ANESTHESIOLOGY NEWS

print this article

Policy

ISSUE: AUGUST 2014 | VOLUME: 40:8

Does Anesthesia Need Its Own NTSB?

by Michael Vlessides

San Francisco—When disaster strikes the aviation industry, the National Transportation Safety Board (NTSB)—an independent federal agency—is there to investigate the accident and disseminate subsequent recommendations. Is there room for such an agency in health care?

A group of experts discussed the issue during a special symposium at the American Society of Anesthesiologists 2013 annual meeting, concluding that although such an organization would undoubtedly benefit patient care in the long run, logistical issues make its inception challenging, if not impossible.

Although there seems to be little appetite for the creation of another arm of bureaucracy in health care, improvements in the airline industry's safety record have been due in part to practice changes introduced after NTSB investigations, the panelists agreed. And they agreed that a similar model could benefit the medical community as well.

Indeed, the NTSB not only points out errors in process but also provides professionals with significant learning opportunities, which would prove equally helpful in health care. Such an organization would not only examine the causes of bad events, it would also provide useful data on what health care practitioners are doing right.

Yet when it comes to ideas, implementation is often far more complicated than inception. Richard I. Cook, MD, professor of health care system safety and chief of the Patient Safety Division at the Royal Institute of Technology, in Stockholm, Sweden, discussed the many factors that must be considered before such an investigatory health care agency could practice.

Three Musts for Success

Any high-quality independent accident investigation system requires three traits for success, Dr. Cook said. The first is recognized independence from stakeholders, including practitioners, the health care facility, governmental and nongovernmental authorities and patient representatives.

The second requirement is technical competence among investigators. “That competence is a complex mélange of expertise not generally available in health care settings,” Dr. Cook said. This mix includes forensic examination of the setting, technologies and physical data; skill at interviewing involved parties; critical analysis of complex data; and presentation of findings in clear, unambiguous terms.

“The third thing you need is rapid start-up of the investigations,” Dr. Cook added. “If you delay, there are features associated with medical accidents that make it extremely difficult to actually perform the investigation.”

Unlike transportation catastrophes, medical accidents can occur in a wide variety of circumstances, leave very little forensic evidence behind and rarely stop work in affected facilities.

John H. Eichhorn, MD, professor of anesthesiology at the University of Kentucky, in Lexington, echoed the sentiment that although developing an NTSB-like board for health care might be admirable, it would be fraught with pitfalls. Indeed, Dr. Eichhorn noted that members of the Anesthesia Patient Safety Foundation proposed a similar agency in the early 1990s, but implementation was impeded by a host of financial, logistical and medicolegal constraints. Specifically, Dr. Eichhorn noted that mustering a team of qualified, immediately available experts requires significant financial resources, and questions of ownership surrounding an investigation’s findings and recommendations could become woefully entangled.

Mark F. Weiss, JD, an attorney in Dallas and Santa Barbara, Calif., who specializes in anesthesia issues, was more blunt in his assessment of the plausibility of such a board, calling it a “pipe dream.” The primary issue is volume as there are thousands of medical accidents for every airplane crash. “It would boggle most minds to learn how many medical malpractice suits are filed in the U.S. each year,” Mr. Weiss said. “So if you’re going to have every medical accident investigated by federal investigators, you’re going to need a lot of investigators; it will create a giant bureaucracy. Most importantly, who’s going to fund this bureaucracy?”

Lack of communication also will hinder any kind of investigatory process. “Everyone is going to clam up, because they’re going to be protecting themselves in terms of liability,” he added.

Rampant Pitfalls

Despite his obvious skepticism, Mr. Weiss was quick to add that learning from health care accidents is possible, although in a much different form. “There are huge stores of health care information in hospitals, physicians’ records and insurance companies,” he told *Anesthesiology News*. “And you could probably get to a similar result if this information was de-identified and could be searched for safety issues.”

In the end, the panelists agreed that leaders in the anesthesia community will need to decide whether pursuing the creation of a central investigatory agency will improve patient care. Although there is a clear benefit to the dissemination of information surrounding accidents, pitfalls are rampant and the opportunity cost may be prohibitive.

“There’s no legitimate argument that safety isn’t a great goal,” Mr. Weiss concluded. “It’s just that the notion of some national task force that goes out and investigates all these things is a dream. There are many other things that can be done, but that isn’t one of them.”

Eugene R. Viscusi, MD, professor of anesthesiology and director of acute pain management at Thomas Jefferson University, in Philadelphia, agreed that the concept of a safety board, although laudable, would be difficult to implement universally in the health care setting. But he offered an alternative: “A review board would be incredibly helpful with those catastrophic events that elude our understanding,” Dr. Viscusi said. “A higher-level review committee would provide expert evaluation of those uncommon events. On the other hand, the majority of incidents can be reviewed at a more local level if the infrastructure is created. For example, I would propose that even administration of naloxone for opioid respiratory depression could be reviewed for root-cause analysis at the hospital level.”

Dr. Viscusi, a member of the editorial board of *Anesthesiology News*, suggested the creation of a mandatory, tiered review system that is linked with reporting of findings, with regular publication. “Implementing a system with tiers of review based on the nature and severity of the event would make the process more accessible and create greater buy-in,” he added. “Voluntary reporting is always the problem with medical misadventures, so in order to make this work, you have to incentivize reporting by creating a blameless review with useful information as the direct benefit.”