Editorial

Are morbidity and mortality conferences DNR (Do Not Resuscitate) or can they be revived?

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INTRODUCTION

Value of the morbidity and mortality conferences

Many physicians were trained when morbidity and mortality (M & M) conferences, although often harrowing experiences, were also the educational highlights of our residencies. We not only learned that we were answerable for our morbidity/adverse events (AEs) and mortality of our patients, but also learned that our mentors had the same inherent accountability, concerns, and responsibilities. In short, we all had to acknowledge, learn, and teach from our shortcomings to avoid repeating them.

Morbidity and mortality conferences supplanted by “Quality Assurance”

More recently, M & M conferences have been supplanted by the latest medical administrative “advance or mandate” for Quality Assurance (QA) meetings. Previously, M & M conferences served to educate all of us in an “open forum” in “real time” through frank discussion “and discovery” (e.g., how to better diagnose and treat our patients). Their replacement, QA conferences, only questions whether “quality measures” or the “standards of care” have been met, and if outcomes (e.g., even including major AEs or deaths) were “acceptable and/or anticipated.”

Medicolegal constraints: Not an excuse

Do medicolegal constraints render the M & M conference “DNR (do not resuscitate)”? The answer should be no, because in most states, physicians may safely participate in M & M conferences, as data from these proceedings are considered “confidential” and are not “discoverable” in a court of law. A glaring exception occurs in the state of Florida, where the Sunshine Law allows for “full access” (rather than “full protection”) to this information (e.g. including access for plaintiff’s attorneys) for anyone who requests it. The result, in Florida, has been fewer M & M conferences with even fewer attending these conferences, likely resulting in an irrevocable loss of educational opportunities for all.

Informal poll asking spine surgeons how to resuscitate morbidity and mortality conferences

How do we resuscitate M & M conferences, and increase the number of physicians attending these conferences? After all, if physicians do not come to these conferences, residents, physician assistants, nursing staffs, adjunctive health care professionals (e.g., nursing assistants and social workers), and our patients, all stand to lose educational opportunities, as do the physicians themselves.

To better glean an understanding of who attends M & M conferences, members of the editorial board of Surgical Neurology International (Spine Supplement) were polled using a questionnaire. Seventeen board members responded to the poll: 13 neurosurgeons and 4 orthopedists. Six respondents were chairs of either orthopedic[1] or neurosurgery[1] departments, and 4 were Chiefs of Spine Sections.

When questioned if monthly M & M conferences were
mandatory, 10 responded yes, 5 said they were not mandatory, while 2 did not know the “requirements.” Nevertheless, nearly all acknowledged that attendance at M & M conferences was considered “part of the culture” (e.g., even if not mandated), and if conducted in a collegial way, discussions provided “excellent learning experiences.” Furthermore, most agreed that residents and attending physicians in university settings were largely “required” to attend M & M conferences, unless they were out of town or performing emergency surgery (i.e., typically, no elective operations were scheduled during these intervals).

When questioned whether surgeons had to attend if their cases were presented, 15 responded yes, and only 2 said no. Almost all commented that if surgeons were operating or not present, whether excused or not, cases were “held over” until they could be present. They agreed that attending physicians must present their own cases at M & M (or physically be present if a resident was presenting them) so that accurate case information, errors in judgment/technique, and related meaningful discussions could take place. Additionally, conferences frequently yielded useful suggestions that could improve patient care. In the extreme, recurrence of similar complications could prompt review/institutional oversight of the surgeon’s practices (e.g., root cause analysis), resulting in greater supervision, probation, and possibly the “loss or curtailment of hospital privileges.”

When asked if attendance at M & M conferences overall was problematic, 13 responded “no”; 11 of these respondents were from universities, 1 was in a university-affiliated private practice, and 1 was solely in a private practice. Four responded “yes,” it was problematic; notably, 3 involved university settings, while 1 was a private practice affiliated with a university.

Recommendations to improve attendance at morbidity and mortality conferences
Board members had several recommendations for enhancing attendance at M & M conferences. First, many recommended offering continuing medical education (CME) credits to add value to the time spent. Second, in a full-time setting, it is often implicitly or explicitly part of their contractual agreement with the department/institution. In two cases, Chairman of departments (1 orthopedics, 1 neurosurgery) noted that 10% of surgeons’ salaries were linked to attendance at M & M and other conferences (e.g., “departmental citizenship”). Several members of the board including the multiple chairman, responded that surgeons should be required to attend at least 50–75% of M & M conferences; some even required 100%. Nearly all commented that surgeons should always attend M & M conferences when their own cases were presented. Finally, failure to attend M & M conferences should have consequences, (e.g., lead to the potential loss of compensation, operating room time, and/or hospital privileges).

CONCLUSION
M & M conferences can be revived, and should not be considered DNR (do not resuscitate). Our common goal should be to learn from our complications, mistakes, and adverse events, and thus, improve future outcomes. We cannot glean the educational benefit from M & M conferences when we are not present. Ideally attendance should be mandatory. The primary surgeon should always be present for a thorough discussion and debate of their case and its outcome. After all, as one member of the board noted, “a crumbling educational infrastructure does not lend itself to quality”.

REFERENCE
1. Orlander JD, Fincke BG. Morbidity and mortality conference: A survey of academic internal medicine departments. J Gen Intern Med 2003;18:656-8.
You raised the issue of Medicolegal issues, and I had totally forgotten that the State of Florida was an exception due to the “Sunshine Law” allowing for “full discovery”. On the other hand, another issue has been the $250,000 cap on pain and suffering that has limited malpractice exposure in Florida. That has been a disaster, and the State of Florida has become a “haven” for doctors who needed to get out of their own States as their practices were at high risk.

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Response to morbidity and mortality editorial
Your paper took me back in time to the “good old days” of medicine. The pecking order was very clear, and the discipline was unquestioned. Dr. Rosomoff was fantastic with M & M Rounds and as I remember, your Dad (Joseph A. Epstein MD/Neurosurgeon) was too. I learned a lot from reading your paper. I think that M & M should be run as it was in those days. I doubt that it can be in today’s times, but the honesty of admitting adverse events, and using that as a learning opportunity was the best way to teach, and still is. I think the accountability was also sobering, and would cause everyone to be much more aware of events and consequences. I can think of nothing more effective than learning from one’s mistakes. That is so lacking in today’s times. I have forgotten about the advent of (QA), and to this day do not think much of it.

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Attendance at morbidity and mortality conferences
Yes, attendance should be mandatory, especially for the surgeon whose case is being presented. I do not remember the process for selection of the case to be presented. You said that the respondents said attendance should be mandatory, however, in today’s times, if you polled the Neurosurgeons at large, how many do you think would agree with that? I think they definitely should be mandatory in University settings, as it is such an important part of teaching/learning.

Nursing morbidity and mortality conferences
Regarding nurses having their own M & M conferences, I would be opposed for the following reasons. Nurses have been isolated from other disciplines for too many years. They have much to learn, and the information they would bring to a multidisciplinary conference is invaluable for other disciplines. In addition, the knowledge they can gain at a multidisciplinary conference would be extraordinary. Nurses have been isolated much too long-enough isolation. The knowledge they can gain by attending M & M conferences would significantly improve the quality of care, and would benefit both patients and staff. Dr. Rosomoff’s conferences and rounds enabled our Team to become the “best of the best”. It was a “win win”. The most common statement patients made at Graduation was “They Gave Me Back My Life”. You can imagine the impact that made on our Team. When I first proposed the idea of Graduation for the program participants, most of the Staff were not thrilled. Later on, it became the event we all looked forward to, as the patient speeches reinforced what we were doing.

Focus on nursing value at morbidity and mortality
One other thought about inpatient nurses and their value to the Team and M & M conferences. They are the only discipline to have a 24/7 presence and therefore can provide the greatest amount of information about the patient and their response to care. They provide continuity of care and obtain the most information, verbal and nonverbal, about the patient throughout the course of treatment. They can also become close to the patient and build a trusting relationship.

How to improve attendance at morbidity and mortality conferences
The recommendation to improve attendance by offering CMEs was brilliant, as financially and “time wise”, it would make sense. The other suggestions were also very good regarding attendance. Your “conclusion paragraph” was right on. Overall your EDITORIAL is brilliant, well thought out, and on the “mark”. You write so well and to the point. BRAVO!!!

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Value of morbidity and mortality conferences: A “Drum” of communication between human beings

I completely agree with your paper’s content. M & M conferences serve as one of the “drums” of communication between physicians as cultured human beings. It allows us to “create the culture” of medicine and collegiality, rather than just being “part of the culture”.

Mankind has developed all means of communication to increase knowledge, including science and culture, through oral traditions, drawing, description, broadcasting, and virtual images. We have prospered using these communication skills, and would be in great danger, like an extinct race, if effective communication methods such as M & M conferences were no longer utilized. If the significance of M & M is denied, we cannot evolve because we could not acquire unexpected knowledge (knowledge that we have not yet experienced), and we also could lose a chance to listen to other people’s opinions and/or evaluations.

Residents should attend M & M because they should learn and by learning, grow up.

Mortality and morbidity conference—Not dead yet

M & M conferences have always served the function of maintaining “local quality assurance” and “accountability” for most residency programs in academic environments. It has traditionally provided a format to discuss complications, their prevention, and management. It can also provide a format to discuss the incidence of complications, and compare these frequencies to those reported in the literature.

Limitation of resident participation in morbidity and mortality conferences detrimental to education

With the limitations on resident work hours, the resulting limitations on resident participation in M & M conference is detrimental to resident education. The discussions that occur at M & M are an invaluable educational tool, not only for the presenter, but also for the entire audience. It provides an excellent format to discuss variations in patient management strategies between attending staff.

Attendance at M & M conference should be mandatory for residents and staff, as it serves as a means of “open” educational opportunity, “accountability”, and potential “optimization” of patient outcomes. M & M conferences should be revived, and should not be allowed to die.

As physicians we have an obligation to our patients to investigate the reasons for failed treatments. The spirit of the conference is to honestly investigate how we might do a better job to avoid a recurrence of failed treatment. Neither embarrassment nor ridicule is part of the conference.

On the other hand, accountability is part of the conference—whether at the level of the resident or the attending—since we work as a team, each person in the team needs to recognize he/she is accountable at the time of treatment.
The loss of morbidity and mortality conferences has impacted quality

No question the loss of M & M conferences has had an impact on quality. By ceding ‘quality’ of clinical performance to hospital QA committees, we have allowed administrators and nursing supervisors to become our quality managers instead of policing ourselves. These QA committees are largely motivated by fear of Joint Commission on Accreditation of Healthcare Organizations (JCAHO) sanctions; their interests are thus more institutionally biased. For instance, JCAHO is more interested in the process than the outcome, whereas an M & M perspective would involve both. Hospitals would argue that the peer-reviewed process of the institution addresses physician discipline, yet the physician officers of the hospital often rubber stamp recommendations from the same hospital personnel involved in the QA committees based on protocol. This flavors the entire process with a decidedly JCAHO stamp.

Unfortunately we have only ourselves to blame in facilitating this problem, and resurrecting M & M conferences would certainly be a step in addressing this issue.

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Commentary

Morbidity and mortality conferences: The added teaching of “Non-scientific aspects of neurosurgical practice”

While the scientific and technical aspects of surgical practice are the foundations for all surgical residencies, we learn other important lessons during our training. As a neurosurgical resident in Memphis during the early 1970s, I was astounded to hear Dr. Francis Murphy during a weekly hospital departmental meeting (we might call it M & M today) stand up before residents and colleagues—some of whom were actually competitors and not part of the university faculty—and forthrightly discuss a case he thought he had botched so others might learn. Dr. Murphy immediately became an even bigger hero in my eyes than he already was. Later, he was joined by James T. Robertson and Duke Samson among others, who by their honest discussion and self-assessment of case complications, taught me and other impressionable neurosurgical faculty members and trainees important, but not scientific aspects of neurosurgical practice. I hope this kind of conference is not doomed in the era of process and system reviews and institutional quality assurance/risk management oversight. Hopefully, the M & M conferences in most states will remain “nondiscoverable”. Otherwise, trainees and young faculty members will have ample opportunity to learn from those who dissimulate, and explain away their complications.

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Morbidity and mortality conferences are required to maintain quality care

I agree with Dr. Epstein, that M and M conferences are required to maintain quality care, and no acceptable quality care is possible without peer review. M & M is an essential function of any department, particularly an academic department. Without M & M you cannot assure consistent patient safety, and quality care delivery. The M & M conference should attempt to be educational, not judgmental, and the participants should know that anything discussed is completely confidential, and not for publication around the institution. Finally, there has to be a requirement for participation to maintain staff privileges. The requirement I instituted as chairman was participation in 50% of department meetings, and 75% of M & M conferences.

Morbidity and mortality is an integral part of every medical group/institution

Enjoyed your piece on the demise of M & M. First, M & M is an integral part of every medical group/institution. In fact, in some respects, our annual Cervical Spine Research Society (CSRS) presentations, and comments following them, are a version of such.

M & M’s have always been a tradition at Johns Hopkins Hospital. Currently, in the neurology department, they are held every quarter at a time when grand rounds are usually held. There are no requirements for attendance, nor penalties for absence, except that the resident who followed the patient in hospital usually presents the case, and the associated attending is expected to be present. The case presented is usually an inpatient. CME credit is given as with all grand rounds.

The case presentation should determine whether the problem is in “the system,”- that is, protocol, or where there are individual errors in judgment, action, risky behavior, etc. The goal is to determine whether changes in system or individual behavior are needed.

But the atmosphere is one where we are warned not to blame or be offensive to the resident presenting, or to cast too much blame; at times this leads to people being overly collegial/polite. This usually results in my leaving early because I see no value in trying to whitewash a serious problem, and/or training experience.

I think that Maryland has laws protecting M & M sessions, and various in-house audits from discovery/litigation.

Quality assurance: “Medicine for dummies”

I have no respect for so-called “quality assurance” or “standard of care” sessions based on criteria from some remote source (e.g., I have no idea as to their (QA team) experience/fund of knowledge!) Their directives are similar to “evidenced based medicine”, otherwise known as “medicine for dummies.” I would rather rely on the judgment and skill of respected colleagues (i.e., as in CSRS critiques). Always enjoy working with you and our CSRS colleagues.

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Commentary

Morbidity and mortality conferences “Require diligence and leadership”
The M & M conference, now frequently called QA, is needed now more than ever. Dr. Epstein’s article skillfully defines for us the history and the value that these conferences have had in medical education, clinical practice, and patient care. These quality conferences, like many aspects of health care, require diligence and leadership to prevent erosion of their impact and effectiveness.

QA Conferences Remains an Open, Critical Evaluation of Care We Provide Our Patients.
The basis of the QA conference remains an open, critical evaluation of the care we provide to our patients. Historically, M & M conferences have typically been steeped in an antagonistic ethos, laying blame for complications on the shoulders of the individual. A new culture is needed moving forward, with a shift toward addressing problems and finding solutions utilizing a systems-based approach. This is not to say that the personal responsibility evaporates. This conference functions as an open and transparent form of peer review over the surgeons’ indications, surgical plan, surgical technique, and perioperative decision making. We can see a clear path for a revival of these conferences in the university setting where mandatory attendance and participation can be enforced. Adapting this to the private practice or community hospital setting remains difficult. CME credit and hospital credentialing requirements are potential enticements to attendance. Additionally, third party certification (i.e., Centers of Excellence) as well as a reduction in malpractice premiums may further encourage these conferences in the private setting. Potential conflicts between “competing” physicians, however, may discourage active, open communication in a peer review process. Perhaps formal nondisclosure agreements may soothe this discontent. Open peer discussion, in both the university and private settings, will ultimately improve our discourse, and the care we give our patients.

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“Confession,” (I am a Catholic), a frank discussion by the various faculty of how the case was handled from beginning to end is a necessary component of the M & M conference. But, like Confession, the contents and conclusions of the conference must be kept confidential, especially given the current litigious system in the United States and some other countries. If the discussion is limited because of fear of legal or other retribution, then the educational value of the conference will be completely lost. Likewise, the conference room should be restricted to the appropriate parties during the proceedings, so there will be no hesitation on the part of all physicians present to participate in frank discussion. With such arrangements, no one will be adverse to partake in discussion, and thus the conference will be successful as both an analytical and educational tool.

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Commentary

Morbidity and mortality conferences are an educational highlight throughout our careers in surgery
As Dr. Epstein notes, M & M conferences are an educational highlight, not only during our training periods, but also should be throughout our careers in surgery. Medicine continues to change, and so, we should continue to learn. The latter is expected of us as a matter of duty to our patients and, for that matter, by all of society. However, M & M conferences should not be limited to case presentations, and related diagnostic investigations. Brain cutting or other appropriate adequate pathological sessions, surgical photographs when available, and reviews of the literature on the topic at hand are a necessary part and parcel of such a conference. Obviously, then, various faculty are needed for an appropriate conference of this sort, and attendance should be so organized.

Morbidity and mortality: The contents and conclusions must be kept confidential
Although often viewed by the attending to the patient as a “mea culpa” conference akin to going to
Morbidity and mortality conferences remain a great educational tool. As noted in the editorial, this success depends on a number of factors:

1-Attendance. Attendings involved in cases absolutely must attend conferences. However, a good discussion of the relevant points is dependent on a critical mass of attendings being present.

2-Preparation. The cases must be thoroughly reviewed before the conference so that important details are available at the time of discussion. Cases must be chosen appropriately as well. It is important that when a case leads to teaching points, the relevant scientific literature be cited.

3-Collegiality. Each conference must be handled in a spirit of collegiality. The general approach is that many problems are “system problems” and can be rectified by improving hospital protocols based upon the best scientific evidence. There cannot be accusations against a particular physician during this process. Any such issues must be handled through the hospital’s established medical staff procedures. The conference must maintain a nonpunitive approach in order to foster learning and process improvement.

4-Leadership. It is important that the leaders of the conference work closely with hospital administration so that the conferences can better align departmental and hospital goals.

5-Follow-Up. It is important that issues identified during the M & M meeting be followed up and the results be brought back to the group.

I do not think that the M & M is a thing of the past, and I do not believe that the Quality Assessment and Quality Improvement initiatives necessarily weaken the M & M. Rather, QA should strengthen the M & M conference/process, as long as care is taken to choose cases and case discussions.

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I read with great interest the editorial by Dr. Nancy E. Epstein regarding M & M conferences and how these conferences are viewed by different individuals. Being trained, and then working in the same institution for the past 22 years, I have always viewed these conferences as a standard part of our academic culture at our institution. Seeing the different viewpoints presented in this editorial, allowed me to see other opinions, which I found exceedingly interesting. We are all victims, to some extent, of the regulations of our workplace. At our institution, we are required to have our complications presented and discussed before our peers; therefore, regardless of our own personal opinions, this is a requirement of employment. Many of the apprehensions that surgeons may have in participating in this type of forum, while certainly perhaps natural and appropriate, would not be issues of debate at institutions where this is required. In other institutions where attendance and participation are not mandatory, I would hope that the individuals would see many of the educational and practical values that can be gleaned from these conferences, many of which are discussed in this editorial. In addition to the improved patient care and potential avoidance of future complications, the knowledge imparted to the participating group can be priceless. Perhaps one of the most valuable traits of these conferences is the behavior patterns we are teaching our young surgeons, residents, and fellows. These conferences are teaching them that it is perfectly fine to treat patients, examine their treatment plans, identify problems, and learn from any mistakes, all to improve patient care in the future, and hopefully turn a complication into a learning experience. I believe that these conferences are extremely important, and should be a critical part of any surgical program.

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Morbidity and mortality conferences: An important and integral part of physician education

The M & M conference was one of many conferences that was an important and integral part of physician education regarding complications, delays and errors in patient diagnoses, treatment, and overall management of the patient. The conference was created and controlled by the physicians. The conference was attended by physicians and residents, and was usually closed to others. Discussions were frank and not politically or socially correct. The underlying purpose was to improve patient care, and for the physician, to learn from his/her errors. The discussions were confidential and protected from disclosure.

Medicolegal environment led to a change in morbidity and mortality conferences

The medicolegal environment was one of the major contributing factors that led to a change in the M & M conference. In the late 1970s, an increase in malpractice claims surfaced for one university department. It was discovered that one of the physicians attending the M & M conference was channeling cases to plaintiff attorneys. One can understand why the M & M discussions became guarded as a result. The advances in laboratory and imaging studies were other factors that decreased the perceived importance of the M & M conferences. They also impacted the Clinical Pathological Conference, and contributed to the decline in autopsies over the years.

Intrusion of hospital quality improvement committees and risk management into morbidity and mortality

The intrusion of hospital Quality Improvement Committees and Risk Management into the M & M conference, and the mandate to report the findings to the Quality Improvement Committees, as well as to share the findings with Risk Management and the Hospital Boards, have changed the M & M conference paradigm. The information is now also used in the credentialing of physicians, and the renewal of hospital privileges.

Another major concern is that the trial lawyers attempt to make the findings of the M & M conference discoverable. Dr. Epstein points out that the State of Florida, under the Sunshine Law, allows for “full access” for anyone that requests the information, including plaintiff attorneys. Will other states follow Florida’s example? Can we trust other State governments or even the Federal Government to protect the sanctity of the M & M conference?

Will Outside Influences Dictate the Format of morbidity and mortality Conferences?

Dr. Epstein in her Editorial believes the M & M conference can be revived; I concur with her enthusiasm of the importance of the M & M conference. However, the uncertainty of the future of medicine as a profession, the loss of physician independence and autonomy, physicians acting as employees, the loss of their voice in policy making, have caused the M & M Conference to take on a new role with outside influences dictating the format of the M & M Conference. The M & M Conference cannot survive as we once knew it. Mandating attendance was not necessary in years past because physicians felt an obligation to be present, but mandating attendance now will not change the attitudes, fears, and behavior of physicians. Discussions will remain guarded and cautious. The educational reward of the M & M conference today is limited by these factors.

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Commentary

Historical preparation for morbidity and mortality conferences

In this era of political correctness and altered sense of responsibility, Dr. Epstein has addressed head-on one of the cornerstones of responsible medical education, the M & M conference. All of us with a little gray in our hair remember the preparation for this conference: in-depth chart review to find appropriately correct and pertinent facts for the presentation, organization of these facts so a clear, concise oral presentation could be made, then a full literature search to provide evidence for the problem to educate ourselves as well as our audience in such a manner as to potentially avoid similar clinical problems in the future.
Morbidity and mortality conferences’ use of the socratic method

Yes, if errors of omission or commission were noted, they would be discussed by faculty utilizing a “Socratic method” rendering this presentation highly educational for the presenter, residents and faculty. Often times, all segments of the surgical procedure and postoperative management were done appropriately, but due to the sometimes fickle biology or noncompliance of postoperative recommendations, this beautiful organism we call a human being would achieve a result that was less than optimal. This fact allows us to appreciate the Art of Medicine as well as the Science of Medicine, and teaches us that it is often impossible to separate the two. It is very important we continue to nurture this important educational opportunity and offer means of resuscitation to those programs where it is languishing. Fortunately, most areas of the country still provide protection of educational conferences from legal scavengers but in those that do not; I think we as medical professionals should work with our state and national legislators to have statutes placed that provide this educational protection. I applaud Dr Epstein’s attempt to provide information to support this excellent educational opportunity… go get the crash cart please!

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Morbidity and mortality conferences vs. preoperative and postoperative conferences

M & M conference is also very important for the training of young residents and for patient safety in Japan. But it is not easy to say that the culture for attending the conference has become well-established. When M & M conference was held in our university hospital, only a small number of physicians participated. Attending conference was not mandatory.

However, we have a preoperative and postoperative conference in each department, in which surgical planning and anticipated or postoperative complications from all the cases are discussed. To some extent this conference can be called an M & M conference, but the discussion is not specifically focused on details of the complications or whether or not mortality occurred. Although physicians in Japan are not contractually tied to attending M & M conference, nevertheless, all of us attend pre- and postoperative conference on a daily basis. Although discussion about preoperative concerns and postoperative issues are of great importance, comparable to an M & M conference, physicians hesitate to talk about their own “faults” or “mistakes”, not only for fear of medicolegal reprisals, but also simply because it is embarrassing. Of note, detailed records of the conference are not officially preserved. Ironically, there are still too many medical lawsuits in Japan. Some structural and cultural difference between the United Stated and Japan may lie behind such medicolegal circumstances.

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Commentary

Morbidity and mortality conferences has important teaching and learning advantages

The traditional M & M conference, though sometimes viewed with trepidation by the presenters, has important teaching and learning advantages. It has the advantage of immediacy, which textbooks, journal articles and lectures often do not. This is because the key actors are personally known to the conference participants, and sometimes the patient is, as well. Certainly the local milieu is well known to all. There is emotional impact as well as intellectual impact. The conference emphasizes our professionalism, by requiring personal accountability. I hope we can keep it alive and well, and improve on it.

As I reflect on the M & M conferences I’ve attended (in internal medicine, not neurosurgery), I think of two fairly easy improvements. First, we sometimes overlook the role of system failures in poor patient outcomes. No physician operates in a vacuum, and physicians cannot care for the patient alone. If scrub nurses, floor nurses, respiratory
A lawyer’s clarification of the term “Not discoverable”

When reading Dr. Epstein’s editorial on M & M conferences, I was reminded of Dr. Sanjay Gupta’s recent book, “Monday Mornings”. While fiction, the story highlights the value of these meetings, and as a physician, Dr. Gupta obviously shares your views about the benefits that can be had from them. I noticed you mentioned that “data” from the conferences is not discoverable except in Florida. New Jersey has a procedure by which the opinions expressed by the participants, the actual discussion that occurred and actions taken as a result of the discussion, may be protected from disclosure to outsiders. When an issue arises about whether attorneys can learn what happened at an M & M meeting, the hospital attorney can submit any written documentation created as a result of the conference, to the court for a private review; the judge determines what portions are made public and what remains confidential. Typically, the attorneys can learn the facts about what happened to the patient, and the rest of the information remains sealed, thus protecting what has been called the free flow of ideas and open and frank discussion about the care given.

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The pace of modern hospital care is making it harder than ever to maintain group teaching activities. But the M & M conference is one tradition that seems well worth preserving.

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Commentary

The “ABC” (Assess, Blame, Criticize) Model of morbidity and mortality is outdated,

The importance of M & M conferences cannot be overstated for all of the reasons that Dr. Epstein eloquently points out. For surgeons-in-training, attendance at M & M instills a culture of safety, transparency, and accountability that provide the foundation for an ethical, patient-centered surgical practice. Unfortunately, several additional challenges to the traditional M & M model exist: 1. With the expansion of neurosurgical and orthopedic surgery departments into hospital networks covering an ever-increasing geographical area, the feasibility of a weekly or even monthly M & M must be questioned. Asking an attending surgeon or surgeon-in-training to drive 120 miles to the center of a metropolitan area to participate in an M & M at the “mother ship” which may last 1 hour (in a sub-specialty possibly completely separate from his/her sub-specialty) may not be the most appropriate use of surgical man hours. 2. Private practitioners who do not maintain an affiliation with a surgical training program or University hospital must weigh the importance of a self-directed M & M against the time away from his/her practice to conduct such. How do you ethically police yourself when you are the only one, or one of a very small group practicing spine surgery at your hospital? 3. The “ABC” (Assess, Blame, Criticize) model of M & M is outdated, at times punitive, and is no longer considered an effective educational strategy for the current generation of learners.

Morbidity and mortality remains a mandatory exercise

Despite these additional challenges, M & M remains
a mandatory exercise that should be required of all practicing spine specialists and surgeons-in-training, regardless of practice style, size, or academic affiliation. Creative solutions to these additional challenges requires altruistic and empathetic surgeon-leaders willing to implement strategies such as teleconferencing to reach out to satellite hospitals or physicians in private practices, and to adjust teaching styles which encourage less experienced surgeons to admit to and take ownership for their mistakes without draconian penalties. As one of my mentors used to put it “An expert is someone who has made all possible mistakes”. In this spirit, we need to be honest and forthright with our complications, and willing to implement change in order to take the most direct path to excellence.

**Morbidity and mortality allows us to take corrective actions that go beyond the conclusion of Conferences**

At best, without M & M we risk compromise of the central tenet of the Oath from Hippocrates: “never do harm to anyone”. Beyond that, and potentially far more destructive, is the loss of credibility, moral degradation, and concomitant governmental oversight/regulations which our profession faces (and as occurs with any institution) if we begin to limit our internal and self-imposed checks and balances on quality. On the other hand, if we expand our traditional M & M approach to include nurse practitioners, physician assistants, as well as operational officers at our institutions, we may find that M & M not only serves to expose our errors, but also allows us to take corrective actions that go beyond the conclusion of the conference.

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**Commentary**

**Spinal surgery is both an art and profession**

Spinal surgery is both an art and a profession. The foundation of this is an ability to be honest with oneself and ones’ abilities. Much of what is learned in a career in spinal surgery is gained through experience. The most critical element of this is judgment. To quote Mark Twain, “Good judgement comes from experience and experience come from poor judgement.” The only way we move forward and improve our craft and decision-making is by critically appraising the results of these decisions and learning from our mistakes.

The Value of M & M Conferences: The Ability to Learn From Our Mistakes

The physical performance of surgery is, with time, performed with a minimal rate of complications. When complications do occur, it requires considerable insight and intestinal fortitude to review each detail of the case, and determine whether some error occurred that could potentially be prevented. Thereby, we learn from our mistakes, and try not to repeat the same mistake, thus providing better care for our patients in the future. This is what underlyes our M & M conferences.

**Morbidity and mortality conferences need to be mandatory**

I would wholeheartedly agree that these conferences need to be mandatory. Surgeons involved should present each case, and must objectively and critically assess not only the performance of the procedure, but also the rationale for doing the operation, and unashamedly hypothesizing the root cause of the unintended outcome, be that morbidity or mortality. One needs to avoid the easy path of blaming the patient for a failed outcome. Rarely this is the case, but I have found that in the majority of instances, some error in technique, preparation, or surgical planning caused an unintended outcome to occur.

**Desire to more carefully select patients**

During a career doing complex spinal surgery I have, at times, made errors in judgment (operating on patients I had no business trying to help); errors in technique (misplaced hardware, dural tears, neurologic injury); and errors in thinking (not recognizing problems that in retrospect were obvious and avoidable). I know of no surgeon who is not guilty of similar errors. It is particularly through the recognition of these errors that every surgeon I know has been able to learn and grow as an individual, as a professional, and as a human being. As time has gone on, I find myself more dedicated to achieving ever more perfect outcomes with minimal complications, and a desire to more carefully select patients who will be best helped by surgical intervention and avoid operating on those who are unlikely to benefit. This desire to improve my “batting average” is something common to any technician who is interested in getting the best outcomes.

**Unfortunately, We Live in a Litigious World**

Unfortunately, we live in a litigious world in which physicians struggle to protect themselves from malpractice
litigation, and any bad outcomes can be associated with plaintiff’s attorneys seeking compensation for a less than favorable result. Therefore, physicians are understandably cautious about openly admitting culpability in any case associated with a poor result or complication. This prevents learning and progress from occurring. Not only do physicians not learn from their own errors, but they also miss the opportunity to learn from the mistakes of others.

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**Commentary**

**Important effect that morbidity and mortality conferences have on patient care**

For practicing neurosurgeons/spine surgeons, Dr. Nancy Epstein has just written the best overview on the subject stressing the educational importance of M & M conferences. Her article is an urgent plea to restore M & M conferences to their previous prominence in medical education. Her rationale is based on the important effect that M & M conferences have on patient care as well as medical education. How to accomplish this is reviewed by references cited.[1-9]

**Attendance should be mandatory for staff involved in cases being presented**

First, attendance should be mandatory for the staff, especially the staff involved in the cases being presented at M & M conferences.[7] M & M conferences have considerable educational importance particularly if the format is interactive.[6] It is of considerable clinical benefit to review “useful errors” to improve physician approaches to clinical problems.[5] In the process of reviewing minor/major complications, vital educational points are made.[5-9] QA efforts attempt, in a broad way, to improve patient outcomes, but lack educational value for practitioners. As Dr. Epstein so eloquently argues, QA efforts/conferences are no substitute for M & M conferences.[1,3] The M & M conference provides relevant hospital based medical education focused on key patient related problems. Clinically focused relevant problem solving is lacking today in medical education and M & M conferences can be helpful in correcting this deficiency. M & M conferences can prevent future medical errors related to the cases discussed, and provide relevant focused medical education at the same time.[2,3] Why would any program not enthusiastically emphasize the M & M conference for physician and patient benefit?

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**Commentary**

Morbidity and mortality conferences deserve to be revived, and should require 75% attendance

Dr. Epstein’s excellent editorial reaching inevitable conclusions that M & M conferences deserve to be revived is appropriate and timely. Quality patient care can only be maintained through peer reviews and education. The M & M conference is an essential function of any department, particularly an academic department with responsibility for resident and fellow education. The M & M conference must be educational, not judgmental or punitive. The physicians whose cases are discussed need to be certain that any conclusions are
completely confidential and not for publication in or out of the institution. Finally, there has to be a requirement for participation to maintain staff privileges. The requirement I instituted as chairman was participation in 50% of department meetings, and 75% of M & M conferences.

**Morbidity and mortality conferences: No problem with attendance**

We never had any problems with attendance. The format was interesting, the discussions educational, and the faculty, residents, and fellows wanted to participate. All attending physicians were required to be present when their cases were discussed. It is essential that any identifying references in the cases reviewed at the M & M conferences be redacted, and neither specific patient nor physician identified. Without identifications no state discovery law can produce any useful documents.

**QA committees may not be as controlled as departments**

Finally, the M & M conference is a departmental function; QA committees are composed of members of any department in the institution, and often have Board of Governors members, administrators, and professionals other than physicians involved. The confidentiality of the proceedings of the QA committees may not be as controlled as the departmental administrative structure.

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**Commentary**

**Morbidity and mortality Conferences Mandated by Residency Review Committee**

M & M conference is a critically important component of any academic department in which residents and fellows are employed. The educational value is critical to their overall training program, and is mandated by the respective RRC (Residency Review Committee). The participation of faculty is also critical as their participation “closes the loop” on the respective M & M discussion. For faculty who are fulltime employees, attendance is mandatory in most centers. For those faculty in private practice, providing CME credit allows the physician or Allied Health individual the ability to accumulate CME credit for recertification and/or academic advancement. M & M provides a critical review of what we do, and should be handled as a learning experience for all involved. QA committees deal with issues such as behavior problems or process issues that interfere with patient care. They are not educational in most instances.

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**Commentary**

**Morbidity and mortality is critical for surgical practitioners, and must be mandatory**

This is a timely and important topic. M & M conference is not only a great educational opportunity for those in training, but also critical for surgical practitioners. It is fine to structure this conference in a QA framework as long as the true attributes of rigorous discussion are not abandoned. Attendance must be mandatory. It is critical that these discussions be held confidential. It is inconceivable that they are not. The goal is for the greater good of society, and in cases of an egregious error, the legal system does not need information from an M & M (or QA) conference to come to a just decision and settlement.

**Morbidity and mortality conferences need to be resuscitated for the greater good of all**

The concerned surgeon is most interested in improving his/her results which will directly impact patient outcomes in a positive manner. Every complication should be viewed as a sentinel event: an incident not to be repeated, or even worse, to recur in a more serious manner. The discussions at these conferences need to reflect the critical importance of the topic, and be pointed and directed in an objective fashion. There is tremendous power in the collective knowledge and experience possessed by those who attend these conferences. This is not a venue for a personal attack, but rather a forum to identify all of the facts and options, and to try to determine what is needed.
to improve the outcome for future patients with the same pathology. The discussion must be impartial, and evidence based. These conferences are critical for our patients, and if they are gasping for life at your institution, they need to be resuscitated for the greater good of all.

Commentary

There is no conference more valuable than morbidity and mortality
I reviewed Dr. Epstein’s informal survey with great interest. Certainly, there is no conference that is more valuable than M & M; the converse of that is that there is none that is more disliked. Facing our demons in public can be very disconcerting, and often very threatening. However, the opportunity to discuss actual experiences in a protected environment is extremely helpful. Similarly, the ability to discuss therapeutic alternatives and expectations is extremely important.

Morbidity and mortality most valuable as true learning experiences rather than Pseudo-Trials
In my limited experience, M & M conferences are most valuable when they are approached as true learning experiences, rather than pseudo trials. Terrorizing residents and students, and grandstanding makes it very difficult to accomplish anything of value; thus, strict rules of engagement are necessary.

Residents required and faculty strongly encouraged to attend morbidity and mortality conferences
In my own institution, the M & M is mandatory for the residents and attendance by faculty is, obviously, strongly encouraged. I am guilty of having been one of those who has not been a regular attendee because of my surgery schedule. However, in the new world of quality, attendance at M & M should be considered critical. Indeed, in order to make M & M the broadest learning experience possible, the conference is about to be made mandatory in our institution, with implications for unexcused absences.

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Commentary

Morbidity and mortality conferences: “Death or do-nots”
M & M conferences (or ‘Death and Do-nots’ as they wryly were referred to by some residents) overall were worthwhile. Often, though, their quality varied with the individual conducting the conference. They served as a source of enjoyment, not education, for the residents who relished seeing the attendings on the hot seat for a change. It is unlikely that there is sufficient time for conducting both the mandated QA meetings and the M & M conferences as known in the past, especially in programs with heavy trauma loads. Restoring M & M in some form, though, would seem to be an appropriate topic of discussion for an organization, such as the Society of Neurological Surgeons.

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Commentary

A hospital administrators perspective on the value of morbidity and mortality conferences
This is an interesting topic, and I agree with your (Dr. Epstein’s) comments. With all the changes in healthcare, senior physicians are retiring earlier in their careers.

We are, therefore, losing the most senior/experienced physicians that historically were able to pass on their
years of knowledge/experience and wisdom. In addition, with residency hour restrictions as well as pressures on attendings, the pressures are to continue to do more with less, M & Ms are most likely secondary on their (the attendings’) agenda. Nevertheless, I believe these forums are increasingly becoming more important to not only continually train our young physicians (residency time is shortened secondary to restricted hours) but also to help maintain the quality we provide to our patients.

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Commentary

Morbidity and mortality: A forum with impartial, knowledgeable and experienced colleagues allow all to profit
We usually learn from our mistakes. Even better is to learn from the mistakes of others. Frank discussions of bad outcomes—and the mistakes that led to them—in a forum with impartial, knowledgeable and experienced colleagues allow all to profit. Honest give-and-take collegiality has been, and remains part of the practice of medicine. Even the greatest neurosurgeons of the past would honestly admit, in conferences, and even in writing, that “I killed this patient!”, “I could have done better”, “learn from my mistakes,” etc. And by sharing that information, medicine, in general and neurosurgery, in particular, advanced. That’s why M & M conferences have always been an important part of our culture! They were initially conducted with the best of intentions. What’s happened to them?

Morbidity and mortality turned into a circus
In many institutions, they have turned into a circus. The audience no longer consists of colleagues of more or less equal stature. Now M & M conferences have become a freak-show where egos clash and nonneurosurgeons, residents, medical students, and, sometimes, nurses, nursing students and even hospital administrators sit on the sidelines to enjoy the show. Rival practitioners and practice groups try to “one-up” one another as they “play to the crowd”. And if some are naive enough to believe that these discussions are all honest, totally for learning and quality improvement?—Well, I have a bridge between Manhattan and Brooklyn that I’d like to sell them.

The problem with present-day morbidity and mortality’s is that there are too many on-lookers
The problem with present-day M & M’s is that there are too many on-lookers who have neither the sophistication nor specific education, to understand the nuances of a difficult case. All they remember is a dead or crippled individual or those that spend needless weeks in the hospital because of wound infections or other complications. These on-lookers leave the conference and start talking: “Yes, when I graduate from Med school, I’ll do so much better than those clowns”. And the nurses, nursing students, social workers pass the stories on. Perhaps some may profit from it: go to a malpractice attorney and get a hefty “finder’s fee”. And some idiot junior hospital administrator will report cases of “obvious incompetence” to superiors—none of whom have ever been to medical school or even in an operating room but make important decisions based on care costs and length of stays as they equate, say, surgeons who do complex spine procedures on elderly patients with surgeons who operate on ruptured disks between L4 and S1.

Surgeons Need a Forum For Serious and Dispassionate Discussion of Results/Complications
Nonetheless, surgeons need a forum for serious and dispassionate discussions of results, complications and their management. We need to return to our “roots” where professional colleagues discussed cases in a gentlemanly, and honest manner. I think that M & M conferences are very valuable, and must continue. But they must be restricted to those who have the level of intelligence, experience, and sensitivities to make refined judgments and distinctions in any particular case. This is not “entertainment” and we do not need an “audience”.

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If morbidity and mortality data is leaked to lawyers, “Morbidity and mortality is dead”
To me, the most shocking commentary above was Robert (Bob) Goodkin’s, stating that someone leaked the cases to lawyers to pursue. That individual should have been fired. We do not know the outcome of that dishonorable behavior.

What Bob has stated in his comments is chilling. Not only is the information and discussion in M & M conferences available to lawyers and thus is not privileged, but also the information is used by the hospital for credentialing. I have two immediate reactions to his statement.

First, it is obvious that under the conditions he states, M & M is dead. No faculty will be honest enough to reveal information that will compromise his/her employment, credentialing, or place him/her in jeopardy of the courts. Also, honesty is lost as is the educational and learning value of the conferences. If I were Chairman in such a circumstance, I would stop the conferences.

Second, Let’s reverse the thinking. Let us say that all discussions among lawyers about any case is nonprivileged, or hospital administrators discussions in private about what they say about the staff, the Board, and others must be recorded and is not privileged. Also what is discussed in Banks, Corporate Board Rooms in private conversations is all open to public evaluation. If that were known, the suggestions that Doctors private conferences about patient decisions would become immediately private and privileged.

Physicians are at fault for “Permitting invasion of their privacy” in morbidity and mortality conferences
The reason why the changes he described happened was that, as one of the commentators stated, it was the fault of the physicians themselves for permitting this invasion of their privacy to occur. The second reason is that this change in M & M is a direct result of Socialization of Medicine. Once the government controls, as it does now 45% of the payers and 100% as it intends under the present Obama Administration, there is no limit to their invasion of the privacy of the doctor patent relationship. This invasion can be justified because the government is paying for the care. Given that scenario, I fear that what Bob Goodkin has stated will become universal. It appears that the precedent has already been established at one major medical center in the USA.

Morbidity and mortality should be private, not recorded discussions, and should be “Privileged”
What physicians need to do is to maintain that these discussions are private discussions among the participants; they may not be recorded, and they are privileged. If the hospital or any participant does not sign appropriate legal documents ensuring the privacy of these meetings, then the individuals will not be able to attend. If they violate the agreement, they are subject to immediate dismissal. The other alternative is to cancel the meetings. They could be held at a private home unannounced and unrecorded. At a minimum, I suggest that doctors having M & M conferences draw up legal documents now insuring the privacy of these meetings as I have stated to protect the participants. Another alternative is to discuss the patients without any identity of patient, location, or surgeon. That solution is less attractive in solving problems among colleagues.

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