The Morbidity and Mortality Conference: A Unique Opportunity for Teaching Empathic Communication

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Abstract

Background The morbidity and mortality conference is an educational tradition in American medicine that dates to the early 20th century. Traditionally, this conference has focused entirely on issues of diagnosis and treatment, in the context of a disappointing clinical outcome.

Intervention We report on a new method for teaching empathic doctor-patient communication skills at an obstetrics and gynecology morbidity and mortality conference. For each case presented, we identified the communications challenges and allowed faculty and residents to "practice" the discussion they would have with the patient and the patient's family in that situation. In some sessions, actors assumed the role of the patient. Following the discussion of the case, we offered didactic presentations on how we communicate with patients and their families. These focused on techniques for being patient centered and included the use of body language, open-ended questioning, reflective listening before offering to explain, and the importance of naming and validating emotions.

Results The majority of participants felt the sessions to be helpful, and after one month many were able to identify a positive change in their interactions with patients.

Conclusions We believe that this unique teaching format allows learners to refine their communication skills in the context of situations that they know to be both realistic and important.

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Introduction

The morbidity and mortality (M&M) conference is an educational tradition in US medicine that dates to the early 20th century.[1] The original M&M conferences began in departments of anesthesiology and surgery, and the approach is now part of the curriculum in numerous fields, including pediatrics, family medicine, internal medicine, and obstetrics-gynecology. The essential format is the presentation of a case or series of cases with a disappointing outcome, either with or without a true medical mistake. Discussion focuses on the educational lessons that can be gained from this experience and on methods for preventing similar adverse outcomes in the future.

Traditionally, the M&M conference has focused almost entirely on issues of diagnosis and treatment. Recently, several groups have suggested methods to broaden the impact of this conference. One such initiative[2,3] involves the systematic use of data culled from the M&M conference to implement quality improvement in patient safety. Others[4,5] have suggested that the M&M conference can be used to teach the core competencies (patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism, and system-based practice). Most recently, education in end-of life care has been incorporated into the structure of the M&M conference in a neonatal intensive care unit.[6]

This paper reports a method for teaching skills of empathic doctor-patient communication at an M&M conference that assists in identifying communications challenges and allows faculty and residents to "practice" the discussion they would have with the patient and the patient's family in the given situation. We believe this format allows learners to refine their communication skills in the context of situations that they know to be realistic and important.

Methods

The M&M conference is a weekly activity in the Department of Obstetrics and Gynecology at Duke University Medical Center. Our model was incorporated into the allotted hour and continued into an additional hour that is usually used for a grand rounds presentation.

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Following the presentation of 1 or 2 difficult cases, one author (N.P.) gave a brief (10–15 minute) didactic presentation on how we communicate with patients and their families. The lecture focused on techniques for being patient centered and included the use of body language, open-ended questioning, and reflective listening.[7] Residents were encouraged to listen carefully before offering to explain and cautioned against the common pitfall of explaining too quickly and too much. Additionally, we emphasized the importance of naming and validating emotions.[8] At the end of the session, the cases were discussed from the point of view of communication. We asked the following questions about each case:

- "How did the patient react to this disappointment?"
- "How did you discuss this with the patient and the patient's family?"
- "How did it go?"
- "How might you handle this better in the future?"

In addition, the specific potential skills that might be helpful in each of the M&M cases were identified by the group.

In one series of 2 M&M conferences, the 32 physicians in attendance were then divided into groups of 3 or 4 and given the opportunity to role-play the skills of empathic communication, using the case that had been presented. Emphasis was placed on listening carefully to the concerns of the patient and the family before offering to explain what had gone wrong. In a second series of 2 sessions, simulated patients (hired actors with a background in improvisation and several years of experience in our medical center's standardized patient program) assumed the role of the patient, and residents and fellows practiced the discussion in the presence of the entire group. Feedback was provided by the actors, other learners, and the authors.

Evaluations were obtained at the end of all sessions. Participants were asked to rate various aspects of the conference and the complete exercise on a 5-point scale from poor (1) to excellent (5). The study was granted a waiver for documentation of informed consent by the institution's Internal Review Board.

Results

Of 41 participants, 38 rated the first conferences as "excellent" (29) or "very good" (9), and 33 residents indicated they thought their abilities would be improved by the seminar. In the second group of conferences, which used standardized patients, 27 of 31 participants rated the sessions as "excellent" (17) or "very good" (10), and 29 thought their ability would be improved by the seminar, with several respondents indicating they found the work with simulated patients particularly helpful. In addition, participants indicated in writing a change they wished to make in how they communicate with patients. We obtained permission to contact the participants via e-mail to assess progress on their goals one month after the seminar. We contacted 23 participants via e-mail and received 9 responses. Most respondents reported positive changes in their behavior, and most of the changes involved listening more carefully and attentively to their patients (BOX).

BOX Sample Comments from Residents Replying to an E-mail One Month After Morbidity and Mortality Conference

"I have tried to sit down more when talking to patients. I could probably work more on 'being there' with the patients..."

"I thank you for 'guiding' me. I think these lectures are very important and look forward to another series. It allows us to act 'human,' say we are sorry, and then move on."

"I do believe that I have improved in the area of listening since the seminar.... As my fund of knowledge has increased, I tend to want to 'solve' more and listen less. I have to remind myself that even though I may know a great deal about a patient's disease, it is impossible to know a great deal about the patient unless I listen to them."

"I've found that sitting down in the patient's room, no matter how long I actually stay, seems to help them relax and feel cared for. Thanks for the presentation. Most helpful."

Discussion

Although interpersonal and communication skills comprise one of the 6 competencies required by the Accreditation Council for Graduate Medical Education, teaching empathic doctor-patient communications has been challenging. In many programs, it is difficult to fit communications training into an already full conference schedule.[9] We focused on incorporating communication skills teaching into an educational activity already in existence. Our experience and questionnaire data suggest that this approach is both efficient and practical.

We included role-play in each of our M&M conferences, both with and without the use of simulated patients, and found both approaches to be successful. Learners tended to approach the exercise with enthusiasm and interest. We hypothesize that basing the role-play on the specific case presented in the M&M conference facilitated "buy in" by the learners. The teaching of communication skills at an obstetrics and gynecology M&M conference now occurs on a quarterly basis. It is our hope to encourage other departments in our medical center to adopt a similar exercise.

Traditional M&M conferences have focused on the medical aspects of an adverse patient outcome and have ignored the associated psychosocial issues. We believe that this new approach to the M&M conference can lead to a more thoughtful and humanistic approach toward families that are facing disappointing outcomes, and that it will allow residents to develop a more complex appreciation of what is required of them as physicians in such difficult situations.

One limitation of our evaluation is that it relied entirely on self-reporting by participants. Future studies could entail confirming the effect of training on communication skills

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through videotaped analysis of doctor-patient interactions, or by feedback from staff or patients.

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