Mortality and morbidity reviews/
Case discussion meetings

Definition
A routine, structured forum for the open examination and review of cases which have led to illness or death of a patient, in order to collectively learn from these events and to improve patient management and quality of care.

Background
Morbidity and mortality reviews (MMRs) originated in America. Ernest Amory Codman, a prominent 20th century New England surgeon suggested that each patient should have an 'end result card' where details of care and outcomes were recorded and publicly available. The first recognisable MMR was held in 1935 and related to anaesthesia outcomes.

MMRs are a regular, organisationally convened meeting, predominantly involving medical practitioners (but increasingly multi-disciplinary) who gather to discuss selected cases for the purposes of clarifying medical management and to provide a forum for teaching and system level learning – focusing on patient safety and quality improvement, including the identification and reporting of errors.

Cases may be chosen because they meet specific criteria (for example, identified through an Adverse Occurrence Screening/Targeted case note review (AOS/TCNR) program) or because they are of interest as a learning exercise.

The frequency, length, method of selection and analysis of cases all vary considerably, therefore it is difficult to formulate an evidence base for MMRs as few are conducted in the same way.

The studies that have been conducted (as opposed to reports of outcomes of MMRs for individual services) indicate that they can be an effective tool for education and quality improvement, if a safe environment is established. Evidence of their ability to assist in the identification of errors is mixed.4

An effective MMR should:
• identify key events resulting in adverse patient outcomes
• foster open and honest discussion of those events
• identify and disseminate information and insights about patient care that are drawn from individual and collective experience
• reinforce system level and individual accountability for providing high quality care
• create a forum which supports open and honest discussion through the provision of a just, patient centred culture
• contribute to clinical governance processes.

4 The literature review for MMR is available at www.health.vic.gov.au/clinicalengagement
**Purpose**

MMRs are primarily a tool for examining opportunities for system level improvement. The purpose of MMRs is **not** to assess an individual senior doctor’s care per se, but to provide a forum or learning opportunity to assist system level improvement, based around the identification and discussion of key issues.

MMRs may provide information to support a greater understanding of clinical practice at the individual senior doctor or clinical team level, but only when conducted in a consistent, reproducible fashion within a ‘just’ culture which emphasises and supports clinical excellence through open discussion of key patient care issues.

**Design principles for successful use of the tool**

MMRs are most valuable as a driver of culture change and clinical improvement when there is:

- a focus on patient care
- support and leadership by senior medical staff – this ensures appropriate peer input and engagement
- a multidisciplinary approach with input from all staff involved
- a consistent and reproducible approach
- organisational support
- a clear link to organisational clinical governance processes.

In addition to these listed above, other key strategies which can contribute to the efficacy of MMRs as a quality improvement and learning process include:

- a safe and supportive environment
- a structured process, including a framework to investigate underlying contributing factors
- a detailed feedback and follow up program.

An example of a structured process is the Learning from a defect tool developed to enhance MMRs (Pronovost, Holzmueller & Martinez 2006). The tool is described as a shorter version of root cause analysis (RCA) and is intended to improve safety and teamwork culture, by providing senior doctors with a structured framework to:

- identify what happened with regards to the adverse event
- determine why the adverse event happened
- implement interventions to reduce the probability of its re-occurrence
- enable those involved to evaluate the effectiveness of those interventions.

To improve MMRs consider:

- a review of the literature relating to the particular case
- the use of summaries to allow doctors, particularly junior doctors, to write up the findings for publication.
How to undertake MMR meetings

MMRs should be undertaken at a level which ensures that peer input is appropriate and available. For smaller hospitals this may be at a whole of hospital or even an interhospital level. For larger hospitals, this may be at the level of a clinical service, department or unit. In general, the approach to developing MMR should mirror the organisational approach to AOS/TCNR, as the AOS/TCNR program should identify most of the cases to be discussed in a MMR setting.

1. MMRs should occur onsite.
2. MMRs should be chaired by a senior doctor who takes responsibility for the process and in doing so has an ability to engage with clinical colleagues and to facilitate change at the patient care level. This may be the medical director, unit/department head or delegate.
3. Where possible, MMRs should be regularly scheduled to maximise participation.
4. Members of other clinical disciplines and junior medical staff should attend.
5. Cases for discussion should be identified by:
   • AOS/TCNR programs
   • senior doctors raising specific cases
   • referral from other MMR meetings.
6. In order to provide sufficient time for adequate discussion no more than two cases should be discussed per hour, although aggregating cases with similar issues into a ‘block’ discussion may be appropriate.
7. Senior doctors and other clinicians actively involved in the care of the patient to be discussed must be made aware of the intention to discuss the case at least 72 hours prior to the case and must be made aware of the date, time and place of the meeting. If they are unable or unwilling to attend the meeting where the case is to be discussed, the case should be referred to the appropriate medical lead for further investigation or action. Cases must never be discussed in the absence of the senior doctors with primary responsibility for care of the patient.
8. Cases should be presented in verbal format in a de-identified fashion, describing only the facts of the case including any confounding factors.
9. The major issues should be identified during the presentation, with the chair providing further clarification if required.
10. The chair should ensure that following the presentation, the key discussion points are agreed. These should always include:

- What went wrong (or right)?
- How did it go wrong (or right)?
- Why did it go wrong (or right)?
- What could we do differently in future?
- What are the key lessons for the organisation?

11. A consistent approach to problem solving should be used to discuss the case.

12. The chair should ensure that any discussion relates to the facts of the case and not to personal issues. This is not a meeting to attack or openly criticise individuals who have contributed to patient care – doing so impedes the development of a ‘just’ culture.

13. If major performance issues relating to an individual senior doctor become apparent at any stage during the discussion, the chair should immediately halt the discussion and refer the issue to the relevant medical lead (medical director, unit head or equivalent), who should then initiate the organisation’s usual performance development processes. Discussion around other matters pertaining to the case may continue.

14. At the completion of the discussion, action points should be agreed and prioritised by all present in the meeting. Responses to these issues should be presented at subsequent meetings.

15. Minutes should be kept – patient and doctor details should be de-identified.

16. An action list and appropriate accountabilities should be generated and circulated to all participants and to appropriate organisation level clinical governance structures.
Critical risks to consider in using the tool

MMR meetings should be conducted with a view to enquiry for the purposes of improvement. They must not be perceived as being punitive. It must be safe for all participants.

The major barrier to effective MMRs is the focus on individual senior doctor rather than a more general, systems approach to issues. This results in a fear of incrimination and recrimination.

Significant problems with an individual’s clinical care which are readily apparent to medical leaders should not be dealt with in an MMR process. Clinical performance issues related to an individual senior doctor would normally be detected through other mechanisms (for example, AOS/TCNR, repeated patient complaints). These issues should be managed using the Partnering for performance framework in line with the organisation’s performance development and support policy. MMR is not the appropriate forum for this and indeed may be counterproductive.

Limitations for MMRs include:
• administrative issues – lack of data
• procedural concerns – includes hindsight and reporting bias, a focus on diagnostic errors, and infrequent occurrence of MMRs
• educational issues – lack of educational/system learning focus.

Victorian approach

All senior doctors working within Victorian public hospitals should participate in some form of regular (for example, as a minimum quarterly) MMR meeting as part of their commitment to their clinical governance responsibilities.

1. This should occur at a level which allows appropriate peer input into the process:
   • for small hospitals, this will generally be at the whole of hospital level
   • for larger hospitals this may be at the level of a unit or department (there would need to be sufficient senior doctors with the same skill set in the unit/department to ensure a degree of independence from the care of the patient)
   • MMR processes should be standardised – the approach outlined above is a suggested minimum, but organisations may extend this process as required.

2. MMR should consider cases primarily identified through the AOS/TCNR process, in addition to other cases of interest identified through other organisational processes.

An example MMR reporting pro forma is available at www.health.vic.gov.au/clinicalengagement