

Refusal of consent for video recording during standard EEG

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Key words: video-EEG, record consent

Received April 15, 2008; Accepted May 21, 2008

Even during standard EEG, simultaneous video recording may provide useful information, by providing unpredictable clinical events (epileptic and non epileptic seizures, movement disorders) or by adding a substantial help to EEG interpretation (identification of artifacts, movements). In the vast majority of EEG recording, the video document is not helpful and can be suppressed. However, in all cases, a preliminary informed consent to videorecording is required from patients themselves or caregivers.

In our unit, all EEG (including emergencies and pediatrics) are videotaped, so that all patients are requested to give their written consent. They are first asked to read the information document, and then their written signature is collected.

From the 1st February 2006 to the 31 January 2007, we consecutively collected all cases of refuse to consent to video recording. Patients or caregivers were further asked to explicit the reason for denying their consent. During this period a total of 2104 video-EEG (excluding critical unit and neonatal recordings) were performed. A total of 21 (1% of the population) refusing were collected: six (28%) from adults and 15 for children (parental refuse, 72%). In seven of the 15 pediatric cases, the alleged reason was the fear having the child's image diffused. In four cases (both pediatrics and adults), the person or their caregiver worked in contact with the medical, academic or research staff of the hospital. In two adult cases, the present clinical state was considered socially unfavorable. Others reported reasons were: "health belong to the person", only one of the two parents was present and could not engage for both, the parent asked for owning the video document, or in one case, the reason was not given. In one case it was stated that the medical staff should have enough video to date. In all cases, the video would not present a clinical interest.

A previous report managing videorecording of clinical examination of patients with Parkinson's disease reported a refuse rate of 2% (Taylor *et al.* 2004). A higher rate of refuse was observed in a general practice study, during which 22.7% of patients stated their opposition to video-recording of consultations (Neal *et al.* 2004),

in contrast to 2% observed in a video-consultation study conducted in Estonia (Maaroos *et al.* 2004). As compared to these studies, our refuse rate was lower. This lower rate of refuse could be related to concomitant EEG recording and to the explicit main objective of the whole procedure to record clinical events in order to provide a diagnosis. We found a majority of refuse regarding children (72% of the total refusing, as compared to 23% of children among the whole population EEG-recorded in our unit), which could reflect the parent's concern regarding their children.

Although this was not specifically addressed in our collection study, we noticed the high proportion of patient of non European origin (North Africa: 9 out of 21 refuses), which could underscored cultural influences in giving informed consent as pointed out by another study (Neal *et al.* 2004).

Video recording rises many ethical issues in very different settings: emergencies (Geiderman *et al.* 2001), surgery (Jones and McCullough 2001), but represents a potentially useful tool to improve and secure medical interventions. Efforts should be further made to improve the rate of refuse, by enhancing the clarity of the written information given to the patient and caregivers, and by providing further oral explanation if necessary.

Acknowledgments. MPN and LV thank the whole nurse team of the EFSN, Grenoble involved in the collection of the data: Nicole, Anne-Marie, Corinne, Christine, Martine, Pascale, Aline, Evelyne, Armelle, Veronique, Patricia, Martine.

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