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The Dangerous Intersection Phenomenon: Why We Act Only After an Adverse Event.

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Every town has one — that dangerous intersection everyone talks about. Vehicles speed past it every day, drivers aware of its risk but cautious only after a serious accident occurs. In anaesthesia, we have many such intersections — places where danger is recognised but not addressed until an adverse event forces our attention. Whether it is a missing monitor, a non-functioning alarm, or an unsafe practice normalized by routine, we often wait for harm to happen before initiating change. This "Dangerous Intersection Phenomenon" is not new — it reflects the gap between awareness and action that continues to challenge our profession. Anaesthesia history is filled with examples of safety advances born out of mishaps. The oxygen pipeline was colour-coded only after cross-connection accidents. Vapouriser interlock systems appeared after cases of wrong-agent administration. Pulse oximetry and capnography became routine only after hypoxic deaths forced change. Even today, we encounter known risks — uncalibrated monitors, poor preoxygenation, ill-maintained machines — that persist until an incident exposes them. Each represents a dangerous intersection where safety depends on vigilance rather than system design.

The reasons are familiar. We often continue unsafe practices because nothing bad has happened so far — a habit safety experts call 'normalisation of deviance.' Cognitive bias also plays its part; rare events feel distant until they strike close. Workload pressure, staff shortages, and the illusion of safety in routine further dull our sense of urgency. Institutions, too, often react rather than anticipate — waiting for a sentinel event before enforcing protocols or purchasing essential equipment. Years ago, I was called to a peripheral hospital to administer anaesthesia — my first visit there. It was a less frequently used operating room, so I began by checking the Boyle's apparatus carefully before starting the case. After induction and intubation, however, I suddenly found that I could not ventilate the patient. Fortunately, I managed to resolve the situation without harm. On re-examining the achine, to my surprise, I discovered that the catheter mount — which in those days was opaque — was completely blocked by a wasp nest.

That incident left a lasting impression on me. Since then, I have never treated a machine check as a mere ritual. Every time I anaesthetise in a new or remote location, I remember that day — a reminder that familiarity breeds safety, but assumption breeds risk. Similarly, things can go wrong when we begin a case without proper monitoring. A simple example would be inserting a central venous line without ECG monitoring, or attempting intubation without keeping a difficult airway cart ready.

Even common steps such as preoxygenation are sometimes hurried or skipped, especially in seemingly 'short' or 'simple' cases. Taking shortcuts in preoxygenation before induction may seem harmless — until one day, the same practice turns a manageable situation into a crisis. Each of these shortcuts can quickly become a dangerous intersection if luck fails to favour us that day.

True safety lies not in avoiding errors but in anticipating them. A mature anaesthesia system learns from near misses rather than waiting for mishaps. Every alarm override, circuit leak, or

difficult airway that ends well should trigger reflection, not relief. Regular incident reporting, root cause analysis, and debriefings must become as routine as charting vitals. Leadership plays a crucial role — by encouraging transparency instead of blame, rewarding those who identify risks early, and ensuring that lessons are implemented, not just documented.

The journey from reaction to prevention demands a cultural change. It begins with curiosity — asking why a problem almost occurred, not just why it did. It depends on teamwork — where surgeons, anaesthetists, nurses, and technicians share a collective sense of responsibility. It is reinforced by systems that make safety the default option: machine checklists that cannot be skipped, standardized pre- induction routines, and simulation-based training for crises that may never happen but must always be prepared for.

Anaesthetists work daily at life's most critical intersection — where vigilance and technology meet uncertainty. Every crisis we prevent silently reaffirms our commitment to safety, yet every ignored warning brings us closer to harm. The lesson is simple: act before the accident. Let us identify and correct our dangerous intersections now, not after tragedy forces our hand. In doing so, we honour the central principle of our profession — that patient safety begins long before induction.