CORRESPONDENCE

***Black box* audio/video recording in the operating room: time for anesthesiologists to get with the picture**

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To the Editor,

I recently spent time at a hospital where the surgical department initiated research efforts to evaluate how audio/video (A/V) recording in the operating room (OR) - akin to *black boxes* in the aviation industry - can be used to improve quality of care through review of critical incidents. However, this workplace surveillance may have ramifications that extend beyond the insights gained from the original objective to review A/V footage after critical incidents. Surgeons have generated most of the published evidence and opinions available on this topic^{1,2} with little participation or input from the anesthesiology community. Even so, anesthesiologists have a vested interest in the pursuit of this type of policy, both as experts in delivering perioperative care, and importantly, because they can become the subjects of A/V footage.

In addition to the parallels in safety improvement drawn from the aviation industry's use of *black boxes*, proponents of routine OR A/V recordings also draw comparisons to the wearable cameras employed by some police forces. However, police forces were motivated to install wearable cameras to improve accountability by influencing real-time behavioural improvements in light of critical lapses in professionalism with regard to racial profiling and abuse of force.³ As routine A/V recordings can motivate both positive and negative behavioural

changes in real time, it is possible that workplace surveillance could increase the potential for litigation and non-allowances for normal practice variations as well as create a culture of overly cautious practice.

There is a growing view that improving quality and safety should be a more dominant aspect of the medical culture. This is motivated not only by the increased recognition that medical error plays a large role in morbidity and mortality but also by a widely publicized catastrophic lapse in professionalism that incited a call for greater means to enforce accountability. A particularly striking incident occurred in Toronto, Ontario where an anesthesiologist was convicted of sexual abuse that took place inside the OR.⁴ In Ontario, events like this have sparked the development of a task force to review legislation to prevent sexual abuse of patients.⁵ It is clear that routine A/V recording could be an influential tool for proponents of such legislation.

The use of A/V recording in the OR (and potentially in other locations in the hospital) raises many questions. For example, how will patients respond? Would patients or staff be able to limit the scope of information captured? Will recordings become part of the medical record? Would physicians be responsible for routinely reviewing the files? Will the recordings become a tool to generate punitive incentives? Will the routine use of the recordings make physicians less likely to proceed with higher-risk procedures or patients? The possibility of it becoming a perverse policy tool will require careful consideration before introduction into clinical practice.

Black box recordings in the OR have the potential to improve but also to limit anesthesia practice. With careful implementation and strong regulatory measures, this technology could potentially improve care, but there are some major issues and motivations that need to be carefully

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considered. We advocate for anesthesiologists to take a more active role in this emerging process.

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