Mixed Methods Assessment of Uncivility During Surgical Mortality and Morbidity Conference

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BACKGROUND

- Mortality and Morbidity (M&M) Conferences enable clinicians to learn from and address individual and system factors that lead to complications.
- Ideally, M&M provides a safe environment without fear of being criticized, blamed, or humiliated is necessary for open discussion and to generate actionable recommendations.

OBJECTIVES

 The aim of this study was to assess occurrences of uncivility during M&M Conference in an academic Department of Surgery.

METHODS

- Convergent mixed methods design
- Quantitative data collection: standardized survey instruments were distributed to all the Department of Surgery faculty and residents:
 - 1. The Positive and Negative Affect Schedule Short-Form (PANAS) and the
 - 2. <u>Uncivil Behavior in Clinical Nursing</u>
 Education (UBCNE) survey
- Linear regression quantified participants' characteristics (e.g sex, academic rank) association with uncivility score.
- Qualitative data collection: Non-participant observations of M&M conferences to collect field notes of uncivility and unprofessional communication.
- Qualitative data were analyzed thematically.

Female and junior faculty were more likely to report uncivility in the context of unstructured discussions.

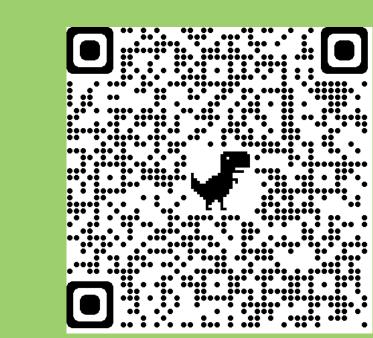
In order to make meaningful changes
in patient care processes, M&M needs
to be a place for open, honest
discussions.

Implementation of guidelines for
structured discussion may minimize
uncivil comments and lead to more
effective communication about
surgical care delivery.



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Data Collection tools



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Results

- 54 (36.7%) participants completed survey (residents: 27.5%, faculty: 37.6%)
- Junior faculty had a 2.60 higher Negative Affect Total score (p-value=0.02), a 4.13 higher Exclusion Behavior Total score (p-value=0.03), and 7.68 higher UBCNE Total score (p-value=0.04) compared to senior faculty.
- Females had a 2.71 higher Negative Affect Total Score compared to males (p-value=0.04).
- We observed 11 M&Ms, involving 30 cases, over four months with four different moderators.

M&M Outline:

- Clinical Scenario
- 2. Decision Making
- 3. Operative Mgt
- 4. Complication
- 5. Mgt of complication

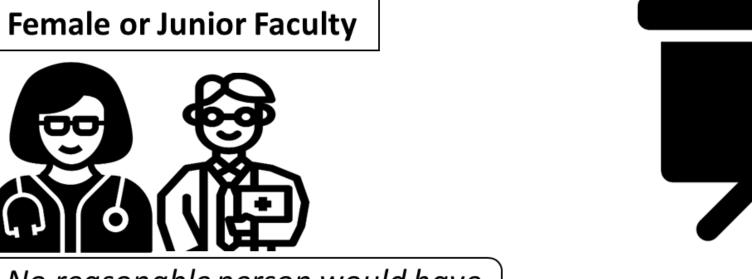
Open discussions

- Errors of Omission or Commission
- Patient risk factors
- System factors
- Complications' impact on patient
- Prevention of future complications.

No Structure

No Boundaries

Qualitative analysis revealed that female and junior faculty experienced uncivil communication during M&M conference

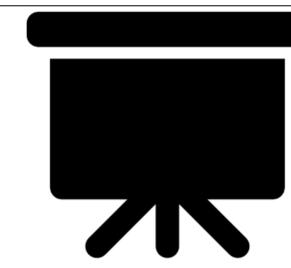


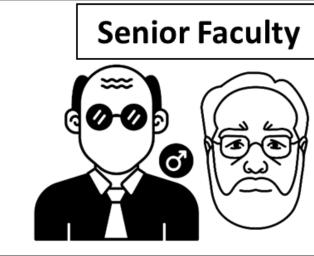
No reasonable person would have made that decision.

At the time of 1st Interventional Radiology (IR) drainage: were intra-abdominal abscesses communicated for IR drainage to work, or did you consider for open drainage?

For an early post op bleeding causing hypotension and significant drop in Hg, why not just go back to the OR for control?

You can't ligate both internal jugulars without neuro consequences. The brain will not drain. ICPs go through the roof.





I think you have done the right thing. The pelvis was a rock. I don't know if there is anything different that should have been done. You stent preoperatively so that they help you identify the ureter or the distal stump when it is injured.

Audience

M&M

Yes, the patient was too ill, had undergone several procedures in the past, which made him vulnerable: he was too sick, he was severely malnourished.