

How can Morbidity and Mortality Conference Contribute to QA?

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During the past twenty years the American public has energetically intervened in what had been the professional private reserve of medical quality assurance. Numerous bills have mandated public reporting of surgical results, changes in training schedules, and increased FDA scrutiny of drug approvals. The public is asking the medical community to re-imagine the meaning of quality control. Medicine is not the only segment of society receiving increased public scrutiny. Everyone from auto and toy makers to vegetable farmers has felt pressure from increasingly well informed and less docile consumers to improve performance. Most segments of society including medicine have responded, if slowly, to this sharp spur. Experts in any field tend to ignore the advice of the unwashed, but remember that Semmelweis proved that it was the experts who were unwashed. So let us return to what it means for a “medical community to re-imagine” its performance. In particular I will concentrate on Morbidity and Mortality conference because of its historical role in medical quality assurance and because in a previous essay I downplayed it to concentrate on the critical role of the entire medical team, not just physicians, in improving performance.

We begin by contrasting M&M conference to comprehensive quality assurance because the origins, intents, and structures of each are entirely different. QA is a late child of the Industrial Revolution. Its goal is to standardize, simplify, measure, and improve product and service quality in order to outperform competition and to preserve customer base. M&M is a heuristic exercise developed by the founders of modern medicine. It intends to improve physician performance by reviewing deaths and complications under the general rubric that those who fail to learn from their mistakes are likely to repeat them. Fair enough, and we shall return to how this important process should work because we frequently subvert it into an exercise of intellectual one-upmanship, or worse, into a Biblical exercise of “judge not lest ye be judged.” As we hope to indicate, it is neither.

M&M is centered on physicians, focused on their needs, and attended by them. QA is team centered, customer focused, and all team members attend and participate. M&M tends to be intellectual and hierarchical like our forbearers; QA is businesslike and collegial. Finally M&M is anecdotal because it depends on the cases presented. QA is an ongoing systematic review of customer service, outcomes, hospital processes, appropriateness of care, and utilization of resources. It would be fair to say that M&M is the part of QA in which physicians try to learn from adverse events. That would make it part of assessing outcomes, but certainly not the centerpiece of QA imagined by our founders.

Modern medicine is now too complex for M&M to have center stage. How should we physicians relate to each other in M&M conference to learn the most from adverse outcomes? First, we should avoid the intellectual pride that often tainted M&M

conferences during my training. The huge disparity in experience level and the residency hierarchy often led to one-upmanship and a focus on affixing blame for failure as if adverse outcomes implied inadequate performance or lax intent. In other words, it was misused to create winners and losers. As we will see in a moment, this is an entirely foolish misuse of M&M. Second and equally foolish is the deafening silence and acceptance of adverse outcomes that often accompanies M&M in the private setting. Experienced practitioners know that they too will have adverse outcomes and therefore choose to judge not. This is the Panglossian approach to M&M – all is for the best in the best of all possible worlds and some patients with life threatening disease will die despite our best efforts.

To the extent that these misapplications of M&M conference prevail, they subvert the value of meeting in the first place. To succeed at M&M conference, the medical community must come together to re-imagine how care might have been delivered without an adverse outcome. This requires shared values from the community and a special mindset from each practitioner. For its part the community must value learning and desire to improve above all else and abandon invidious judgment. Practitioners must have the honesty and humility to recognize their contribution to an adverse outcome and/or the willingness to re-imagine care with a better outcome. A few ideas may facilitate this process:

- Ask at which point critical decisions were taken that increased the likelihood of the adverse outcome.
- Ask what information or analyses might have led to a better outcome.
- Avoid defending or attacking a bad outcome. Neither helps.
- Downplay pure technical failures unless they are occurring at a rate that exceeds community standards.

As simple as it sounds, re-imagining care is challenging in practice because many physicians resist acknowledging their failures or are hesitant to offer a better idea. This is precisely the place where a robust medical community can provide the most value because it will encourage each of its members to engage in this important process. We have all been inadvertently trained so deeply to make the “right” diagnosis and perform the “correct” procedure that we recoil from failure of any sort, particularly our own. But like it or not, failure accompanies all human activity. A healthy medical community insists on supporting its members so they are sufficiently comfortable to recognize and re-imagine their failures. The community grows stronger as it reduces adverse outcomes and as it spares itself the ongoing embarrassment of commenting on the Emperor’s new clothes. Those of us who care for critically ill patients are always teetering on the edge of technical and intellectual failure. Do we have the courage and compassion to set ego aside and honestly re-imagine our care? Can we construct communities that value this?

