

Morbidity and mortality rounds in a Saudi hospital

To the Editor

We read with interest the excellent review by Dr. Ahmad M. Zubaidi¹ about morbidity and mortality rounds (MMR) in a Saudi hospital. We totally agree with the author that learning from one's error is important, but confronting them is difficult and is particularly a delicate topic when carried out at a meeting. We have a very outstanding experience in conducting MMR in the Department of Surgery in our institution. We believe that MMR meeting is the ideal vehicle for implementing a small team approach to patient care, a forum for ongoing educational change, and develops organization and presentation skills.² Developed, for both clinical research and quality improvement purposes, Quality and Data Management Unit of our department collects information of all admissions, discharges, and surgical procedures performed in the operating room or day surgery unit for all 9 sections (general and minimally invasive surgery, breast and endocrine surgery, colorectal surgery, ophthalmology, pediatric surgery, plastic surgery, renal transplant surgery, thoracic surgery, and vascular surgery) of the Department of Surgery. In our surgical department, the morbidity and mortality meetings follow weekly and monthly meeting schedule. The general and minimally invasive surgery section meets every Wednesday (last day of the week) to discuss their MMR cases. Other sections meet once a month. All adverse events occurring within 30 days of surgery are categorized, using general and specific indicators. Before each meeting, the moderator, the chief resident of the general and minimally invasive surgery, selects morbidity and mortality cases and supplies the senior clinical analyst with information for the preparation for the preceding meeting. The senior clinical analyst also works with the coordinator of each section to produce high quality patient case reports for all sections. At the meeting, individual cases are presented by the junior or senior resident involved in the case in the presence of a treating consultant. The treating consultant answers any query regarding the case and respond to any comment. All cases once discussed in the sections meetings are then prepared by the senior clinical analyst and presented in the section coordinator meeting of the department by the chairman of the MMR, which is held every month. After the section coordinator meeting, the Senior Clinical Analyst will provide the cases to 3 assigned reviewers for the upcoming Review Board meeting. If reviewers decide that some cases need more clarification and detailed discussion, then those selected cases will be reviewed again in the Review Board meeting. The

Chairman of the MMR ensures completeness of the individual section work before the section coordinator meeting and serves as the driving force behind this changing educational approach.² The final decision is made on the individual section report in the review board meeting. After the approval of MMR Chairman and Department Chairman, the cases are reported to the hospital morbidity and mortality meeting and then to the Medical and Clinical Operations. In reviewing trends in complication rates over time, we also explore potential relationships between practice changes and outcomes. When appropriate, local performance is compared to the external benchmarks using data from published studies. Incorporating surgical outcome data into the MMR meeting is both feasible and practical. In addition to its educational value for both residents and attending physicians, we believe that this approach creates many opportunities for improving the quality of our surgical practice.³

In conclusion, we found MMR as a very educational training to the surgical residents and fellows in the training program and they do learn from every incident discussed during the rounds. We thought our experience should be documented and represent an excellent example for such beneficial MMR for the training as well as for the hospital authorities.

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Reply from the Author

It is my pleasure that my article previously published in this journal has drawn the attention to the importance of MMR. I think it awakens people interest and inspired others to scrutinize their rounds and scan them carefully to maximize conclusions and benefits driven out of them. In my opinion, MMR should be standardized as maximum as possible so all of us "not only physician, but also all other medically concerned personnels" can have a common recognizable and understandable comprehensible language. It is an honor to have those valuable comments written by Dr. Akram and her colleagues on my article. However, they partially share with us how they perform their rounds. My concern is that mortality cases are presented by a junior staff while the treating consultant himself should be the presenter. Morbidity and mortality rounds

must be educational and act as an index guidance to the department performance and dealing with clinically disastrous as well as less moribund situation where valid directional conclusions are drawn that enhance audience experience and enable everybody to learn how to prevent such tragic events from happening.

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Statistics

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Describe statistical methods with enough detail to enable a knowledgeable reader with access to the original data to verify the reported results. When possible, quantify findings and present them with appropriate indicators of measurement error or uncertainty (such as confidence intervals). Avoid relying solely on statistical hypothesis testing, such as the use of P values, which fails to convey important information about effect size. References for the design of the study and statistical methods should be to standard works when possible (with pages stated). Define statistical terms, abbreviations, and most symbols. Specify the computer software used.