Christopher Williams (Author photos 1-12; Video 1, available online at www.VideoGIE.org), of St Mark’s Hospital, London, United Kingdom, had a successful and fulfilling career in colonoscopy and its teaching from 1970 to 2011.

The son of 2 physicians, he spent most of the Second World War as an evacuee in Boston, Massachusetts, returning to England where his schooling and subsequent college life in Oxford stimulated a lasting interest in skills and practical achievement. After deciding to train in medicine, a career in gastroenterology appealed to him. A residency became available at St Mark’s Hospital, London, a tiny but renowned postgraduate teaching hospital specializing in bowel disorders and attracting surgeons and physicians from around the United Kingdom and internationally.

He was handed a donated colonoscope in 1970 (“Try this, Williams!”), and he partnered with a Japanese postgraduate surgeon, initially in a side room and then moving to out-of-hours sessions in an X-ray screening room. The intention was to achieve complete examinations, regardless of time, changing between endoscopists every 15 minutes. With no facilities—nursing, finance, or recovery—kindness and patience, hand skills, and “tricks of the trade” were essential to avoiding use of heavy sedation. Over 97% success in reaching the cecum was achieved by 1972 (insertion times ranging from 2 minutes to 1-2 hours); thereafter, no adverse events other than postpolypectomy bleeds occurred in 5000 procedures.

Author photo 1. At 1 year.

Author photo 2. At 3 years in the United States.
Active relationships with manufacturers, US or Japanese, geared toward improving colonoscope instrument design yielded an invaluable flow of instruments and practical results, such as the introduction of stiffenable or ultra-flexible pediatric colonoscopes. Derided by some, use of fluoroscopy for occasional checks allowed an objective understanding of colon loops.

The flow of postgraduate observers at St Mark’s made routine teaching a necessity. In the small endoscopy unit created by charitable sources, a key element was a learning area with a range of models and audio-visual facilities. In addition to explaining practicalities, emphasis was placed on the need for kindness and a warm atmosphere, as learned from private practitioners in the United States. The informality of the National
Health Service in the 1970s helped to spread colon skills and attitudes to other general and pediatric hospitals, most having only upper GI experience. Because he was the only practicing colonoscopist in London, outside referrals and requests sometimes meant travelling on a motorcycle with the equipment required and working in unfamiliar side rooms or X-ray departments.
Invitations allowed visits with other pioneers in the field (notably Jerry Waye and Hiromi Shinya in New York), resulting in friendships worldwide and invaluable tips incorporated into films and publications. One-day demonstration colonoscopy workshops at St Mark’s proved to be popular, bringing together UK endoscopists and their nurse teams, fostering know-how and good relationships, and encouraging others to host similar events.

Simple hand-illustrated explanatory hand-outs were produced for visitors and were then developed into textbook chapters and the book *Practical GI Endoscopy* (with Peter B. Cotton), in multiple editions and translated into 7 languages. For hand skills, teaching practice models were assessed, starting with hairdryer tubing and developing into a whole-colon model requiring loop control for successful intubation. However, use of models needed supervision, could damage endoscopes, and gave no measurable feedback. Endoscopes modified to work with simple videogames gave proof of concept for a 1982 Imperial College, London, prototype computer simulation with feel of sigmoid colon looping. The ergonomic deficiencies of endoscope control-body design for the colonoscopist were addressed with trials of thumb-joystick servo-motor steering and a lumen-seeking, self-steering instrument. A spin-off was the GPS-type electromagnetic imager, which provided real-time non–X-ray loop visualization (commercialized as ScopeGuide; Olympus). The key programmer subsequently worked for 20 years on a sequence of semi-realistic Olympus-financed prototype colonoscopy teaching simulations.

Development was halted, and Williams’ electronic teaching aspirations were abruptly terminated in 2011 as a result of the “Olympus scandal” and dismissal of Olympus’ supportive CEO. However, able successors at St Mark’s, along with other UK enthusiasts, have formalized effective colonoscopy training and assessment as part of the UK National Colon Cancer Screening protocols, which also originated from the little hospital. The legacy (and pride) lives on.

**DISCLOSURE**

*The author disclosed no financial relationships.*