Confessions in Essence: The Power of Observation, Acknowledgement and Pure Enlightenment

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Confessions in Essence: The Power of Observation, Acknowledgement and Pure Enlightenment

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Confessions NOT Rare but Confessing RARITY Itself

Background
In our department of anesthesiology there has been informal discussion forum called "Confessions" regarding difficult anesthetic scenarios where no patient harm had occurred (defined here as near-hit-near-miss (NHNM) incidents). These confession sessions are currently held only among the anesthesiology residents during didactics sessions and are based on the principle of developing a practice of intellectual honesty without repercussions similar to religious "confessions" in essence [1]. These "confession" sessions are in no way related to the Anesthesia Quality and Assurance (Q&A) Committee forums (including Mortality and Morbidity (M&M) Forums) which are required by law to maintain the accountability/answerability in reporting events of anesthetic adverse events/poor clinical practices. Q&A committees are confidential but not anonymous. Q&A forums are used in part to improve education based on these peri-anesthesia incidents/events. However, there are numerous underreported near-hits-near-misses (NHNM) which can also provide valuable information regarding anesthetic practices.

As peri-anesthesia incident reporting systems are an integral part of clinical education through local Q&A committees and M&M forums, the American Society of Anesthesiologists constituted the Anesthesia Quality Institute (AQI) and initiated National Anesthesia Incident Reporting System (AIRS) with the aim for dispersion of local Q&A sessions' elicited observations for the benefits of nationwide readers [2]. AIRS system has novel Anonymous Electronic system for report submissions [3]. This national concept further inspires local system to collect NHNMs anonymously without overlapping the domains of Q&A committees and Risk Management committees [4-5]. This is the basis for the formal development of the current Confessions Model.

Confessions in essence (whether academic or spiritual) envisage primarily the power of observation, acknowledgement and "pure enlightenment" and relegate the legality/liability issues and accountability/answerability concerns to be managed by risk management agencies. Similar to religious/spiritual confessions model [1], this anonymous portal is envisaged to empower the confessors to acknowledge their mistakes or oversights, and to facilitate the educators to share newly-found or revisited anesthesia knowledge (gained from anonymous confessions) with fellow colleagues for prevention of similar future NHNMs.

Objectives
Primary Objective is to devise formal-local-institutional system called "Confessions" for voluntary reporting of NHNMs that
1. is totally anonymous
2. will not replace mandated Confidential Q&A forums
3. will be an additional forum for intellectual stimulation
   1. i. Anesthesia care providers to discuss NHNM incidents
   2. ii. Anesthesia care providers to analyze pathophysiology of observed NHNM incidents
   3. iii. Anesthesia care providers to learn from the newly-found understanding
   4. iv. Anesthesia care providers to acknowledge their mistakes/oversights of diseases and clinical scenarios secondary to uniqueness of each individual patient, procedure and/or operator
   5. v. Anesthesia care providers to educate the community through the anonymous confessions without any repercussions
4. increases the amount of shared anesthesia knowledge related to NHNM incidents due to anonymity of confessions
5. can improve anesthesia education of all local peers and their anesthesia practice in the long run
6. can hopefully decrease the number of future peri-anesthesia NHNM incidents

Materials and Methods
The first and foremost step is the education of Anesthesiologists (Board-Certified or Board-Eligible) to attend the faculty development presentation as Faculty Development Power-Point presentation (See Attachment) explaining the underlying thought process, our shared experiences at our worksites and our recommendations for other institutions so that they can imbibe the methods as well as raise their own worksite specific concerns/concerns/solutions for better application of the "Confessions" Model.
The next step is prompting all anesthesia care providers to come forward and confess as explained below but only after reading the detailed Instructions to the Submitter document. The general forum of all anesthesia care providers’ can be first time informed about this process utilizing one 15-minute time slot informal chit-chat presentation (See Attachment) during any regular anesthesia didactics sessions that are attended by maximum anesthesia care providers (in our institution, it is usually our monthly M&M meetings). Subsequently, all the attached forms with the detailed information can be sent out as a group email to all providers so that they can further review and get used to the forms and instructions. Additionally, small single-page fliers (See Attachment) can be attached to "Confessional" Boxes to reminding one-last-time how to confess in this forum.

Essentially, Anesthesia care providers [Anesthesiology Residents, Anesthesiology Sub-specialties’ Fellows, Certified Registered Nurse Anesthetists, Student Registered Nurse Anesthetists, and Anesthesiologists (Board-Certified or Board-Eligible)] are asked to anonymously report NHNM events. All peri-anesthesia events that amount to NHNM are eligible for these submissions. These NHNM events are collected in sequential order on 4 different forms (See Attachments FORMS A-D) as:

1. FORM A Confession Submission (CS): written anonymously by the confessor
2. FORM B Confession Discussion (CD): anonymous comments of the peers in regards to CSs
3. FORM C Confession Follow Up (CFU): confessor’s anonymous reply to CDs
4. FORM D Averted Confession (AC): written anonymously by peers as an event that was averted due to information learnt from previous confessions.

The forms submitted as printed typed documents needs to be placed in locked "Confessions” Boxes. Completed confession forms can be collected at the end of each month. Confessions then need to be reviewed by the designated clinical educators' teams as follows:

Step 1. Removal of any identifying marks with correction white colored fluid
Step 2. Sorting of de-identified forms by the Q&A liaison officer to remove any confessions that were not NHNMs. These removed confessions can be anonymously discussed in Q&A forum. N.B. These non-NHNM confessions can be used in classroom teaching and discussions and these removed confessions can NOT be electronically shared
Step 3. The remaining confessions (NHNMs) are reviewed with the aims of

- Better understanding of the pathophysiology of the confessions
- Addressing the event management issues (if any)
- Advocating a plan for prevention of recurrences of these confessions

Step 4. Reviewed confessions can be shared via monthly email to anesthesia providers

- For continuing medical education (CME)
- For eliciting comments (CDs) as typed forms and NOT electronic forms
- For continuing anonymous dialogue with the confessor through his/her CFU forms
- For encouraging more submissions (AC) if any confession is averted by the electronically shared confessions

Step 5. Selected confessions can be ANONYMOUSLY shared with the National Anesthesia Incident Reporting System for the benefits of nationwide audience

Outcomes

Primary Outcome

1. Number of Averted Confessions per month as an objective indicator of Confessions Model’s success

Secondary Outcome

1. Number of Confession Submissions (CSs) per month over time (an indication of acceptance for model)
2. Number of Confession Discussions (CDs) and Confession Follow Ups (CFUs) per month as a learning interests indicator of anesthesia care providers’ group
3. Frequency of various characteristics (patients’ and personnel’s) among the submitted confessions

Our Experiences

As the running title suggests "Confessions are NOT rare but Confessing itself is rarity", there are no formal outcomes to report. However, this is a vision for future sprouting from past observations that had led us to initiate the formalization of the existing informal confessions model within the anesthesiology residency program to extend beyond the confined boundaries of closed door resident didactics sessions. Though it out-rightly failed to prompt any of the "confessors" to "confess" their "confessions", it has been still worth a honest try on the part of the developers.

"Confession” 1. As an internal medicine intern, the management of esophageal injury in a post-cardiac surgery patient in a medical intensive care unit
ensured the extra-vigilance to avoid trans-esophageal echocardiography based esophageal burns when the same intern started cardiac anesthesia rotation.

"Confession" 2. Difficult endotracheal intubation in a patient who was unable to tolerate supine position secondary to history of gastric pull-through procedure (s/p total esophagectomy) led to the development of the feasibility research and popularity of endotracheal intubation in sitting position.

"Confession" 3. When a multicity anesthesia educational meeting discussed the consequences of un-recognized and often overlooked diagnosis of patent foramen ovale (PFO) as a cause of hypoxemia in intensive care unit (ICU), the immediate-next month ICU rotators diagnosed and confirmed two patients wherein if PFO (intracardiac shunting with/without intrapulmonary shunting) would have been overlooked, the patients would have been unwarrantedly managed with mechanical ventilation.

"Confession" 4. In a morning educational session, the guest speaker (a plastic surgeon) was applauding the mother of a child who (un)knowingly kept her child's injured airway intact by placing the child prone so that the child's detached and overhanging tonsils do not catastrophically obstruct the glottic opening; and the same day, the anesthesia team encountered the detachment of an enlarged tonsil while attempting endotracheal intubation and the catastrophic intraoperative diagnosis was made in no-time thanks to listening to the morning educational sessions.

"Confession" 5. Constant caution elicited by cardiothoracic surgeon regarding fentanyl based pancreatitis (based on anecdotal experiences) in post-cardiac surgery patients led the ICU rotator to consider fentanyl induced pancreatitis in a chronic pain patient during pain clinic rotation; and subsequent to consideration of this pain management causing physical pain scenario, a different patient was considered as fentanyl induced vesico-ureteric spasms eliciting the difficulty of managing pains caused by pain management itself.

These are just a few of the many examples that have strengthened (irrespective of whatever) authors' resolve to develop, promote and propagate Confessions Model.

Our Recommendations

Based on our experiences (or our limitations causing lack of any first-hand experiences of confessors coming forward), our recommendations for "Confessions" Model's future use and expansion into other anesthesia institutions:

- Place Locked "Confessional Boxes" in Anesthesia Care Providers' LOUNGES rather than Worksite Chief's Offices
- Mandate Anesthesiologists (Board-Certified or Board-Eligible) to "Confess" as Surrogate for the Supervised Residents/Fellows/CRNAs/SRNAs during the submitted NHNMs
- Inspire Residents/Fellows/CRNAs/SRNAs to "Confess" even if they were NOT directly involved in submitted NHNMs but had enough first-hand/direct knowledge of submitted NHNMs
- Averted Confessions can actually be used as Sign of Improved Patient Outcomes directly related to the "Confessions" Model that can be turned into Money-Saved-Money-Made-Model in current paradigm of Outcome-Based-Reimbursements

References