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Trauma video review: how long do we curb our enthusiasm?

Madhu Subramanian , Jeff Jopling

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In mature trauma centers, video review should be mandatory as a component of quality improvement. Trauma video review has been shown to be more accurate for data collection than chart review or real-time bedside collection.[1] Quality improvement benchmark assessments, including thoroughness of the trauma survey, time to critical events,[2 3] and even team communication and dynamics,[4] have all been evaluated through video review. The benefit can be dramatic, as a single institution can examine its own inefficiencies and generate solutions that can be evaluated and adjusted in real time.

Despite the proven benefits, only 30% of level 1 and level 2 centers have video review capabilities.[5] The most cited reasons for not pursuing video reviews are concerns regarding punitive treatment based on individual performance reviews, medicolegal concerns, and cost/resource allocation.[6 7] In an effort to understand the evolution of staff comfort with video recording in the trauma bay, Murray *et al* surveyed a multidisciplinary group of staff impacted by their implementation of a video review program. Their survey was deployed both prior to and 1 year after deployment. They found that provider discomfort with video recording improved after implementation, as did perceptions of team dynamics.

This is the first study that looked at changes in perception regarding video review over time. Centers striving to implement trauma video review programs should be encouraged by the results of this study. In fact, these findings should encourage those working to deploy video-based improvement programs in operating rooms and intensive care units as well. The principles driving acceptance of video recording are likely to be consistent across these diverse healthcare settings. Success is linked, at least in part, to transparency in communication, demonstration of practical benefits, absence of negative consequences, and normalization through use.

The authors should be commended for their work. Future efforts could be put towards further detailing the 5 years that they spent laying the groundwork for the implementation, including a robust socialization of the program through multiple forums and communication modalities. Establishing a validated survey instrument that is useful for the implementation of video reviews across diverse healthcare settings would also be of great value. Other future work should directly address how to optimize the cost and resource allocations required for trauma video review. The initial investment cost can be high, but what other tool or strategy currently exists that is cheaper and has demonstrated a positive effect on team dynamics as a video review?

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ORCID iD
Madhu Subramanian http://orcid.org/0000-0001-9798-4584

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Johns Hopkins School of Medicine, Baltimore, Maryland, USA

Correspondence to
Dr Madhu Subramanian; madhu@jhmi.edu