WIDENING THE PERSPECTIVE OF SURGICAL MORBIDITY AND MORTALITY CONFERENCES: ENHANCING RESILIENCE BY TOWARD LEARNING FROM EVERYDAY PERFORMANCE AND OUTCOME

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Abstract
The surgical morbidity and mortality conference (M&M) is a deep-rooted tradition that aims to improve surgical quality and safety by learning from past cases. M&M typically focuses on cases with adverse outcomes, i.e. the negative and the *absence* of safety, and does not review desired outcomes nor the capacity to achieve safety. This approach is analogous to a soccer team trying to improve penalty kick skills by only reviewing missed shots. Resilience science emphasizes that increasing safety in complex socio-technical systems, such as healthcare, requires understanding the *ability to achieve safety*. This ability is reflected in the adjustments that professionals make in daily practice to make things work despite challenging circumstances (e.g. limited information or time). These adjustments are essential to ensure safety in complex systems, because circumstances vary constantly and unexpectedly. However, these adjustments are easily framed as 'mistakes' or 'deviations' when only reviewing cases with poor outcomes, partly because this is done in hindsight while knowing the outcome. As an alternative to the current approach, the positively directed approach could be applied to M&M practice to increase our ability to learn from everyday performance and continuously improve the quality and safety of surgical care.

Resilience is enhanced when teams discuss everyday practice rather than only cases with specific (adverse) outcomes. In this manner, discussions cover both adverse and desired outcomes as well as the preceding performance and adjustments that usually go right but occasionally go wrong. These discussions serve to increase understanding of how professionals mostly manage to achieve good and safe outcomes, often despite challenging conditions. Such insights can inform efforts to enhance this ability to make things go *right*, rather than only investing in preventing recurrence of specific things that went *wrong*.

These principles were implemented in weekly team meetings (60-90 minutes), during which teams debrief and brief by discussing all discharged and upcoming cases of their service or subspecialty. By covering the entire spectrum of cases, teams also discuss things that went right. Depth of review differs per case, depending on the discussion. For upcoming cases, issues can be anticipated and success factors can be supported. Besides lessons for patient care, this meeting also exposes bottlenecks for discharged and upcoming cases in logistics or

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information systems, such as planning or administration. Thereby, this format evokes discussion of not only clinical dilemmas, but also the many logistical, operational issues that often lie outside the scope of M&M. Our surgeons and trainees value the collective reflection on both good and poor outcomes, and on both routine and exceptional situations. They feel more informed, motivated, and able to bring discussions to a higher level compared to traditional M&M. Because all patients are discussed soon after and before admission, this format empowers teams to reflect and anticipate on strengths and challenges in a timely manner. As an alternative to traditional meetings that strive to improve safety but study its absence, this format strives to understand how safety is *achieved* in everyday work.