar
 288 31]; Available from: <http://linkinghub.elsevier.com/retrieve/pii/S1553465017312566>
- 289 17. Artola M, Chauvet P, Rabischong B, Botchorishvili R, Canis M, Bourdel N. Lumbo-
 290 Aortic Lymph Nodes Dissection in Ten Steps. *J Minim Invasive Gynecol*. 2015
 291 Nov;22(7):1138–9.
- 292 18. Boulay E, Gałczyński K, Canis M, Bourdel N. Laparoscopic pelvic lymphadenectomy
 293 in 10 steps – let’s make it easier! *Gynecol Oncol*. 2017 Apr;145(1):217–8.
- 294 19. Bourdel N, Tran X, Botchorhisvili R, Pouly J-L, Canis M, Mage G. Hystérectomie par
 295 coelioscopie en dix étapes. *J Chir (Paris)*. 2009 Oct;146(5):483–91.
- 296 20. Gałczyński K, Chauvet P, Canis M, Bourdel N. Laparoscopic extraperitoneal
 297 lumboaortic lymphadenectomy in 10 steps – Let’s make it easier! *Gynecol Oncol*. 2016
 298 Nov;143(2):448–9.
- 299 21. Gałczyński K, Chauvet P, Ferreira H, Bourdel N. Laparoscopic dissection of female
 300 pelvis in 10 steps. *Gynecol Oncol*. 2017 Oct;147(1):189.
- 301 22. Kemp MM, Gałczyński K, Botchorishvili R, Bourdel N. How to facilitate laparoscopy in
 302 obese oncologic patients – 10 steps towards successful surgery. *Gynecol Oncol*. 2018
 303 Apr;149(1):223–4.
- 304 23. Madalina AO, Jeremie S, Benoit R, Canis M, Revaz B, Bourdel N. Laparoscopic
 305 Ureteroneocystostomy with a Vesicopsoas Hitch in 10 Steps. *J Minim Invasive Gynecol*
 306 [Internet]. 2017 Nov [cited 2018 Mar 31]; Available from:
 307 <http://linkinghub.elsevier.com/retrieve/pii/S1553465017312918>
- 308 24. Jacquemart M, Bouletreau P, Breton P, Mojallal A, Sigaux N. Teaching Surgical
 309 Procedures with Movies: Tips for High-quality Video Clips. *Plast Reconstr Surg - Glob Open*.
 310 2016 Sep;4(9):e1025.
- 311 25. Mota P, Carvalho N, Carvalho-Dias E, João Costa M, Correia-Pinto J, Lima E. Video-
 312 Based Surgical Learning: Improving Trainee Education and Preparation for Surgery. *J Surg*
 313 *Educ* [Internet]. 2017 Oct [cited 2018 Mar 31]; Available from:
 314 <http://linkinghub.elsevier.com/retrieve/pii/S1931720417303859>
- 315 26. Deal SB, Alseidi AA. Concerns of Quality and Safety in Public Domain Surgical
 316 Education Videos: An Assessment of the Critical View of Safety in Frequently Used
 317 Laparoscopic Cholecystectomy Videos. *J Am Coll Surg*. 2017 Dec;225(6):725–30.
- 318 27. Davis BG. Tools for Teaching. In San Francisco, CA: Jossey-Bass; 1993.
- 319 28. Wankat PC. The Effective Efficient Professor: Scholarship and Service. In: Allyn and
 320 Bacon. Boston, MA; 2002.

322

323 Table :

324 **Table 1.** Characteristics of our respondent population.

325

326 Figure legends :

327 **Figure 1:** the questionnaire

328 **Figure 2:** Benefits of teaching videos

329 **Figure 3:** Distribution of each criterion used for the multiple correspondence analysis.

330 For each section, the different colors represent the answers.

331 Each of the five column correspond to an age group (20-30, 30-40, 40-50, over 50), and the
332 global results for all the age groups.
333 The abbreviation of the different section and their correspondence to the questionnaires
334 questions, about the importants informations to figure into the videos.
335 **Duration:** Do you think the duration of the video should depend on the media type?
336 (specialized educational platforms, or open platforms like YouTube)
337 **Dur/proc:** Do you think the duration of the video should depend on the surgical procedure?
338 **Installation:** Do you think that the surgical set-up should be carefully described ?
339 **Age/BMI :** Do you think that the age and the BMI of the patient should always be indicated?
340 **Trend :** Should the Trendelenbourg be measured and detailed?
341 **Anesth :** Should the anesthesia protocol included in the closing credits or in the journal with
342 abstract?
343 **Pressure :** Should the pressure used be routinely reported ?
344 **Electro :** Should the electrosurgical unit setting be reported ?
345 **Instrument :** Should instrumentation used be reported in details including the electrosurgical
346 unit ?
347 **POstop :** Should the postoperative data be included ?
348
349 **Figure 4:** Distribution of each criterion used for the multiple correspondence analysis.

350 For each section, the different colors represent the answers.
351 Each of the five column correspond to an age group (20-30, 30-40, 40-50, over 50), and the
352 global results for all the age groups.
353 The abbreviation of the different section and their correspondence to the questionnaires
354 questions.
355
356 **Easy access:** Should medical professionals have easy access to videos platforms or online
357 revues?
358 **Review access:** For reviewed and fixed video, do you think that the reviewer should have
359 access to the original video, entire and not
360 modified?
361 **Steps:** Do you think that a surgical video should be always divided by steps clearly defined?
362 **Keysteps:** Do you think that key steps of the procedure should be reported without being
363 edited ?
364 **Didactic steps:** Do you think that division in steps clearly defined is a good didactic way to
365 learn surgical procedures?
366 **Inform:** The patient should be informed that her video may be anonimely used for teaching ?
367 **Consent:** The patient should give his/her consent for the video to be on free online platform?
368 **Cons/platform:** The online free video platforms should always require patient consent?
369 **Badproc:** Do you think that there should be more "How not to do" or "what should not be
370 done" videos?
371 **COI:** Do you think that a conflict of interest statement should be included at the beginning of
372 the video?
373 **Guidelines:** Do you think that after discussion between experts acceptable guidelines for
374 teaching video should be proposed ?
375

376

377



On behalf the scientific committee organisation of the congress "Beyond gynecologic surgery", we take the opportunity of the carrying out a survey about teaching video, and would really appreciate your input.

This questionnaire will take only a few minutes of your time to complete.

The results of this survey will be presented in the 1st Beyond Gynecologic Surgery : From Imagination to Innovation and Education, which will be held in Clermont-Ferrand, France from 4-6 April 2018.

Thank you for your participation!

Dr Pauline Chauvet, Dr Nicolas Bourdel, Pr Michel Canis, Department of gynecologic surgery, CHU Estaing Clermont-Ferrand, FRANCE

Are you:

- a woman
 a man

[réinitialiser la valeur](#)

How old are you:

In which country do you practice surgery?

In what kind of hospital?

In which speciality?

- Gynecologic surgery Urology Vascular surgery Digestive surgery Other

[réinitialiser la valeur](#)

For how long have been a surgeon? (in years)

- < 5
 5-10
 10-20
 > 20

[réinitialiser la valeur](#)

How would you quantify the pedagogical benefits of teaching videos?

- Not at all important
 Low importance
 Slightly important
 Neutral
 Moderately important
 Very important
 Extremely important

[réinitialiser la valeur](#)

Duration

Do you think the duration of the video should depend on the media type? (specialized educational platforms, or open platforms like YouTube)

- Strongly disagree Disagree Neither agree Agree Strongly agree

[réinitialiser la valeur](#)

Do you think the duration of the video should depend on the surgical procedure?

- Strongly disagree Disagree Neither agree Agree Strongly agree

[réinitialiser la valeur](#)

Surgical Set-up

Do you think that the surgical set-up should be carefully described ?

- Strongly disagree Disagree Neither agree Agree Strongly agree

[réinitialiser la valeur](#)

Do you think that the age and the BMI of the patient should always be indicated?

- Strongly disagree Disagree Neither agree Agree Strongly agree

[réinitialiser la valeur](#)

Is it important to show the external view of the surgical set-up (images from the surgery room)?

- Not at all important
 Low importance
 Slightly important
 Neutral
 Moderately important
 Very important
 Extremely important

[réinitialiser la valeur](#)

Should the Trendelenbourg be measured and detailed?

- Strongly disagree Disagree Neither agree Agree Strongly agree

[réinitialiser la valeur](#)

Should the anesthesia protocol included in the closing credits or in the journal with abstract?

- Strongly disagree Disagree Neither agree Agree Strongly agree

[réinitialiser la valeur](#)

Should the pressure used be routinely reported ?

- Strongly disagree Disagree Neither agree Agree Strongly agree

[réinitialiser la valeur](#)

Should the electrosurgical unit setting be reported ?

- Strongly disagree Disagree Neither agree Agree Strongly agree

[réinitialiser la valeur](#)

Should instrumentation used be reported in details including the electrosurgical unit ?

- Strongly disagree Disagree Neither agree Agree Strongly agree

[réinitialiser la valeur](#)

Should the postoperative data be included ?

- Strongly disagree Disagree Neither agree Agree Strongly agree

[réinitialiser la valeur](#)

Video accessibility

Do you think that good teaching videos should be only on specialized educational platforms, or on open platforms like YouTube?

- Specialized educational platforms
 Open platforms
 Both
 No opinion

What kind of surgical video would you trust more: a reviewed video, fixed with a movie maker software? Or an entire and free access video?

Is the access cost to the video an important point?

- Not at all important
 Low importance
 Slightly important
 Neutral
 Moderately important
 Very important
 Extremely important

[réinitialiser la valeur](#)

Should medical professionals have easy access to videos platforms or online revues?

- Strongly disagree Disagree Neither agree Agree Strongly agree

For reviewed and fixed video, do you think that the reviewer should have access to the original video, entire and not modified?

- Strongly disagree Disagree Neither agree Agree Strongly agree

réinitialiser la valeur

Do you think reference to another video may be proposed to expose that as references are used in written papers for instance to avoid to report installation steps of the procedure?

- Yes
 No

réinitialiser la valeur

Steps

Do you think that a surgical video should be always divided by steps clearly defined?

- Strongly disagree Disagree Neither agree Agree Strongly agree

réinitialiser la valeur

Do you think that key steps of the procedure should be reported without being edited ?

- Strongly disagree Disagree Neither agree Agree Strongly agree

réinitialiser la valeur

Do you think that division in steps clearly defined is a good didactic way to learn surgical procedures?

- Strongly disagree Disagree Neither agree Agree Strongly agree

réinitialiser la valeur

The patient should be informed that her video may be anonymously used for teaching ?

- Strongly disagree Disagree Neither agree Agree Strongly agree

réinitialiser la valeur

The patient should give his/her consent for the video to be on free online platform?

- Strongly disagree Disagree Neither agree Agree Strongly agree

réinitialiser la valeur

The online free video platforms should always require patient consent?

- Strongly disagree Disagree Neither agree Agree Strongly agree

réinitialiser la valeur

Do you think that the picture may be sometimes foggy if the disease is rare or difficult to record ?

- Yes
 No

réinitialiser la valeur

Reviewing

When reviewing a video for a journal, the reviewer may suggest a revised editing ?

- Yes
 No

réinitialiser la valeur

When reviewing a video for a journal, a reviewer may or should ask for intermediate steps if he feels that these steps would be important to allow the readers to repeat safely the procedure reported in the video?

- Yes
 No

réinitialiser la valeur

Do you think that there should be more "How not to do" or "what should not be done" videos?

- Strongly disagree Disagree Neither agree Agree Strongly agree

réinitialiser la valeur

Do you think that a conflict of interest statement should be included at the beginning of the video?

- Strongly disagree Disagree Neither agree Agree Strongly agree

réinitialiser la valeur

Do you think that after discussion between experts acceptable guidelines for teaching video should be proposed ?

Strongly disagree Disagree Neither agree Agree Strongly agree

[réinitialiser la valeur](#)

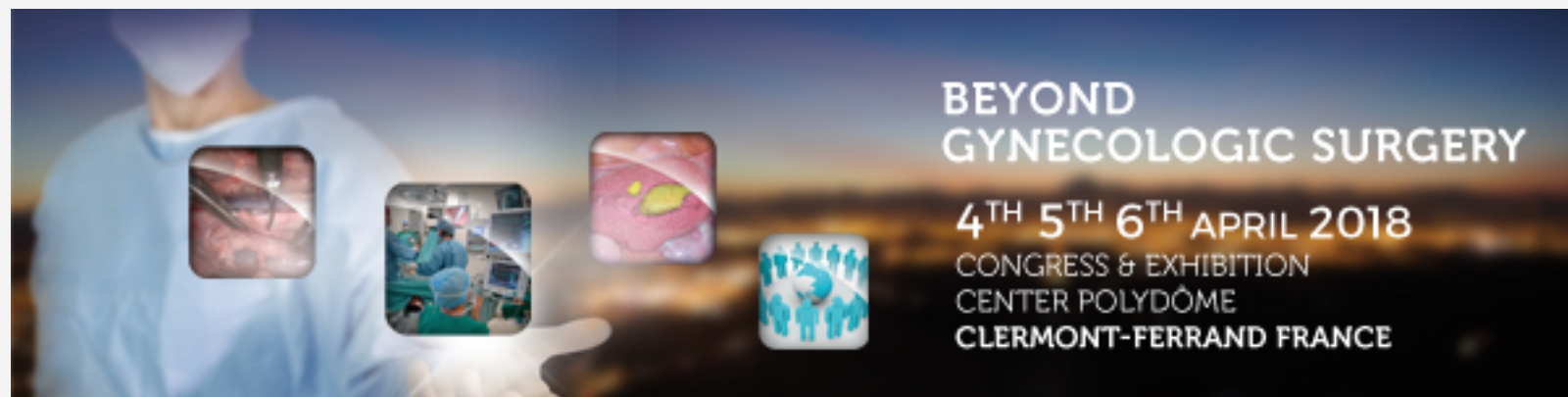
If you have any comments or suggestions, this space is for you

Développer

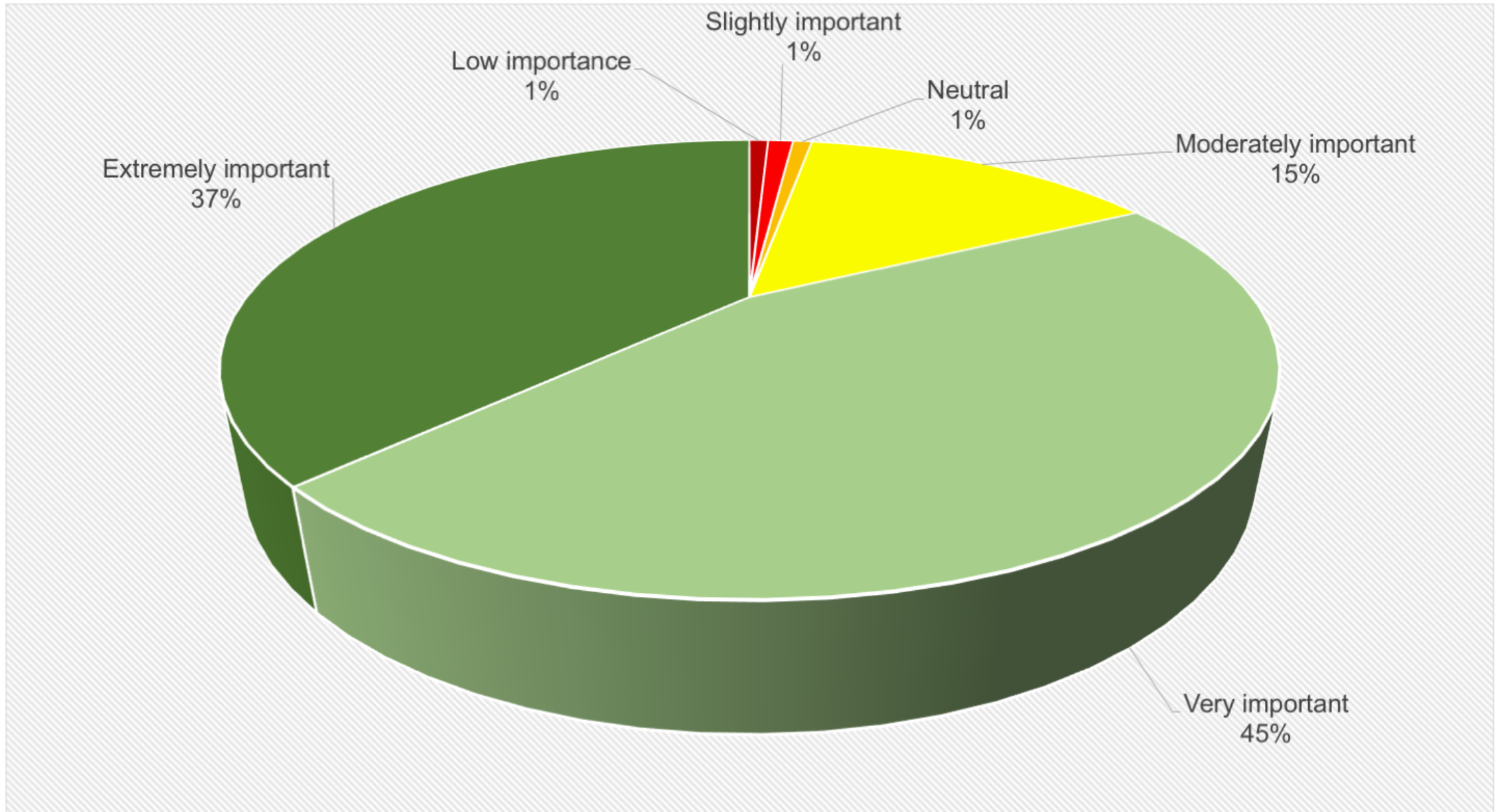
Thank you very much for your participation!

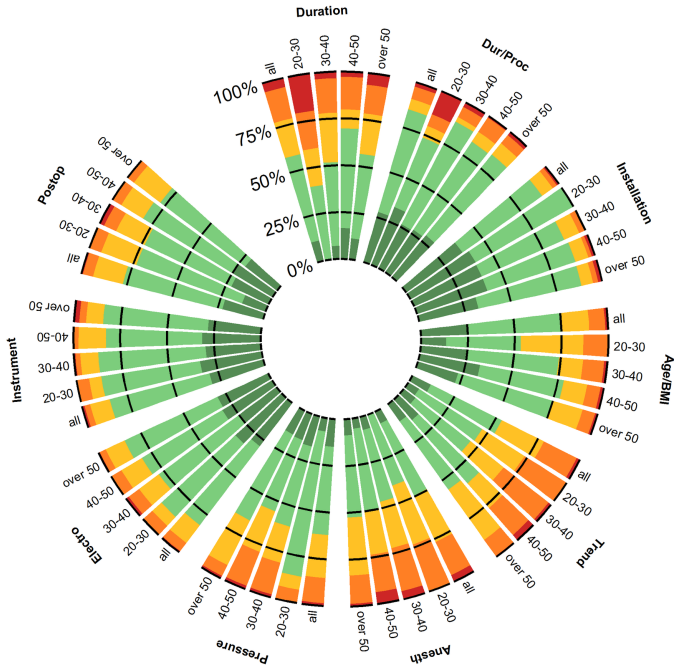
The results of this survey will be presented in the 1st Beyond Gynecologic Surgery : From Imagination to Innovation and Education (BGS) that will be held in Clermont-Ferrand, France from 4-6 April 2018.

For more information : <https://www.gynecologic-surgery.com/>



Envoyer





■ strongly agree
 ■ agree
 ■ neither agree
 ■ disagree
 ■ strongly disagree

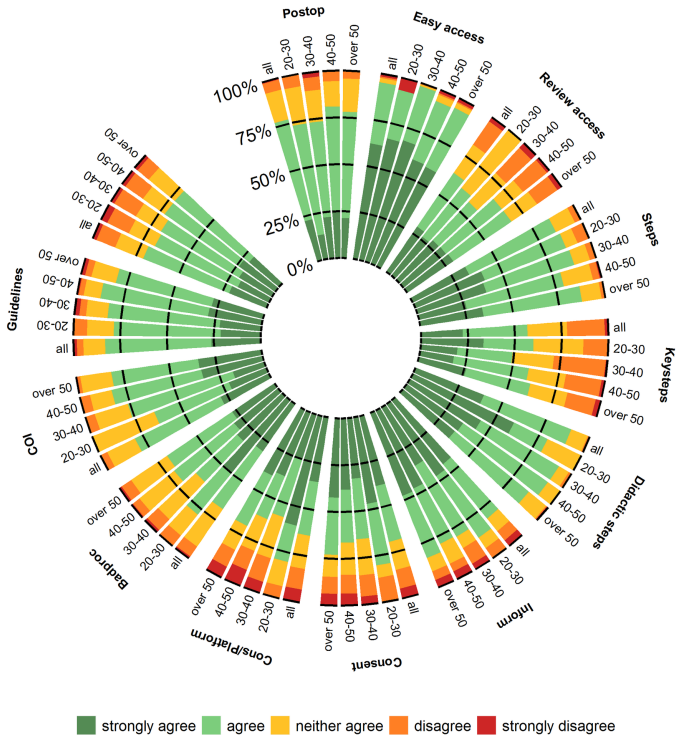


Table 1. Characteristics of our respondent population.

Question					Total
Women or men?	226 men (59,6%)		154 women (40,53%)		N=380
How old are you?	Age 20-30 N=15, 3.90%	Age 30-40 N=11, 29.87%	Age 40-50 N=111, 28.83%	Over 50 N=144, 37.40%	N=385
Hospital	Community hospital N=60, 15.63%	Public hospital N=51, 13.28%	Teaching hospital N=179, 46.61%	Private hospital N=94, 24.48%	N=384
Experience	< 5 years N=76, 19.84%	5-10 years N=61, 15.93%	10-20 years N=97, 25.33%	> 20 years N=149, 38.90	N=383