Confessions & Connections: Cultivating Wellness Through Honest Dialouge

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OBJECTIVES:

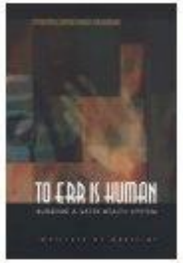
- Describe “second victim syndrome” and identify its common signs & symptoms in healthcare professionals
- Identify strategies for conducting supportive conversations with peers following adverse events.
- Understand the confession session framework as a means for open communication and peer support

“TO ERR IS HUMAN”

November 1999

INSTITUTE OF MEDICINE

Shaping the Future for Health



TO ERR IS HUMAN:
BUILDING A SAFER HEALTH SYSTEM

Health care in the United States is not as safe as it should be--and can be. At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented, according to estimates from two major studies. Even using the lower estimate, preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS.

Medical errors can be defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Among the problems that commonly occur during the course of providing health care are adverse drug events and improper transfusions, surgical injuries and wrong-site surgery, suicides, restraint-related injuries or death, falls, burns, pressure ulcers, and mistaken patient identities. High error rates with serious consequences are most likely to occur in intensive care units, operating rooms, and emergency departments.

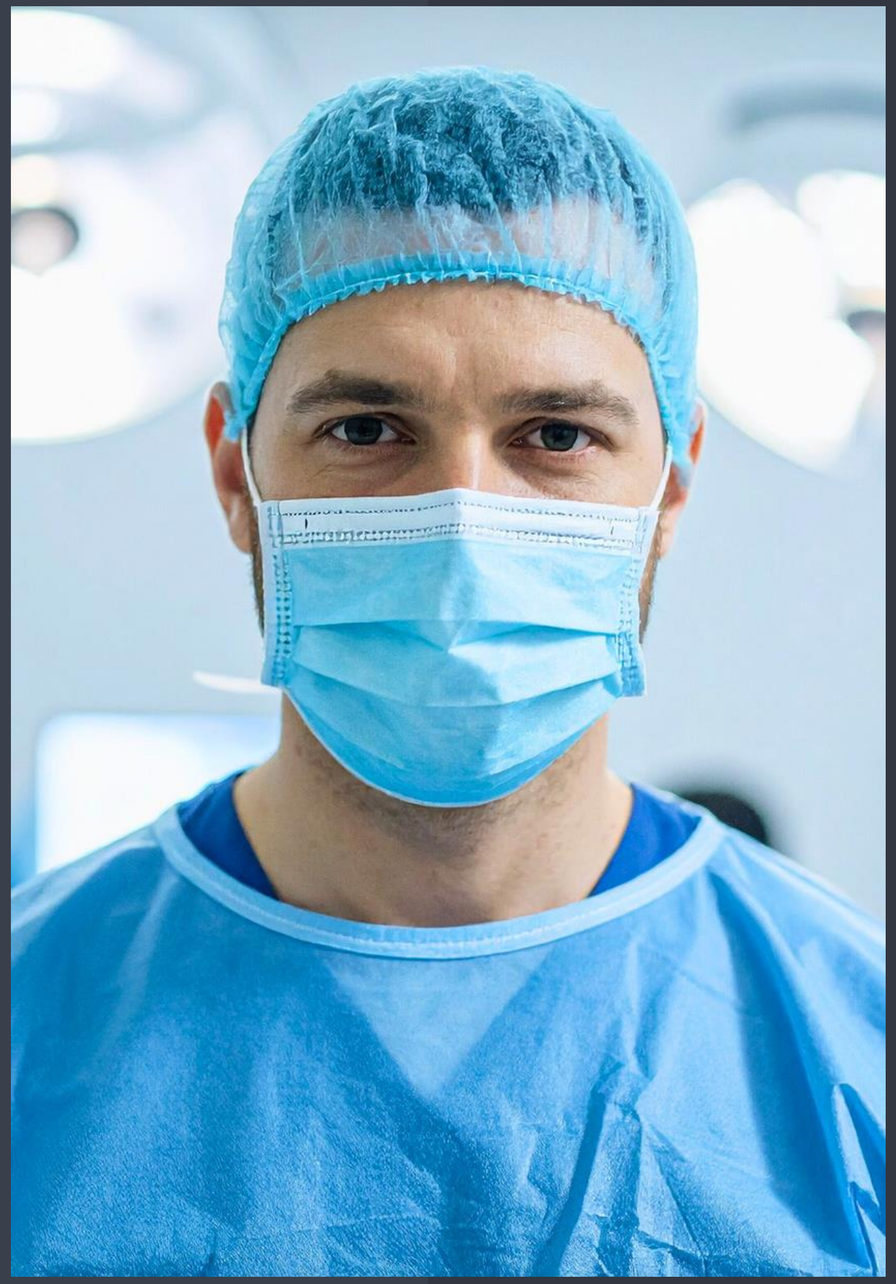
Beyond their cost in human lives, preventable medical errors exact other significant tolls. They have been estimated to result in total costs (including the expense of additional care necessitated by the errors, lost income and household productivity, and disability) of between $17 billion and $29 billion per year in hospitals nationwide. Errors also are costly in terms of loss of trust in the health care system by patients and diminished satisfaction by both patients and health professionals. Patients who experience a long hospital stay or disability as a result of errors pay with physical and psychological discomfort. Health professionals pay with loss of morale and frustration at not being able to provide the best care possible. Society bears the cost of errors as well, in terms of lost worker productivity, reduced school attendance by children, and lower levels of population health status.

A variety of factors have contributed to the nation’s epidemic of medical errors. One oft-cited problem arises from the decentralized and fragmented nature of the health care delivery system--or “nonsystem,” to some observers. When patients see multiple providers in different settings, none of whom has access to complete information, it becomes easier for things to go

Errors…are costly in terms of loss of trust in the health care system by patients and diminished satisfaction by both patients and health professionals.

- In 1999 the Institute of Medicine (IOM) published “To Err is Human: Building a Safer Health System”
- The goal was to shed light on the widespread problem of medical errors in the U.S.
- This lead to a huge push for a national movement toward public safety
- Key findings:
  - Up to **98,000 Americans die each year** due to preventable medical errors
  - Most errors are not individual failings but SYSTEMIC problems

“The problem is not bad people in health care—it is that good people are working in bad systems that need to be made safer.”



“TO ERR IS HUMAN”

- Specific impacts on anesthesia practice:
  - Checklists and protocols
  - “WHO Surgical Safety Checklist (2008)
  - Medication safety in the OR
  - Team communication
    - A “culture of safety”
  - Simulation training
  - REPORTING & QUALITY IMPROVEMENT

Figures

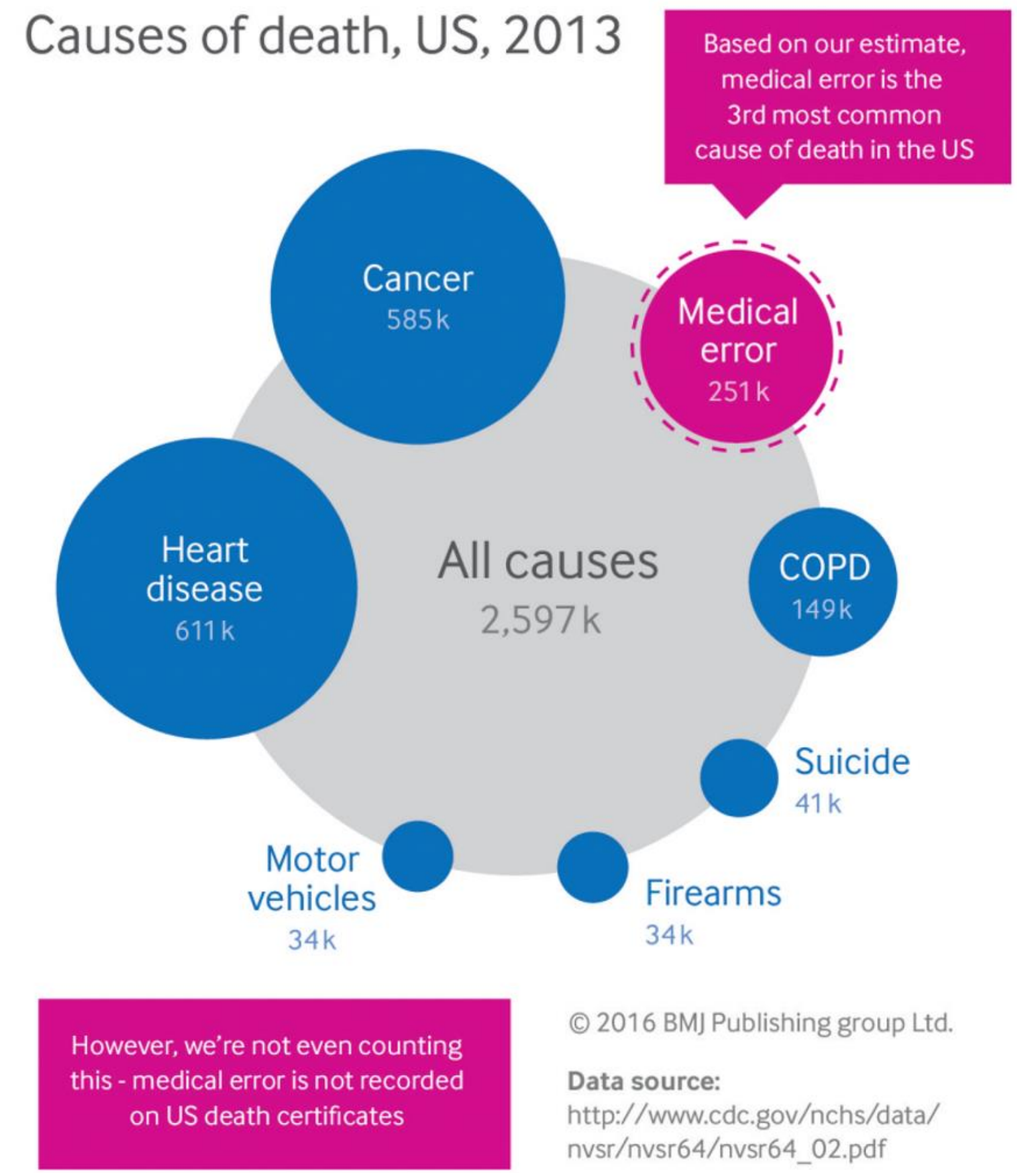


Fig 1 Most common causes of death in the United States, 2013[2]

MAKARY & DANIEL, 2016

- A young woman recovered well after a successful transplant operation. However, she was readmitted for non-specific complaints that were evaluated with extensive tests, some of which were unnecessary, including a pericardiocentesis. She was discharged but came back to the hospital days later with intra-abdominal hemorrhage and cardiopulmonary arrest. An autopsy revealed that the needle inserted during the pericardiocentesis grazed the liver causing a pseudoaneurysm that resulted in subsequent rupture and death. The death certificate listed the cause of death as cardiovascular.

ARE WE REPORTING ERRORS?

- **Less than 10%** of serious medical errors are ever formally reported through hospital systems (IOM, 1999; AHRQ follow-up reports).
- A 2012 U.S. Office of Inspector General (OIG) study found that **86% of adverse events in hospitals were not reported** to internal reporting systems.
- A 2017 Journal of Patient Safety review suggested that **only 10–20% of all adverse events are detected and reported** in voluntary systems.
- Even with mandatory reporting programs, near misses (where harm was averted) are reported at even lower rates — sometimes **less than 5%**.

WHY AREN'T WE REPORTING ERRORS?

- Fear of blame or punishment (despite the push for "just culture").
- Time burden – reporting systems are often cumbersome.
- Normalization of deviance – providers see certain risks as "expected" and not worth reporting.
- Lack of feedback – clinicians feel reports "go into a black hole."
- Hierarchy and culture – trainees and nurses (including CRNAs, RRNAs) may hesitate to report out of fear of retaliation.

ANESTHESIA SPECIFIC TRENDS

- Medication errors in anesthesia are **underreported by up to 50–70%** (studies from APSF and Canadian Anesthesiologists' Society).
- One multicenter anesthesia study (Cooper et al.) found that **only 25% of critical incidents made it into reporting systems**, even in hospitals with strong safety cultures.
- Near misses in anesthesia (e.g., wrong drug drawn but not administered, airway mishaps avoided) are rarely reported unless harm occurs.

WHAT HAPPENS AFTER A TRAGEDY?

DR. ALBERT WU

- In the 1990s, Dr. Wu noticed that when medical errors occurred, the emotional toll on clinicians was profound but largely invisible.
- He recalled cases where providers, after making an error that harmed a patient, were left isolated, ashamed, and unsupported.
- At the time, medicine’s culture was dominated by “blame and shame.”
  - If a mistake happened, they were often judged harshly.
- He observed colleagues who made errors and then struggled with grief, depression, and loss of professional confidence.
  - Some became withdrawn, others left practice entirely.

“

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the OR late that night. The news spread rapidly , the case tried repeatedly before an incredulous jury of peers, who returned a summary judgement of incompetence. I was dismayed by the lack of sympathy and wondered secretly if I could have made the same mistake - and like the halpess resident become the second victim of the error

”

SECOND VICTIM DEFINED:

- *“The patient who is harmed is the first victim. The second victim is the health care provider who is involved in the error and who is traumatized by the event.”* -Dr. Wu

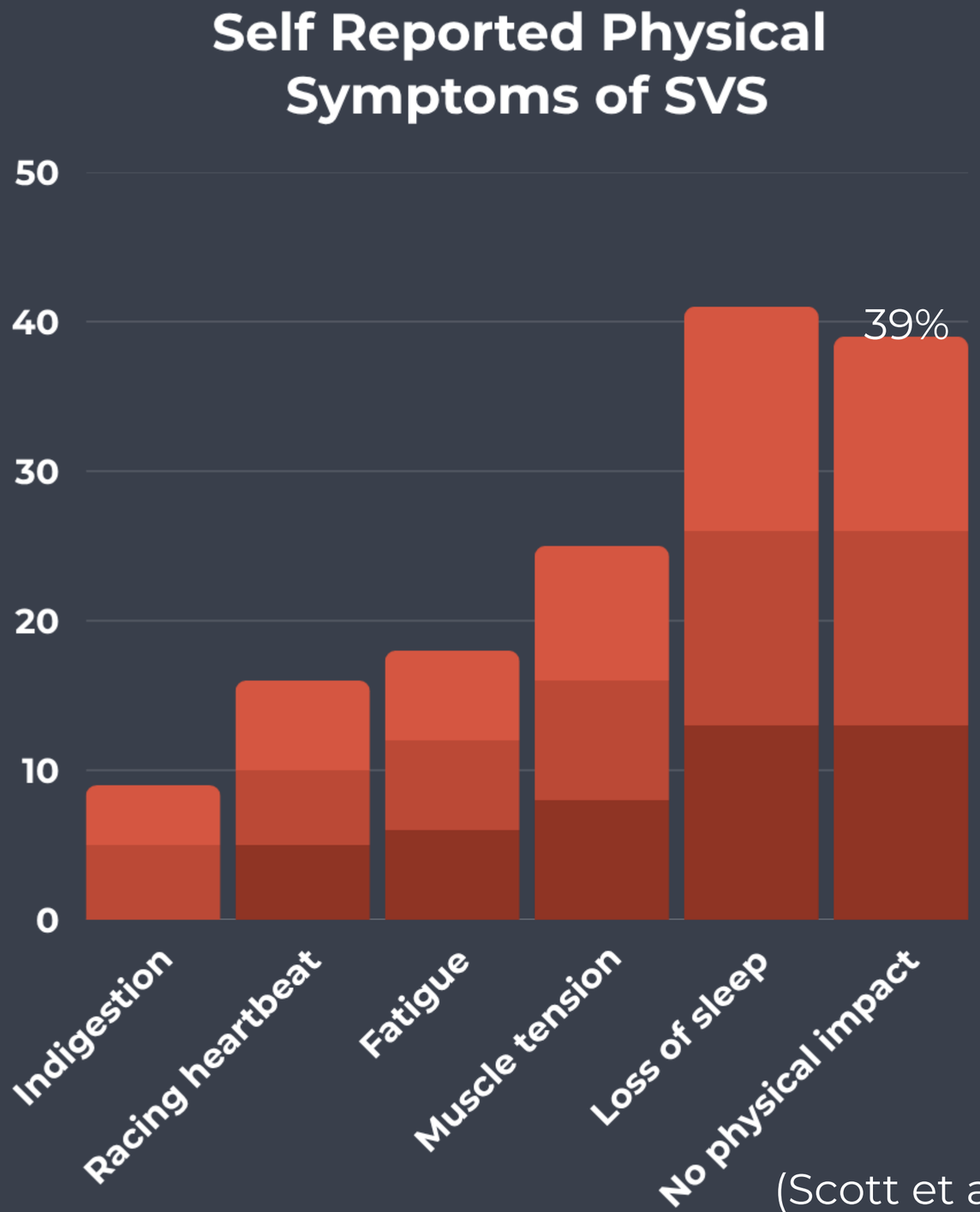
- Healthcare team members involved in an unanticipated patient event, a medical error and/or a patient-related injury & become victimized in the sense that they are traumatized by the event

STATISTICS & RELEVANCE FOR CRNAs/RRNAs

- Up to **50% of clinicians** report experiencing second victim symptoms at some point in their careers
- Anesthesia providers face frequent high-risk, high-consequence situations (e.g., airway emergencies, medication errors, intraoperative crises)
- Even when the outcome is not directly caused by the provider, CRNAs may internalize responsibility
  - “What could I have done differently?”
- Without support, some clinicians leave the profession or suffer long-term psychological harm
  - Including increased risk of suicide among CRNAs/RRNAs

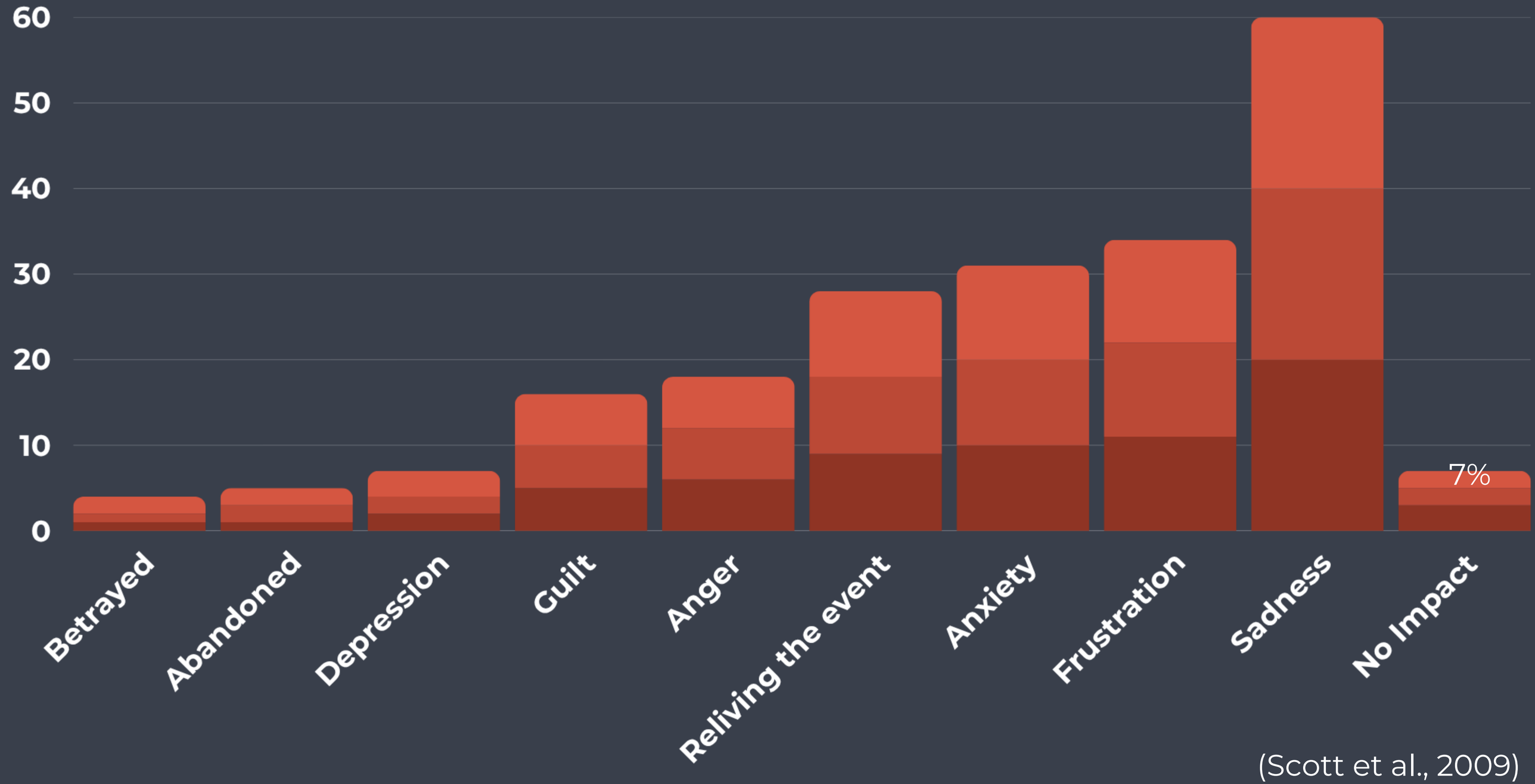
KEY FEATURES

- **Emotional Impact:** guilt, shame, anxiety, depression, and loss of confidence.
- **Physiological Stress:** sleep disturbance, fatigue, and hypervigilance.
- **Professional Consequences:** fear of litigation, disciplinary action, or peer judgment.
- **Isolation:** many providers feel unable to talk openly about the event due to stigma or blame culture.



(Scott et al., 2009)

Self Reported Emotional Impact of SVS



(Scott et al., 2009)

SIX STAGES OF RECOVERY

Chaos & Accident Response

↓

Intrusive Reflections

↓

Restoring Integrity

↓

Enduring the Inquisition

↓

Obtaining Emotional 1st Aid

↓

Moving On

1. CHAOS & ACCIDENT RESPONSE

- Immediate shock and panic after the event.
- The provider may feel overwhelmed, replaying what just happened, and fearing for the patient's outcome.
- Comming clinician reactions at this time are confusion, distraction, self-blame, & disbelief

- Rumination begins:
  - "What could I have done differently?"
- Flashbacks, self-doubt, and difficulty concentrating are common.
- Providers may isolate themselves, fearing judgment.
- Anger, remorse, depression, sadness, & lack of concentration

2. INTRUSIVE REFLECTION

3. RESTORING PERSONAL INTEGRITY

- The provider struggles with maintaining credibility in the eyes of colleagues, patients, and themselves.
- Feelings of guilt, shame, and fear of losing professional reputation are heightened.

- The “institutional response” phase — facing morbidity & mortality reviews, legal inquiries, or peer scrutiny.
- This can be extremely stressful and, if punitive, may worsen the psychological impact.

4. ENDURING THE INQUISITION

5. OBTAINING EMOTIONAL 1ST AID

- The stage where recovery can begin — reaching out for **peer support**, counseling, or mentorship.
- Having a compassionate colleague or structured program makes a huge difference here.

- Three possible outcomes:
  - Dropping out
    - Leaving the profession or role entirely
- Surviving
  - Continuing work but with lingering anxiety and self-doubt.
- Thriving
  - Emerging stronger, with greater resilience and often becoming a patient-safety advocate.

6. MOVING ON


PEER SUPPORT

WHY IS PEER SUPPORT SO POWERFUL?

- **Validation & Normalization**
  - Many clinicians think: **“I’m the only one who has felt this way”** after an error
  - Peer support shows them they are not alone — that others have been through similar events and recovered
  - This **normalizes their emotions** (guilt, shame, fear) as part of the recovery process, not as personal weakness
- **Breaking Isolation**
  - SVS often leads to withdrawal and silence out of fear of judgment.
  - Peer supporters — usually trained colleagues — **offer a safe, confidential space to talk openly**
  - Simply being listened to by someone who **“gets it”** reduces feelings of loneliness and stigma

WHY IS PEER SUPPORT SO POWERFUL?

- **Psychological First Aid**
  - Peer support provides immediate, non-judgmental comfort in the critical period after an error
  - Early intervention prevents distress from escalating into long-term anxiety, depression, or burnout.
- **Rebuilding Professional Confidence**
  - CRNAs and other clinicians often fear being **“unsafe”** after an error.
  - Through guided conversation, **peers help them reframe the event** as a systems issue rather than purely personal failure.
  - This restores confidence in their skills and professional identity

WHY IS PEER SUPPORT SO POWERFUL?

- **Encouraging Constructive Reflection**
  - Peer supporters can help shift the focus from self-blame → system improvement:
    - “What can we learn? How can we prevent this for the next patient?”
  - This transforms guilt into purpose, fostering **a culture of safety rather than shame**
- **Pathway to Thriving**
  - Effective peer support helps clinicians not just survive but grow after trauma
  - Many “second victims” who receive support later become peer supporters themselves, fueling a cycle of resilience

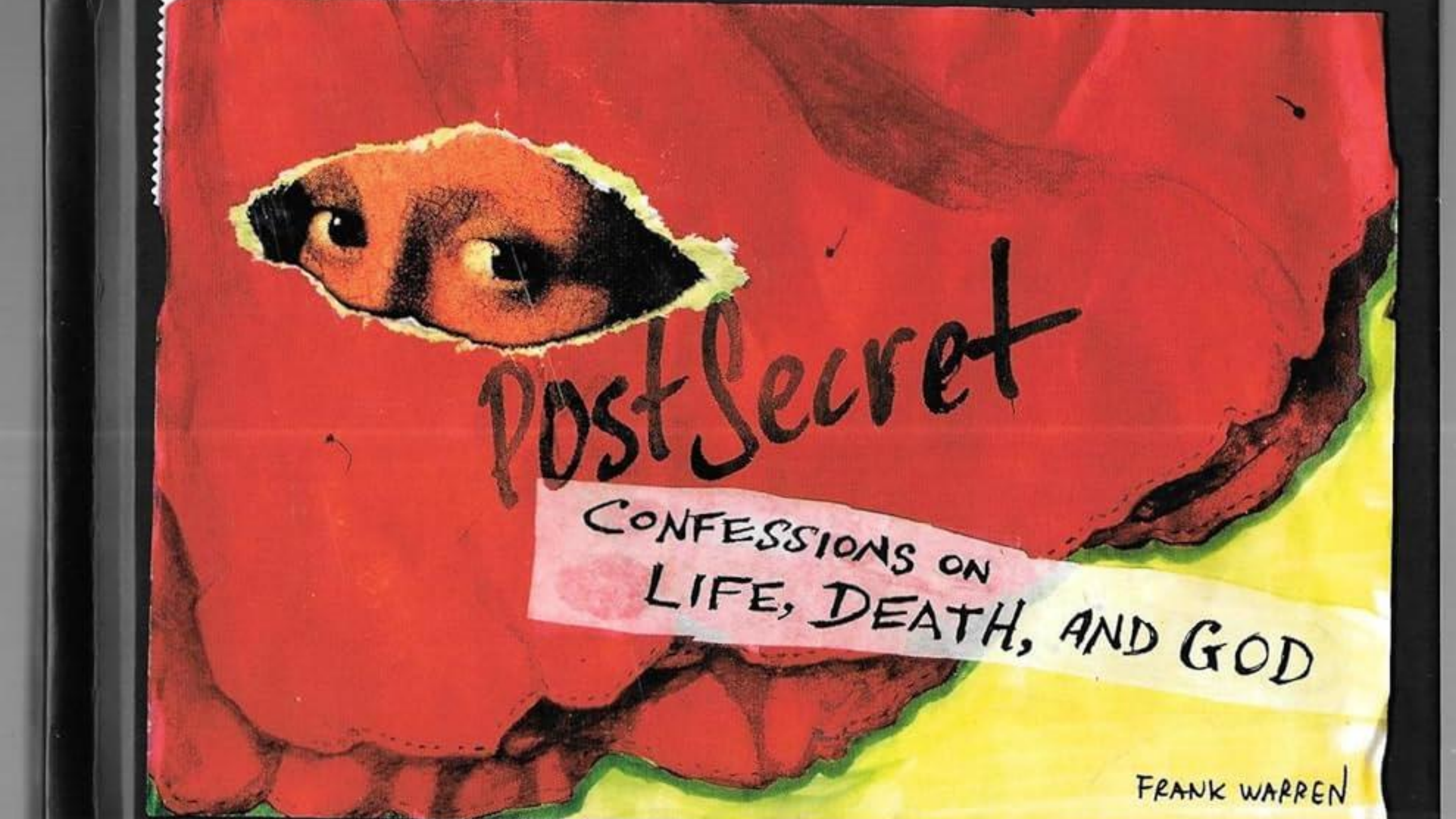
WHY ISN'T EVERYONE REACHING OUT FOR PEER SUPPORT?

- Fear of stigma or judgment
- Worry about being seen as weak or incompetent
- **Concerns about confidentiality**
  - **Fear the disclosure could affect career advancement or credentialing.**
- Cultural norms
- Lack of awareness
  - Many do not know formal peer support programs exist in their institution.


I NEED
HELP!

THE CONFESSION SESSION FRAMEWORK

“People rarely admit the things that didn’t work, the mistakes they made, and how they found out what went wrong”


PostSecret
CONFESSIONS ON
LIFE, DEATH, AND GOD
FRANK WARREN

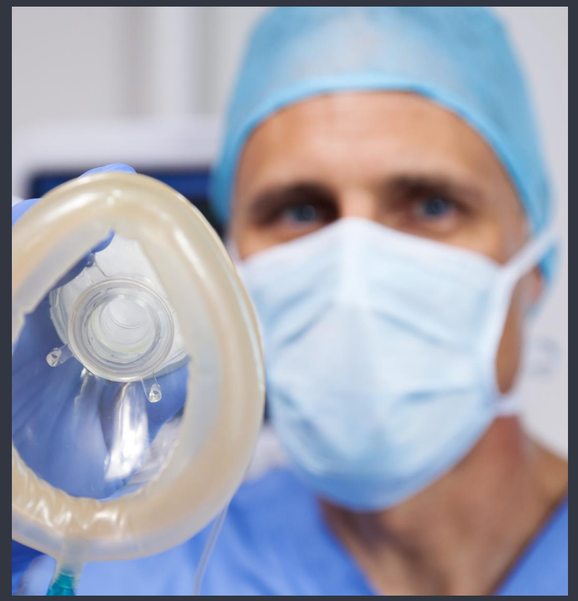
HISTORY

- In 2008, J.E.D. Hurwitz of Gigle Networks was organizing the IEEE International Solid State Circuits Conference
  - He proposed the idea of a forum dedicated to confessions of **“goofs”** in analog design
  - A webpage was designed so people could **anonymously** submit their goofs
- In 2009, this technique was implemented at another tech conference
- In 2015, a “confession session” framework was utilized to get Physician Anesthesia Residents to “open up” to their program director about issues they’ve encountered.
- Since 2024, I have utilized this framework to teach RRNAs the QI process
  - Thefeedback about the wellness aspect of this project has been overwhelmingly positive

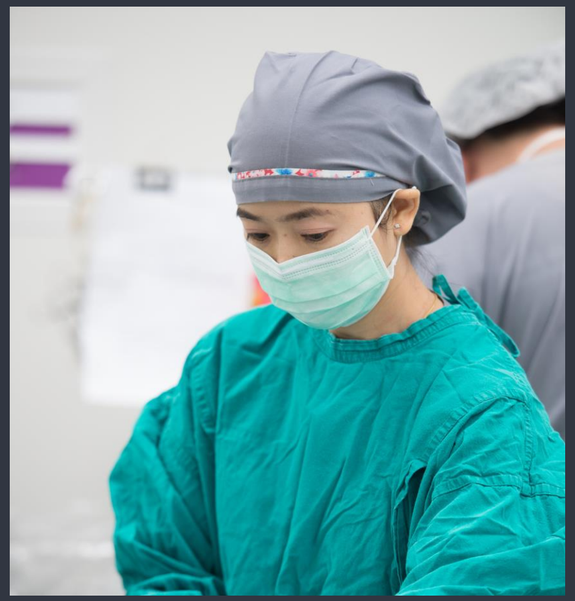
CONFESSION SESSION RULES & OBJECTIVES

- **Rules:**
  - Confessions must be typed
  - Confessions will be submitted anonymously
  - All identifiers will be removed
  - Respect all confessions
  - If your confession is chosen, please do not reveal that you were the author
- **Objectives:**
  - Understand that EVERYONE makes mistakes
  - Allow others to learn from our mistakes
  - Promote wellness
  - Promote cohesiveness within the cohort
  - Have an open and honest discussion about how we're feeling

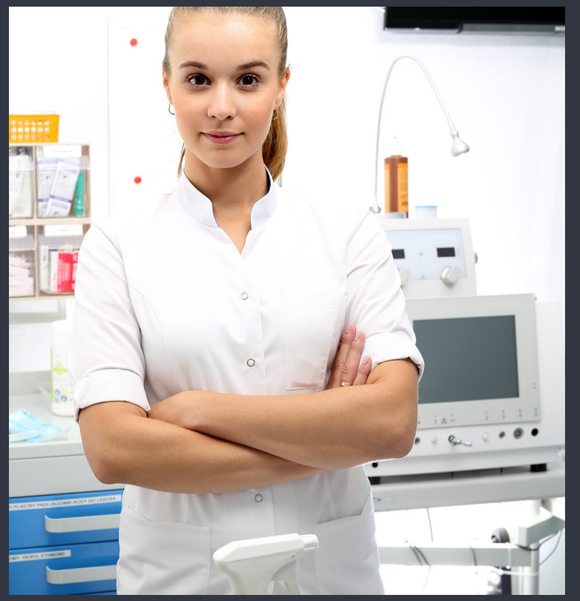
(Karan, Berger, & Wajda, 2015) EXAMPLES



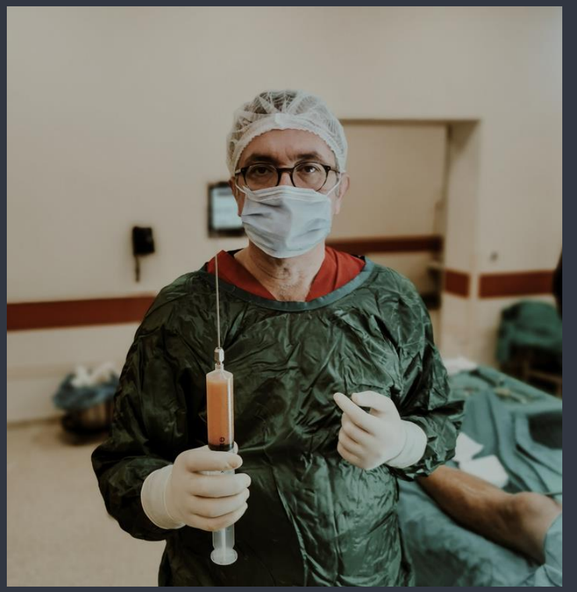
Been really repulsed by the whole room “turnover” process. Reusing blood pressure cuffs that have questionable stains on them; the EKG wires go straight from the sticky, bloody floor to being hung on top of IV pole for next patient use. What a gross-out this has been . . . yuck.



I mistakenly pushed an entire syringe of ephedrine thinking it was my flush syringe I usually keep on the line. The label was facing away from me, and my attending had put it on the line while I was out on break. I almost had a heart attack, but the patient barely reacted to it. I did not tell my attending.

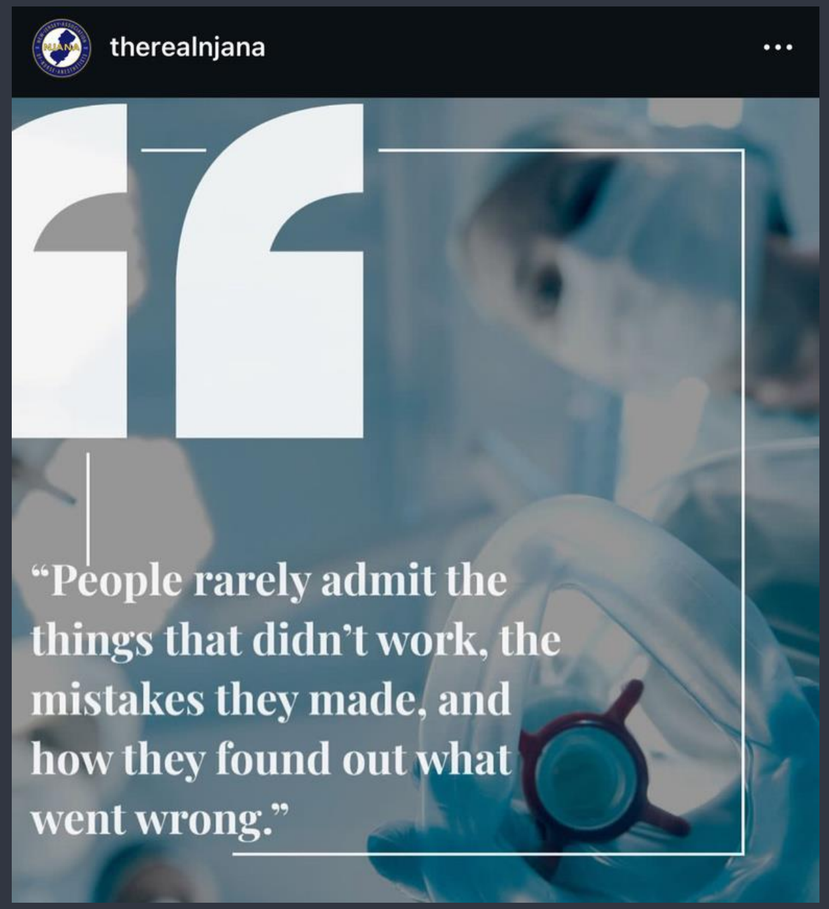


I had 2 instances where I went to get my drug, only to find that I forgot to label the syringe. In both instances, I knew what the drugs were because I had drawn them up myself recently and placed them in their usual places and all the other drugs I had were labeled. I used the drugs, but now looking back, this is probably bad practice and where mistakes happen.



A mediocre hitter in the MLB probably has a higher batting average than my intubation success rate.

LET'S GIVE IT A TRY!



therealnjana As a part of our wellness lecture for the Fall Meeting, we are asking that you anonymously confess something that has occurred to you professionally (in training or as a CRNA). It can be an error that you made clinically, a near miss or sentinel event that you witnessed, or just an overall feeling about the profession.

Please use the link below to anonymously submit your confession:
https://rutgers.ca1.qualtrics.com/jfe/form/SV_eri1mvloVWNWnNc

During my peds rotation, I was inducing for GA with an ETT. As usual, I gave propofol followed by “rocuronium”. But when I went to intubate, it was clear the patient hadn’t achieved neuromuscular blockade. They were gagging, biting, and actively resisting the tube. It got stressful fast. We had to give another full induction dose of propofol and try again.

After intubation, the anesthesiologist reassured me and told me to save the vial of roc so we could send it to pharmacy, since there had been a lot of “duds” lately.

While cleaning up after the case, I found the vial of roc… unopened. My heart sank and I realized I had accidentally drawn up (and given) lidocaine instead of roc. I tossed the unopened roc into the sharps container and told the anesthesiologist I couldn’t find it to send to pharmacy. I couldn’t bring myself to admit what had happened to a peds attending who was already anxious and micromanaging my every move.

Thankfully, the patient was okay. But I still feel sick at the thought of my mistake harming a child, and disappointed in my inability to own up to it. It took me twice as long to draw up induction meds for the rest of my peds rotation.

I have been practicing as a CRNA for about six months and I’m not sure if I made the right decision. Everyone talks about how high job statisfaction is for CRNA and I just don’t feel it. Is there something wrong with me???

While on my peds rotation, I cared for a 5-month-old undergoing a urology procedure. Preoperatively, the parents reported that the patient had an occasional productive cough with no fever or rhinorrhea. My findings were reported to the attending, and they decided to proceed with surgery. After an uneventful induction and LMA placement, the attending stepped out. During the case, the LMA started to have an audible leak, though my tidal volumes remained adequate. After a couple of minutes, the patient SPO2 started to drop. Initially, I was able to increase the SPO2 by manually bagging the patient. I wanted to take the LMA out and switch to mask management, but I hesitated without the attending present. However, the patient's SPO2 soon dropped to 80%, and I called the attending. During that split second of calling the attending the patient's SPO2 was now 40%. I was instructed to administer some propofol and I pulled the LMA out and started manually bagging the patient. When I pulled the LMA out, I noticed the infant's face was blue. My mind went blank, and I was unable to go through the differentials. The attending arrived and administered more propofol, succinylcholine, and albuterol. Oxygenation improved and the case proceeded safely.

In the moment, everything we learned about laryngospasms or bronchospasms escaped me. All I could see was the cyanotic infant in front of me and hear the loud SPO2 alarm. It wasn't until I saw the attending's actions that I recognized the likely causes. Although the patient ultimately did well, I was deeply shaken, guilt-ridden, and felt incompetent. I relentlessly combed through every detail and thought about the missed signs and interventions.

This is an incident that I recall from when I first became an ICU nurse. It happened to a senior nurse on the unit and I will never forget it. This patient was intubated and had a NGT. I remember walking past the patient and seeing a Pleurovac on the floor filled with cream colored drainage. The drainage appeared to be thick and I asked around about what happened to the patient. I don't know the history of the patient, but he was either a medical or surgical ICU patient. I found out that the nurse read the impression of the CXR, which said that the tip of the NGT was in the stomach. She proceeded to administer tube feeding to the patient through that NGT. Unfortunately, after feeding the patient over 1L of tube feedings, everyone came to realize that the tip of the NGT was in the lung. The cream-colored liquid that was being drained into the Pleurovac was actually tube feeding. The nurse said that she didn't auscultate for air before starting the tube feeding since the radiologist confirmed position of the tube via the CXR. It's really unfortunate that the patient got hurt in the process.

A cardiac attending that I was frequently with always placed red caps on the vasopressor syringes and confided that anesthesia needed to be “idiot-proofed”. I was with a different attending who insisted on mixing her own medication syringes. Somewhat overwhelmed and definitely exhausted, I reached for the norepinephrine syringe to give a bolus and soon after the patient became more hypotensive. The attending immediately intervened and asked me if I pushed norepinephrine and I responded “yes”. I rechecked the syringe I had just put down and realized that I had accidentally pushed nitroglycerin. Both the norepinephrine and the nitroglycerin were in 20 cc syringes with red caps. While I should have read the syringe, I just assumed that the red cap was an identifier for vasopressor. The patient’s hemodynamics stabilized following additional boluses of actual vasopressor and was successfully transferred to the cardiothoracic intensive care unit with overnight extubation. I never shared my mistake with the attending.

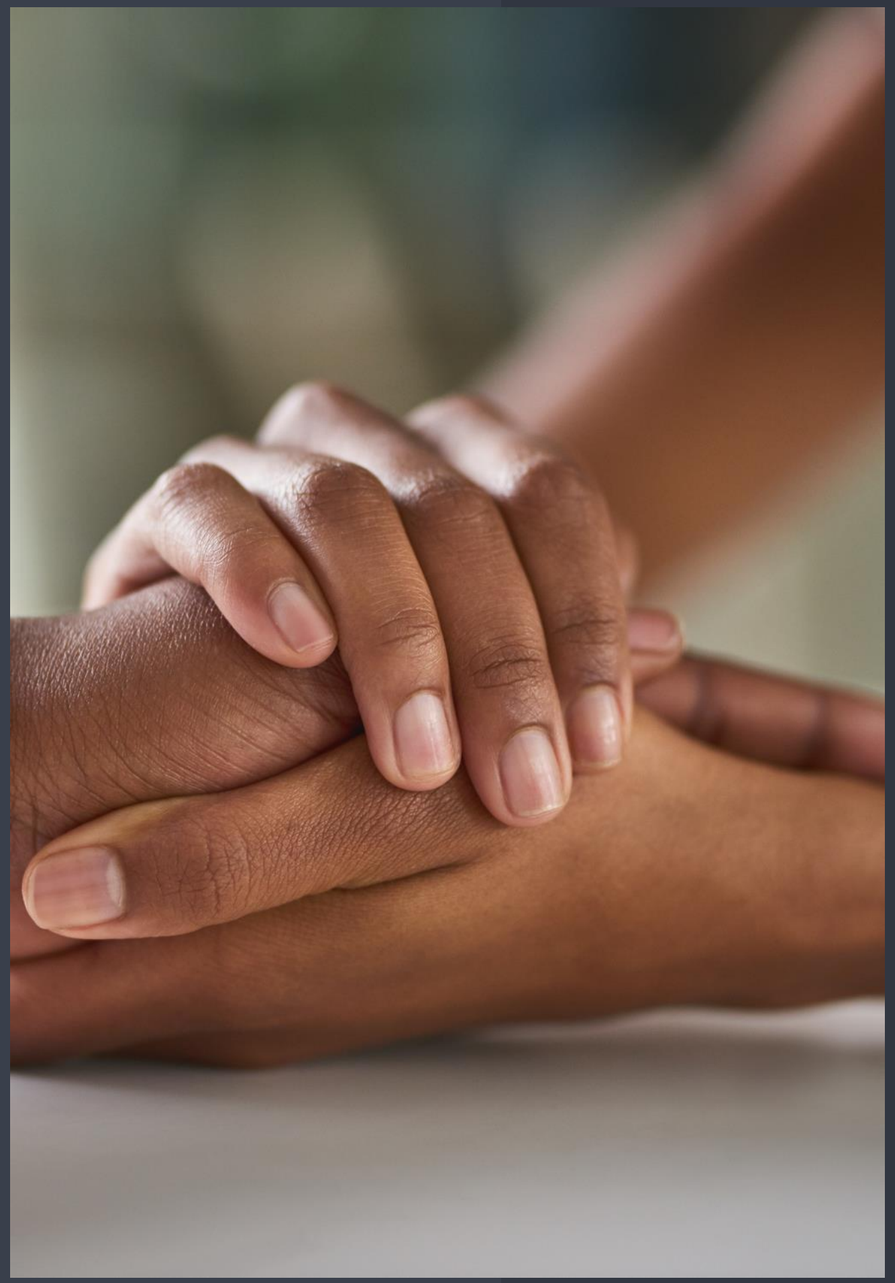
I felt terrible for the mistake for weeks and felt even worse for not admitting the mistake due to fear of judgement and repercussions. Three weeks later, I watched the head cardiac anesthesiologist at that institution make the same mistake. Moving forward, I only put red caps on my vasopressors and specifically label antihypertensive medications in a distinct manner. I am very lucky that nothing bad happened, and since that event I quadruple check any medication I go to administer, am overly communicative in any emergency situation, and am overtly honest in the clinical setting.

RRNA FEEDBACK

“The confession assignment made me reflect on my mistakes and how to improve in order to prevent this from happening in the future.”

“Dr. Pilot created a safe and supportive learning environment where it was okay to make mistakes, as long as we learned from them. Through the ‘Confession Session’ project, he encouraged openness, reflection, and growth, helping us turn challenges into valuable lessons.”

“His exercise about clinical confessions helped me to finally get some relief about a tough outcome that was weight heavily on me.”



LET'S WRAP THIS UP!

- If **50% of clinicians** report experiencing second victim symptoms at some point in their careers, we have to do all we can to help
- **Anonimity is a powerful tool!**
  - Classrooms
  - Anesthesia Dept. meetings
  - Everyday life
- Ground rules are important
  - Elect a "gatekeeper" to filter through confessions
- Remember, **"it's okay not to be okay"**

24/7 AANA resources are available

Text or call 988

Here when you need us.

The AANA Helpline wallet card puts help for alcohol or other drug concerns at your fingertips.

To order cards, visit **store.aana.com**

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