Trauma Video Review: A Valuable Resource
Jeffrey S. Upperman, Debi Balise, Yolanda Morad, Henri Ford and G. Hossein Mahour

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Trauma Video Review: A Valuable Resource

To the Editor.—

We read with great interest the article in Pediatrics by Oakley et al1 on using video recording to track resuscitation errors in pediatric trauma. We believe this article raises some significant issues regarding training and quality trauma care. The authors introduced videotaping emergency department resuscitations as a mechanism for detecting medical errors and auditing trauma team response. We support the use of videotaping resuscitation for quality assessment, but an educational opportunity is lost if the tapes are not reviewed by the practitioners.2 During the study period, emergency physicians were assigned the role of trauma leader instead of the senior registrar because of poor attendance at the start of the resuscitation. It seems that leadership changes that occurred during the study were not analyzed. Were there more or less errors when the emergency department took over the trauma resuscitation? Did registrars communicate better than emergency physicians? The analysis should not only focus on errors but also include the nature of communication between the team leader and supporting cast and the outcomes. It cannot be determined by the analysis if responders did not listen to the team leader or if the responders did not receive directives. The other important item missing from the methods section is a description of the ideal trauma team response. Some centers clearly define who is supposed to participate in the trauma code and where these individuals should stand and work. We believe that a lack of this type of organization leads to changing expectations and communication with each trauma alert.

Recently, some facilities have decided to limit trauma video review. Campbell et al3 demonstrated a dramatic decrease in videotaping in US level 1 trauma centers after introduction of the Health Insurance Portability and Accountability Act. It is not clear if this will have an effect on the quality of trauma resuscitations. Fortunately, Oakley et al were not hindered by this type of policy. We believe that overinterpretation of some regulations may lead to the premature abandonment of techniques that may enhance quality care. In the case of some centers choosing to forgo video review and quality improvement on the basis of the video findings, it seems that the fear of litigation outweighs patient safety.

In summary, we support the use of video review for trauma resuscitation. The current report should have expanded its analysis to examine the team-communication process.

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In Reply.—

Upperman et al make some important observations regarding the use and role of video recording in trauma resuscitation education. It is disappointing indeed that the use of video recording is on the decline in the United States, seemingly as a result of medicolegal concerns and resource issues.1 In contrast, although in December 2001 amended health privacy legislation was enacted in Australia to enhance issues of patient confidentiality, our
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