



A Morbidity and Mortality Conference in Psychiatry and Psychology

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Disclosures

- None relevant to this presentation.



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Learning Objectives:

1. Be able to describe the background of morbidity and mortality conferences
2. Have familiarity with barriers to open conversations about less-than-ideal events
3. Be able to take back one example of an ongoing process to learn from errors or less-than-ideal outcomes in patient care.



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First M&M conferences – 1890s by surgical group

Ernest Amory Codman



Born 30 December 1869
Boston, Massachusetts

A STUDY IN
HOSPITAL EFFICIENCY

*As Demonstrated by the Case Report
of the First Five Years of
a Private Hospital.*

BY
E. A. CODMAN, M.D.

THE PROGRESS OF THIS REPORT IS
THE LAST WORD OF THE LAST REPORT!

*It is idle to consider the Standardization of Hospitals
without considering the Standard of the Product of such
Hospitals, the part which the Professional Staff plays in
raising the Standard of the Product, and the Compensation
which the Hospital grants the Staff in return for
their services.
This Hospital has for sale a Product of the Standard
found on pages 17-27. It was in its a Hundred Dollar
Hospital with a Hundred Dollar Surgeon.*

The argument in our previous Reports has been somewhat as follows:

That the Trustees of our Charitable Hospitals do not consider it their duty to see that good results are obtained in the treatment of their patients. They see to it that their financial accounts are audited, but they take no inventory of the Product for which their money is expended. Since the Product is given away, they do not bother to standardize it and to see whether it is good enough to be sold.

At present, in most hospitals, no such investigation is made by any one. *There is no standard of good results to go by, but we are setting standards in this Report. We believe they are as high as any. The questions which should interest you are: Are yours better or worse? Are you making any effort to find out?*



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Examples of two cases from that time..

A simple case of appendicitis may be abstracted thus:

- Came for the relief of: acute abdominal pain for 24 hours.
 - Diagnosis on which treatment was based: acute appendicitis.
 - Important points of treatment: a gangrenous appendix removed and drainage established.
 - Complications: none.
 - Final diagnosis: acute appendicitis.
 - Result one year later: perfect.
-
- Came for the relief of: many ill-defined symptoms.
 - Diagnosis on which treatment was based: consultants varied in opinions.
 - Treatment: expectant for 4 weeks, and then exploratory laparotomy which revealed no pathologic conditions.
 - Complications: phlebitis, cystitis.
 - Final diagnosis: undetermined except for phlebitis and cystitis.
 - Result a year later: condition the same as before treatment.



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Advocated for the “End Result System”

That the Trustees of Hospitals should see to it that an effort is made to follow up each patient they treat, long enough to determine whether the treatment given has permanently relieved the condition or symptoms complained of.

Codman, Ernest, The Classic: A Study in Hospital Efficiency...Clinical Orthopaedics and Related Research 2013 Vol 471

It is simply to follow the natural series of questions which any one asks in an individual case:

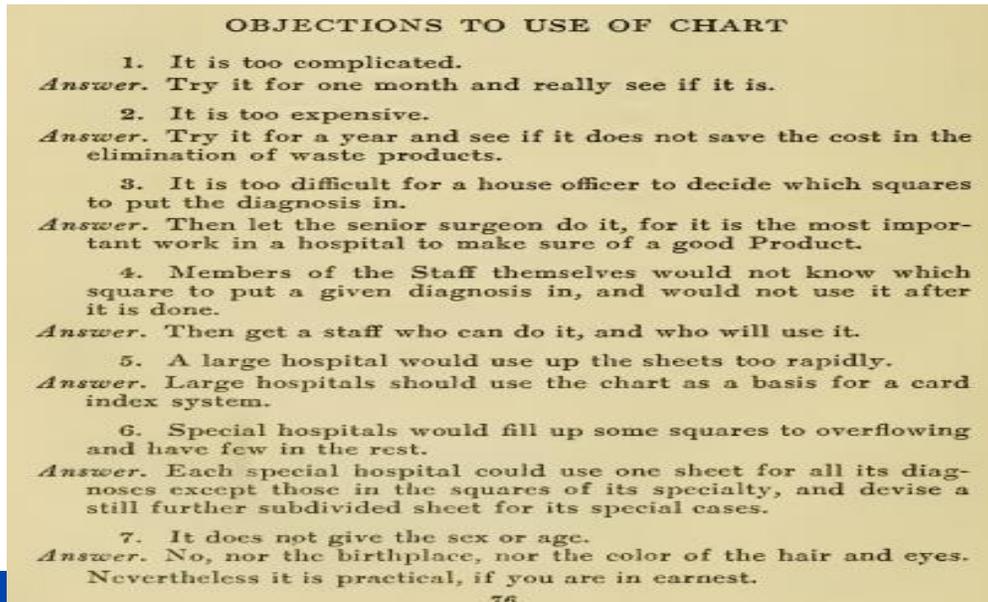
- What was the matter?
- Did they find it out beforehand?
- Did the patient get entirely well?
- If not—why not?
- Was it the fault of the surgeon, the disease, or the patient?
- What can we do to prevent similar failures in the future?



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Déjà vu – Objections to use of the chart



Psychiatry M & M in the literature

- Implementation article from 2009
 - Children's hospital in Boston
- Included staff and trainees
 - Psychiatry, psychology, nursing, social work
- Cases selected on a priori risk criteria and rated on hospital four-level risk management scale.
- 80% of cases in four areas
 - Diagnostic/formulation errors
 - Communication problems
 - System-based problems
 - Class/culture misunderstandings

Goldman S et al., Psychiatry morbidity and mortality rounds: implementation and impact, Acad Psychiatry. Sep-Oct 2009.

Considerations in starting Psych M&M at Mayo

- Issues
 - Review previously in a room where everyone involved is visible
 - Zoom – assign someone to remind people to turn on camera
 - Concerns raised about shaming those who's cases were reviewed
 - Clarify ground rules, focus on system versus individual
 - Past M & M involved only Psychiatry and Residents
 - Include all clinical staff of Rochester Psychiatry department
 - Common models – chose not to follow.
 - Residents do all the reviews
 - Only discuss unusual cases
- Instead - cases where there appears to be an opportunity to improve.



Mechanics

- Every 2 months in place of departmental grand rounds
- Invitation sent to everyone in clinical practice in the department of Psychiatry and Psychology in Rochester.
- Case identification from anyone bringing a case forward, those identified in root cause analysis, etc.
- Presenter chosen as someone not involved in the care of the patient
- Meeting via ZOOM with introductory slides to set expectations
- Those involved invited and allowed to see slides before if interested. They can speak up/not speak up.
- Seek opportunities to identify system related opportunities to improve.
 - *Every system is perfectly designed to get the results it gets.*
(Deming)



Slides used to start Morbidity and Mortality Conferences: What goes on?

- Identify adverse events or less than ideal events
- Foster discussion of those events
- Encourage accountability for providing high quality care
- Create a forum in which care providers acknowledge and address reasons for mistakes or poor outcomes.
- Identify/disseminate what is learned
- *Seek opportunities to improve care delivery*

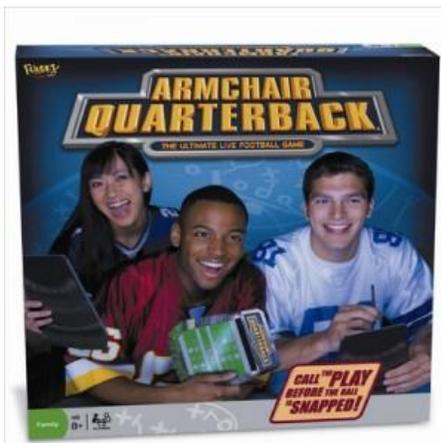


Orlander JD, Barber TW, Fincke BG, Orlander JD, Barber TW, Fincke BG. The morbidity and mortality conference: the delicate nature of learning from error. *Academic Medicine* 2002;77(10):1001-6.

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What this is not.



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Barriers/challenges

- Focus on individual clinicians vs. system
- Fear of incrimination and recrimination, and litigation
 - Studies show M&Ms do not increase the risk of malpractice suits



Benefits

- One study in surgical center
 - Mandatory review process in academic center led to 40% decrease in gross mortality over 4 years
 - Required all adverse outcomes and deaths to be reviewed
 - Use of a standardized case critique
 - Root cause done on major cases
- Allows us to process things that turned out poorly
- Reduces a tendency to cover up bad outcomes by allowing a forum to review
- Helps to learn how to improve our care
- Helps to create group norms on how we will manage common challenges



Overall Ground Rules

- Non-discoverable and confidential
- **Prefer attendees on zoom keep cameras on**
 - Feel free to eat your lunch...
- Case reviewed by someone other than participant
- Currently Rochester Psychiatry/Psychology
- Invite those involved but voluntary and self identify
- Highlight opportunities to improve versus blame



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Institute of Medicine – Crossing the Quality Chasm 2001

- Six dimensions of US care needing attention/improvement
 1. Safety
 2. Timely
 3. Effective
 4. Efficient
 5. Equitable
 6. Patient-Centered

<https://www.ahrq.gov/talkingquality/measures/six-domains.html>



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A Range of Topics – Past M and M

Nov 2020- Patient not progressing with identical recommendations several times

Jan 2021 - Overdose of lithium (non-fatal) after discharge from child inpatient

March 2021 - Suicide of patient despite multiple resources available

May 2021 – Sexual behavior of inpatients

Oct 2021 - Patient outpatient elopement results in injury to patient and security

Dec 2021 – Staying against medical advice - patient goes to ED on discharge

March 2022 – Death of patient - management of med/psychiatric patients

May 2022 – Challenging patient threatening lawsuit

Sept 2022 – ADHD patient angry about not receiving testing

Nov 2022 – Handoffs from inpatient to outpatient



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Challenges/questions that remain

- Small group present (bring) cases – how to broaden this?
- Lack of resources for QI projects – move from case to action?
- Most common cases are ED and hospital – harder to get cases from outpatient care.
- Practice already has Root Cause Analysis (RCA) – how much to link processes?
- Should we have set criteria?
 - E.G: every case reviewed in root cause analysis or every suicide attempt by a patient?



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Thank You

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