CORRESPONDENCE

Critical incident reporting and learning

Editor—We were interested to read the article of Professor Mahajan and concur with his view that safety can be improved by learning from incidents and near misses. Furthermore, we agree that investigation of incidents should not underestimate the potential of analysing incidents that are near misses or which have not led to patient harm. We also accept that under-reporting of incidents by doctors can be a significant problem. Whatever the reasons suggested by Mahajan for poor incident reporting, including lack of clarity of what to report, discrimination, and unfamiliarity with reporting systems, they can be overcome relatively easily. We have developed a Portable Digital Assistant-based (PDA-based) incident reporting system for anaesthetists that achieved a 97.5% incident reporting rate with 50% of reports relating to near-miss incidents where no patient harm ensued. The data derived from 14 000 anaesthetics showed that 3.5% will encounter a reportable event. The data could also be used to generate comparative reporting rates for organizations, grade of registrar, and time of day (in-hours vs out-of-hours). A second component of the programmed devices included the ability to record and display progress in acquiring competencies in practical procedures such as spinals, epidurals, arterial lines, central lines, etc. Such data demonstrated added value to our organization by proving invaluable in handling a patient complaint. The changes observed in the trainees provided with the devices in our Department of Anaesthesia led us to conclude that we had improved their ethical behaviour by facilitating incident reporting and thus had helped to achieve the highest incident reporting rate in the medical literature. Consequently, we would wholeheartedly endorse the comments of Mahajan and hope that future anaesthetists and other clinicians will feel part of the loop and empowered to improve existing systems and patient safety. However, we would add our lessons that incident reporting and logging performance data must be easy (taking <5 s to complete each task), must occur in a supportive environment, and individual feedback must be made available online.

Conflict of interest
None declared.

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Cormack–Lehane classification revisited

Editor—The survey and lab simulator work on the Cormack–Lehane classification is interesting and provocative but unclear in its primary aim. I am sure that if we tested the reproducibility of the ASA classification, it could end up with similar results, but would you stop using it? (Well we all agree that more classes are probably needed with more details, but it would add more confusion.) The Cormack–Lehane classification is one of the longstanding laryngoscopy view classifications (and as usually in medicine divided into less than five classes) which has received several revisions in order to get it more detailed, but creating also confusion in the newer versions. The results of your survey are not actually new, as a Spanish group also found that more than 50% of attending physicians and residents were unsure about a Mallampati. Does this suggest that we should stop using Mallampati, possibly for its lack in sensitivity, or should we train anaesthetists better? A closed-claim analysis has shown that the effort made to improve airway management mortality and morbidity in the 1980s and 1990s has paid off. Modern technology and new airway devices make difficult airway easier to manage, so possibly, in that sense, there is a need to review the value of the Cormack–Lehane classification. However, I think that you still need a classification and you need it to be simple. The primary responsibility is training anaesthetists and to keep on learning.