Mini M&M Conferences Create a Structured Opportunity for Self-Reflection

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Residency is HARD.

- Time of substantial growth and development
- Intensive work schedules
- Strenuous academic demands
- High-stakes decision making
  - Literally life & death

- Rather than seeking to eliminate this distress—which will be present throughout a career—we should teach residents to manage it in a healthy manner.
  - A 2018 study found that appropriate educational programming could improve stress management skills and prevent burnout².

- Debriefing is a great tool
  - Has been shown to promote resilience in the medical field³.
  - Can relieve stress among those involved in adverse events⁴
  - Can result in improved confidence and self-esteem⁴
Our Goals

- To provide normalization of the high emotional distress that can be associated with medical practice.
- To educate residents on ways to cope with this distress.
- To help senior residents assist their team in managing and processing traumatic events.
Methods: Setting & Participants

• **Setting**: Milwaukee Veterans Affairs Medical Center
• **Participants**: Residents and medical students on internal medicine ward teams between July 2019-February 2020
  • Placed on hold in March 2020 given COVID-19
  • 6 cycles of this program were fully completed
The Mini M&M

1. Case Selection by Residents
   Each ward team selects a case
   Evaluates & analyzes using a worksheet

2. Case Review & Analysis
   Chief Resident reviews all submissions
   Compiles a presentation with in-depth analysis, prompts

3. The Noon Conference
   Held during protected time & closed to faculty
   Starts with review of reporting systems
   5 minute teaching on how to lead a debrief
   Review of each case with prompts provided by Chief
   Review of MCWAH Mental Health resources
Methods: Evaluation

Pre-Survey
• Assessed residents’ comfort with leading a debriefing session using a 6-point Likert Scale
  • Extremely Uncomfortable = 0 to Extremely Comfortable = 5
• Analyzed participants’ experiences

Post-survey
• Evaluated Perception changes
• Compared comfort with debriefing
Pre-Survey

N = 65 (140 possible)
Most participants felt they had been “emotionally affected by at least one patient I have cared for throughout my training”
Some disagreed that “residents receive enough education in managing the emotional effects of adverse patient events during residency.”
Less than ½ of our participants had participated in a prior debriefing session.
Post-Conference Perceptions
Majority agreed they were “increasingly aware of the significant toll distressing patient care events have on providers”
Most also agreed that “discussing difficult cases from an emotional aspect is beneficial to me”
Comfort with Leading a Debrief
Participants felt more comfortable with the idea of leading a debriefing after this program.
Participant Feedback
“It was helpful to hear that other providers experience the same obstacles and emotional stressors in typical scenarios”.
“I think it's helpful to know that people can voice frustrations or situations with which they feel a bad outcome occurred without retribution”
1. Figure out who should submit cases each month
   • Goal is to limit it to 1/team to force group discussion
   • Needs to be mandatory at first
   • Worksheet is helpful!

2. Set deadlines for submission
   • Should be ~1 week in advance of conference so that you can compile a substantive presentation
   • May need to remind resident teams
How do I adapt this for my program?

3. Find a protected venue and time for the conference
   • Encourage all residents & students to attend
   • Prohibit faculty from attending to encourage free speech
   • Review confidentiality prior
   • Keep the promise of confidentiality after
     • If an issue is identified, encourage the involved parties to file a safety report

4. Let the residents talk.
   • Show the prompts but be comfortable with silence. Someone will talk eventually.
   • Be willing to let the residents lead where your conversation goes. Similar cases and different experiences are wonderful to discuss!
   • Don’t fret about finishing the entire presentation.

5. Have tissues and chocolate.
Conclusions

1. A mini M&M program can provide a succinct, integrated approach to emotional and resiliency education.

2. Debriefing education can easily and quickly be incorporated into educational programming with improvement in perceived confidence.

3. Residents feel that having time to discuss emotionally-charged cases is beneficial to them.
References


Part 1: Case Selection by Resident Physicians

- Each ward team (5 total) would choose one case from their month to evaluate using a standardized worksheet
  - Goal was to select a case that was particularly challenging or where an error (systems or cognitive) had occurred
  - Worksheet is quick (two pages) and walked the team through a reflection
    - Were there interventions could have prevented this event?
    - What should be learned from this case?
Part 2: Case Review and Analysis

- Chief Resident would review worksheets
  - Provided feedback to residents
  - In-depth evaluation of cases
    - Answered questions raised by the teams in regard to systems processes
    - Identified any potential cognitive biases
    - Followed up on outcomes

- Compiled into a single presentation
Part 3: The Conference

• Open to all residents and medical students
  • Closed to any faculty aside from chiefs
  • Sign hung on door of conference room each month
• Relaxed, open atmosphere
• Privacy is essential
  • Door to conference room was shut
Conference Format

- Conference Format
  - Statement of confidentiality
  - Review of event reporting processes at our hospitals

- Debriefing Education
  - Reviewed the model adapted by McDermott et. al \(^6\).
  - Invited seniors to include pearls and advice
Conference Format (continued)

• Case Review
  • Deidentified version of each case presented.
  • Prompts presented, but free discussion allowed moderated by Chief
  • Residents would discuss a lot
    • Similar cases
    • Coping mechanisms
    • Practical advice
    • Ideas for QI projects

• Reviewed mental health resources at the completion of the session.

Thoughts on Case 2?

• How does it feel when you can’t get the team under control during a code?
• How would you have felt if you showed up to a rapid that should have been a code?
• How do you deal with frustration with other team members while coding a patient or in an equally acute situation?