# Morbidity and mortality for the dermatologist: Resident-led pilot project

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The morbidity and mortality (M&M) conference is a traditional forum for the discussion of adverse events, particularly among surgical specialties. These conferences play a valuable role in identifying opportunities to improve patient care.[1-3] Interventions that promote safety through error disclosure should also benefit dermatology trainees. A recent survey of dermatology residents showed that 45.2% failed to report needle-stick injuries and that 96.7% reported body part mislabeling during biopsy.[4] Responders reported feelings of guilt, shame, and fear of intimidation as reasons for nondisclosure.[4]

The classic surgical M&M model consists of a case presentation followed by open discourse. Critics caution that this model may propagate allocation of blame and public shaming through a structure of hierarchy.[5] Alternative models to maintain anonymity have been proposed[6,7]; however, outcome studies demonstrate lack of explicit error disclosure and relatively little audience participation.[8]

Our resident-led pilot study involves the novel implementation of the traditional M&M conference in a dermatology residency curriculum. Our so-named reflection rounds are held quarterly for all residents and faculty to establish a culture of safety surrounding discussion and disclosure of error, promote professionalism, and identify areas for improvement in a positive, supportive environment.

Residents voluntarily proffer their own cases that involve (1) a poor or unintended outcome, (2) a near miss that could have led to a poor outcome, or (3) a unique ethical dilemma. Before the conference, cases are reviewed by the resident leading the conference and the program director to select those of highest educational yield and the best opportunities for system-based quality improvement.

The conference format is resident led with emphasis on the process being judgment free, promoting a climate of comradery. Faculty are also in attendance and are encouraged to model disclosure of error informally sharing their similar experiences. The resident provides the case overview, including potential or actual harm, identifies "take-home learning points," and suggests changes to prevent reoccurrence; this is followed by a group discussion brainstorming changes for quality improvement and reaching a consensus on actionable items.

To assess the impact of the intervention, surveys were administered to residents 1 year after implementation, with an overall response rate of 92%. Residents agreed this was a valuable learning experience in disclosing errors and identifying areas for improvement. Perhaps most notably, 95% of residents felt safe and supported disclosing an error to peers and faculty, with 87% being more likely to disclose an error in the future. By analyzing the number of cases submitted for review over the 1-year period, there was a 4-fold increase in the rate of error disclosure.

Future plans to make this a monthly conference in conjunction with grand rounds could increase faculty attendance and enable discussion of errors in a timelier fashion. Ultimately, this sustainable model will serve as a blueprint for other training programs.

In summary, this resident-led quality improvement intervention shows how case discussion

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surrounding medical error can be a powerful tool to enhance resident education, drive advances in patient safety, and engage residents in a lifelong culture of improving systems of care.

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