The Morbidity and Mortality Conference: Past, Present and Future

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Objectives

Define what M&M was and what it is now

Become familiar with best practices of M&M conferences

Opportunities for the future of M&M conferences
M&M: What it was and what it is now

PAST

Blame & Shame
Accusation
Accountability
Education
Accounts for Failures

PRESENT

Quality Improvement
Peer Review
Medical Education
Evidence-based Medicine

ACGME
BEST PRACTICES
More Depth, Less Breadth

• 76% of responding institutions presented all deaths\(^1\)

• 50% of these institutions presented all complications\(^1\)

• Too many cases per conference was observed to be a barrier\(^2\)


Moderators are a Must

- Often a senior participant who is skilled in medical education, systems-based practice, interpersonal skills
- Review cases beforehand in preparation
- Unbiased and uninvolved in the case presented
- Remain fair-minded and objective
- Represent the middle ground

- Promote a safe environment
- Rephrase / moderate comments that are not supportive or constructive
- Steer discussions and prevent deviations
- Foster high-quality discussion
- Increase audience participation and interaction
- Able to reflect and recount similar errors they may have made and lessons learned

Who should relay the message?

When practice changes were presented by residents, learners were more accurately able to cite specific practice changes on post-conference questionnaires.
Structure is Important

SBAR Framework\(^1\)
Situation = the complication
Background = pertinent clinical information
Assessment = analysis / identify root cause
Recommendations = lit review / guide for future care

House staff led conference\(^2\)
Organization, case selection, case preparation and moderation are done by residents of various level.

Root Cause Analysis (Ishikawa Model)\(^1\)
Cause and effect model, originally used as a quality control tool. Fishbone diagram with the problem at the head and a backbone with factors that can bring success or failure to the process.

Process Mapping\(^3\)
An illustration that describes an event in which each step is summarized chronologically in a text box, connected by arrows.

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Timing is Everything

- 5 minutes: Statement of Complication
- 10 minutes: Statement of Potential Causes
- Questions from the Audience
- Presentation of Learning Points

Integration of evidence-based medicine into the M&M discussion is widely agreed upon by all levels of conference participants.


Audience Participation ⇔ Safe Place

<table>
<thead>
<tr>
<th>Participation in conference</th>
<th>Senior faculty</th>
<th>Junior faculty</th>
<th>Senior resident</th>
<th>Junior resident/intern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver presentation</td>
<td>Rarely (56%)</td>
<td>Rarely (64%)</td>
<td>Sometimes (37%)</td>
<td>Rarely (38%)</td>
</tr>
<tr>
<td>Ask questions</td>
<td>Sometimes (51%)</td>
<td>Rarely (45%)</td>
<td>Rarely (37%)</td>
<td>Never (44%)</td>
</tr>
<tr>
<td>Critique care</td>
<td>Sometimes (44%)</td>
<td>Rarely (45%)</td>
<td>Rarely (30%)</td>
<td>Never (52%)</td>
</tr>
<tr>
<td>Analyze errors</td>
<td>Sometimes (38%)</td>
<td>Rarely (45%)</td>
<td>Sometimes (42%)</td>
<td>Never (30%)</td>
</tr>
</tbody>
</table>

Median response between never, rarely, sometimes, often (% frequency of median response).
More Quality Improvement and Less Medical Management

CONTRIBUTING FACTORS RELATED TO COMPLICATIONS

- Poor communication (67%)
- Poor coordination or utilization of care (47%)
- Poor process or workflow (40%)
- Inadequate training or error in decision-making (33%)

THE FUTURE of M&M: Closing the Quality Loop

- Identify areas of improvement and action items
- Participate and develop sustainable quality improvement projects
- Enhances skills in systems-based practice
Thank you.