Royal College of Surgeons
ADVANCING SURGICAL CARE

Morbidity and mortality meetings

43%

In 43 out of 100 reviews, there was discussion around the quality of morbidity and mortality processes.

The open discussion of patient deaths (mortality) and operative complications (morbidity) helps surgeons and those responsible for surgical services understand the effectiveness of surgery. It is also essential for ensuring that a surgical service learns from surgical complications.

Our experience from invited reviews is that surgical services do not always undertake morbidity and mortality review effectively. Examples include:

- Insufficient time being scheduled for meetings, with meetings either not frequent enough or not long enough.
- Discussion of clinical incidents taking place a long time after they happened, potentially due to issues with scheduling or availability for attendance.
- The selection of episodes of patient care for discussion at the meeting not being well managed and being perceived to be biased for or against a particular surgeon.

- A lack of regular attendance by key consultant team members, either due to individual behaviours or system issues such as problems with job planning.
- Inconsistent presentations of episodes of care when being discussed, in terms of format and/or quality.
- Absence of dedicated administrative support for the meeting.
- A lack of structure when discussing episodes of care, leading to missed opportunities for learning.
- A lack of constructive or well-managed challenge within discussions leading to missed opportunities for learning.
- Discussions not reaching specific conclusions about the contributory factors, or agreeing clear actions to improve care in the future.
- A poor recording of discussions, and the agreed actions.
- A poor follow up of agreed actions and how they are implemented.
- A lack of monitoring of overall trends in the problems that arise within the team's delivery of care to ensure future learning.

The absence of good quality morbidity and mortality processes means surgeons are not able to learn from their own and their colleagues' experiences. Our experience of the problems that this can cause for surgical safety shows how critical this is to providing a safe, high quality surgical service, and why it should be prioritised.

Resources

- Royal College of Surgeons | *Morbidity and Mortality Meetings*
- GMC | *Morbidity and mortality meetings to improve patient care*