

Who's Sorry Now?

Some Thoughts on Acculturation and Meaning in Morbidity and Mortality Meetings¹

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Over the past decade, a series of celebrated accidents and structural changes in healthcare delivery and funding have generated new interest in patient safety (Cook, Woods et al. 1998). Early optimism regarding the prospects for substantial improvement in patient safety has largely disappeared. What appeared to be easily obtained increments in safety -- sometimes described as 'low hanging fruit' -- via applications of technology, reporting systems, and proceduralizing work, are now seen to be of limited value (Cook 2001). It seems likely that accidents, errors, and failures will continue. Handling such events will be part of anesthesia training and practice for the foreseeable future.

Safety enthusiasts advocate a change from a "culture of blame" to a "culture of safety" (Sibbald 2001; Horns and Loper 2002). Substantial reductions in blame are thought to promote event reporting which is, in turn, regarded as a prerequisite for generating insight and developing countermeasures. Uncoupling "blame" from accident analysis is far easier to claim than to achieve. There is some suggestion that some institutions have reduced the *sanctions* that are applied to operators after accidents. Reduction in *blame*, in contrast, would involve shifting investigation and attribution of cause away from individuals working at the sharp end of systems (Cook and Woods 1994). Human performance is a critical component of successful and unsuccessful operations in hazardous systems and meaningful assessments of the contributions of practitioner performance to safety remains entangled and contentious. All hazardous socio-technical systems have formal mechanisms for making such assessments. The morbidity and mortality conference one such mechanism widely used in anesthesia and surgery.

Paradoxically, increased public emphasis on safety (Eisenberg, Foster et al. 2001) may have increased the difficulties of those trying to evaluate the performance of medical trainees in the setting of accidents and incidents. Public pressure for accountability and the need to demonstrate control are, in practice if not in theory, diametrically opposed to the "blame free" culture tenant (McNeill and Walton 2002). In the abstract, a blame free culture seems attractive and reasonable. After an incident (which is, in essence, an accident without bad consequences) withholding sanctions is possible and blame may be moderated. It is much harder to accomplish this in the aftermath of an accident (which is, in essence, an incident with bad consequences). Hindsight bias makes bad outcomes seem predictable and human performance more egregious in ways that tend to glue blame to individuals working at the sharp end of practice (Woods and Cook 1999). It is these issues that play out in the M&M conference.

Nearly everything in morbidity and mortality conferences is conflicted at some level. Technical, organizational, intra- and inter-personal issues interact and what emerges is the result of trying to keep the resulting conflicts in check. Although M&M is ostensibly a narrow technical activity, it functions as a means of obtaining and asserting social control, authority, and responsibility. Bosk's *Forgive and Remember* (Bosk 1979) remains the most insightful description of the social function of M&M. Bosk makes it clear that managing failure entangles technical and social issues. Smooth handling of failure allows groups to maintain a distinct identity and, at the same time, tolerate

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devastating failure. M&M functions socially as a process of acculturation of trainees, a ritual means for rationalizing failure, and also a defense against encroachment by external agents. The symbolic, ritual character of M&M is remarkable. Participation in M&M identifies group membership and many trainees regard experiences with M&M as pivotal moments in their training.

The strong preference of participants for a narrowly technical view of M&M creates the appearance control. If M&M is only about the technical aspects of failure, then only technical expertise (that is, the expertise contained within the group itself) matters and the process of evaluating morbidity and mortality is immune from external assessments.

It is not surprising that M&M participants do not use Bosk's categories of "error" (Table 1). The processes of acculturation and the active construction of meaning that are at the center of M&M conferences remain largely hidden from practitioner view. It is not so much that these topics cannot be spoken about as that they need not be spoken about because they are not directly visible to participants. Making M&M 'work' requires figurative blindness to the distinctions Bosk makes.

Type of error	Example	Improves with training ?	Inferences regarding individual	Reaction of group
Technical	Technically poor wound closure	Yes	No moral significance	Tolerance
Judgmental	Repeatedly missing diagnosis	No	No moral significance	Ejection from the group without prejudice (e.g. good letters of recommendation; support in job search; continued association)
Normative	Saying "I examined the patient" when this is untrue. (Violating a general standard)	No	Moral failure	Prejudiced ejection from the group (e.g. no references; shunning)
Quasi-normative	Using the 'wrong' suture. (Violating a local standard)	?	Moral failure	Varies

Table 1: Bosk's Error Categories Identified in Surgical M&M

The need to reduce blame on individuals and the need to demonstrate organizational accountability conflict and the resolution of this conflict may be seen in the structure of the M&M conference. Some reduction in the perceived punitive character of M&M proceedings can be obtained by reformulating the conference as an educational venture (sometimes heralded retitling the conference, e.g. as "quality improvement"). But this does not so much reduce blame as shift the assignment of blame outside the conference. The incentives to take action, reassert control, reestablish coherence, and demonstrate authority remain and must be dealt with elsewhere. Similarly, pressure to demonstrate accountability for patient safety may lead to efforts to 'open up' M&M conferences to outside scrutiny, e.g. institutional representatives, professionals from other disciplines. As this happens, the incentives for participants to keep the conflicts inherent in practice out of sight

are increased. Both the need to reduce blame and the need for openness create incentives for elites to handle more controversial cases *in camera*.³

The management of failure is something that trainees learn gradually. It is part of the acculturation of the individual into a professional community. Efforts to create less conflicted structures in which to handle failure may succeed in shunting conflict into other venues but they do not remove the sources of conflict, which are deeply embedded in the technical work that practitioners do and that trainees must learn. The tensions that permeate M&M do not arise from the conference *per se*. Rather, the conference reflects the tensions that are present in the world of work. Managing the tensions that surround failure is a critical competence that trainees must master if they are to function effectively in the work world and the experience of M&M serves both to teach and test that competence. The value of M&M as a forum for developing this competence may, paradoxically, be undermined by external pressure to improve patient safety.

The argument made here is that M&M performs multiple functions -- technical and social -- simultaneously and that these cannot be disentangled or segregated. The meaning of failure is not so much revealed as *constructed* by M&M and trainees' exposure to M&M teaches them to construct meaning in the presence of conflict. The process of extracting meaning from failure is at least as much a cultural, social process as a technical one and trainees learn how to do this social work by observing and participating in M&M. It is here that the technical and social aspects of the genesis of failure and the reactions to it are learned.

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³ Evidence for this is a shift from M&M as a conference where all complications are discussed to one where only some cases are discussed. Criteria are not static or unidimensional. For example, a conference may routinely present low consequence failures (incidents) because of their 'educational' value but sometimes present a high consequence failure because it "needs to be discussed"; the ways in which the criteria vary may reflect both intra-organizational and external factors (e.g. the need to demonstrate accountability and control after a catastrophe). The selection of cases for discussion in M&M is a largely unstudied area.