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November 20, 2009

Dr. David Gifford
RI Department of Health
401 Cannon Building
Three Capitol Hill
Providence, RI 02908

Dear Dr. Gifford:

I am writing in response to the compliance order that you issued to Rhode Island Hospital on November 2nd after its fifth wrong-site surgery in three years. Let me begin by emphasizing our understanding of, and appreciation for, your actions in seeking to protect patients. However, we have deep concerns about one particular aspect of the order: requiring audio- and videotaping of surgeries at the Hospital. For the reasons expressed below, we urge you to reexamine and rescind this particular requirement.

Before explaining our objections, it is worth reciting in full the specific section of concern to us. The order requires the Hospital to:

> *"install audio and video monitoring equipment in all operating sites for all surgeries to ensure monitoring and reviews for each surgical physician, to include:*
> *1) an analysis of and recommendations regarding at least the safety of surgical services, implementation of site marking and time out procedures, and team dynamics of the surgical team;*
> *2) patient notice and consent documentation about the audio/video recording in accordance with existing protections of personal medical information;*
> *3) a minimum review of two surgical events per year for each surgical physician."*

In light of the history prompting this order, we can understand how some might conclude that taping surgeries is a useful and protective measure that furthers patients' rights. However, we believe there are a number of problems with this approach.

First, it is difficult to think of many more intimate places to be videotaped than on an operating table. Although the order refers to "patient notice and consent documentation," none of the details for this consent is spelled out in the order, nor is it clear how patients will be notified. Just as importantly, we question how meaningful any consent will truly be in such a sensitive setting. Nor does the order explain the default option that will be utilized: will the surgery be taped unless the patient opts out, or will a patient need to opt in and affirmatively approve taping? Critical questions like these should not be left unanswered. That they are only highlights some of the difficult issues associated with a taping requirement.

The order does not address many other key issues, such as the standards that will govern who has access to the videotapes and under what circumstances, how long tapes will be kept, how the patient will be able to obtain copies, and what limits – if any – will be placed on use of the tapes.

In light of all these concerns, it is especially difficult to understand the rationale behind the taping mandate since another part of the order requires an independent medical observer to be in the operating room for every surgery performed at the Hospital for the specific purpose of ensuring that proper procedures are followed. Surely this is a sufficient – indeed, a more efficient and less invasive – way to do precisely what the taping is supposed to do. Thus, in light of the physical monitoring requirement that remains in effect for at least one year, taping surgeries strikes us as redundant at best, and extraordinarily intrusive at worst.

We also note a significant ambiguity in the wording of the order. It is unclear to us whether all, or just some, surgeries must be taped. We understand that your Department recently suggested that the order was never meant to require taping of all surgeries, but instead to require, as point #3 in the above-quoted order references, only "a minimum review of two surgical events per year for each surgical physician." However, we don't understand how this minimum review can be implemented without taping a much larger number of surgeries for each physician.

Obviously, it would defeat the purpose of the taping requirement if the surgeon were advised in advance of the two particular surgeries that were going to be taped for review. Instead, like monitoring of patient medical charts for errors, the hospital would be required to tape numerous surgeries of any particular doctor in order to be able to randomly examine two of them. In short, though obviously designed with the well-being of patients foremost in mind, implementation of this order will necessarily lead to a serious and disturbing invasion of their privacy in many instances.

Separate from, but complementary to, the videotaping issue is the order's requirement that surgeries be audiotaped as well. Again, on the surface one understands why audiotaping might be suggested if the goal is to ensure that proper protocols are being followed by medical staff. But, as with the videotaping, it is difficult to comprehend the utility of this if an independent observer is physically in the room monitoring these very activities.

In addition, in an operating room – as in most other non-public settings – a recognition by hospital employees that they are being audiotaped can have a potentially chilling effect on their speech and conduct. To the extent the audiotaping has an additional purpose – for example, to help evaluate the group dynamics that takes place among the staff in operating rooms – there is a kind of Heisenberg's Principle created by implementing this order. Knowledge among the staff that they are being audiotaped will inevitably change the dynamics among the group, and not provide a real picture of what the taping is supposed to capture. Further, this forced changed dynamic will not necessarily work in better ways for either the patient or the employee.

For all these reasons, we urge the Department to revise its November 2nd compliance order and eliminate the taping provisions contained within it. Thank you in advance for your attention to our views, and we look forward to hearing back from you about it.

Sincerely,

Steven Brown
Executive Director

cc: Dr. Timothy Babineau, RIH CEO
Lawrence Auburn, RIH Board Chair
George Vecchione, Lifespan CEO
Al Vericchia, Lifespan Board Chair
Linda McDonald, UNAP President
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