Learning from Incidents and Near-misses Reports

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Learning from Incidents and Near-misses Reports

To the Editor:—We strongly support reporting systems and therefore read with interest the Editorial View by Auroy *et al.*[1] However, before these methods become a standard audit or educational tool, some of their limitations must be considered further.

Clinicians can often select the type of adverse incident or outcome they will record. These tend to be those that are more severe, or those in accordance with individual perspectives of safety.[2,3] For example, prolonged paralysis after a regional block is more likely to be reported than transitory paresthesia. Temporary complications are often ignored, despite their potential educational value. Sometimes, reporters select those incidents most likely to carry a message to the organization's management.[4] Incidents over inappropriate waiting times for patients or surgeons are not exceptional in anesthetic incident–reporting systems. Such selection and reporting biases may seriously distort perception of safety problems in anesthesia.

When reporting systems focus on near misses (prevented or mitigated adverse events), another difficulty arises, one familiar to aviation safety experts: information overload.[4] A progressively larger amount of data is collected and stored to be further analyzed. It can become increasingly difficult and costly to classify and retrieve meaningful events in such an extensive system analysis.[5] Gradually limited by resources and complexity, experts may end up fixing near misses instead of addressing system errors concealed behind the data overload. This may jeopardize the didactic value of such events.

Finally, anesthetic and medical practices in general are largely controlled by a professional body of knowledge.[6] Organizational guidelines and standards are much less the norm than, for example, in chemical or nuclear industries.[7] Variability in local practices, professional culture, and political context seriously challenge the generalizability of organizational analysis.

To address these problems, suggested approaches could include the use of international standardized definitions of incidents and the development of guided reporting through generic adverse event indicators. The specificities of the healthcare organization analyzed could also be more systematically described and addressed.

If limitations such as these are not well understood and properly addressed, case reports and root cause analyses of adverse incidents and near misses are likely to remain largely narrative and of limited educational value within the broader anesthetic community.

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The above letter was sent to the author of the referenced Editorial View. The authors did not feel that a response was required.—Michael M. Todd, Editor-in-Chief

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In Reply:—We thank Dr. Lambert for his interest in our study, which was performed primarily to investigate the incidence of severe complications after central neuraxial blockades.[1] The strength of our study is the comprehensive study design and the large number of cases recorded. The limitation, common to most retrospective studies, is the relative lack of detail. Before attempting to answer the ultimate question of "why does it happen," we set out to answer the question of "does it happen," because the causal relation between central blockades and complications has been questioned, even recently.[2] Our data were subsequently analyzed to answer the question "to whom does it happen." This is a straightforward epidemiologic approach that can produce some but not all of the answers.

We share Dr. Lambert's preoccupation regarding the high number of patients with cauda equina syndrome.

This patient group is heterogenous, regarding both type of blockade and patient characteristics and, most importantly, probably also regarding pathophysiology of the complication. To attempt a better understanding of the different pathogenetic processes, we grouped nine of the patients with cauda equina syndrome and the four patients with paraparesis, because they were all found to have spinal stenosis (table 5 in the article).[1] Most of these patients were older than 70 yr, and nine had received epidural blockade or combined spinal epidural blockade. Compression was thought to have an important role in the development of the complication in these patients. The proposed pathogenetic process is demonstrated by a recent case report of transient paraplegia during epidural infusion in an elderly woman with severe kyphosis.[3] This case report included a magnetic resonance image showing cord compression caused by epidural infusion: Remarkably, the neurologic deficit spontaneously receded shortly after the infusion was stopped, thus illustrating the possibility of creating high epidural pressure with epidural pump infusion in subjects with restriction of the spinal canal and with outflow obstruction. Also, during spinal anesthesia in a patient with spinal stenosis, maldistribution of local anesthetic in the subarachnoidal space could cause higher concentration, thus favoring neurotoxic processes.

In our study, a remaining 23 patients experienced cauda equina syndrome in the absence of spinal stenosis. Single-shot spinal blockade had been given to 15 of these patients, and in 1 additional patient, a spinal catheter was placed. These patients were younger, half of them being younger than 55 yr. Lidocaine had been used in seven cases, bupivacaine had been used in five cases, and a combination of both drugs had been used in one case. No information was obtained in three