The Psychosocial M & M: A Tool in Reinterpreting Problematic Medical Situations

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ABSTRACT

This article explores the concept of a psychosocial morbidity and mortality (M & M) conference as a useful adjunct to the traditional M & M in physician education. It argues that understanding significantly unexpected and disturbing patient outcomes often requires a shift in the analytic paradigm used and offers an interpretive and relational perspective as a way to deepen the understanding of physicians-in-training. In particular, it is argued that the psychosocial M & M can highlight previously missed or trivialized dimensions of patient, family, and physician interactions which affect care and, simultaneously, can help address the affective distress of the physician-in-training which results from a difficult and painful case. Definition, goals, and a theoretical formulation are provided, as well as a detailed description of how a psychosocial M & M might be conducted. A discussion of potential difficulties and anecdotal positive outcomes are also included.

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A patient who has unusually enigmatic issues or who has a shockingly unexpected outcome creates in the physician-in-training feelings of loss of control, incompleteness, confusion, even anger, and often guilt and remorse as well.[1] This is particularly true when the patient dies, leaving a legacy of remorse that cannot be repaired.[2] The traditional morbidity and mortality (M & M) conference was designed to provide a structure within which to review, primarily from a biomedical perspective, potentially problematic issues in diagnosis, treatment, and clinical judgment. Under certain circumstances, it also may be useful to conduct a psychosocial M & M, to explore from a psychological framework possible misinterpretations, misplaced emphases, and outright misunderstandings which may have contributed to an unsuccessful patient and physician outcome.

The psychosocial M & M is loosely patterned after its biomedical counterpart. Like a traditional M & M, it assembles participants involved in the health care of the patient to reexamine the course of that care. Just as the traditional morbidity and mortality conference does not exclude psychosocial information, so the psychosocial M & M considers appropriate biomedical findings. However, it has a substantially different emphasis, as its primary concern is the analysis and understanding of the subjective, inner, emotional worlds of the patient, family, and physician, and the potentially problematic ways in which these worlds interact. For the traditionally trained physician, a process with such an emphasis requires a significant paradigm shift,[3] the willingness to examine and understand the patient, family, and self from a radically different vantage point.

One might legitimately question whether such an activity is useful in the already complicated and overburdened lives of physicians-in-training. It is possible to argue, however, that significant patient, family, and/or physician anxiety over the outcome of a particular case is an important sign that the traditional modes of assessment, diagnosis, and treatment have proved inadequate. Crises of ineffectuality in the prevailing paradigm, those unwelcome and unsought surprises[4] in the direction of care, occur with depressing frequency in the practice of medicine, where what is supposed to happen according to the rules as they are known fails to transpire. Under these circumstances, the ability to reframe, reinterpret, and comprehend problematic situations in a new light becomes crucial.[5] It is through adopting a different mode of analyzing and understanding the situation that true insight and learning can occur.

Goals of the Psychosocial M & M

The demands of a busy inpatient service, as well as the overall biomedical ambience of the hospital at times, make it difficult for physicians-in-training to regard the psychosocial component of patient care as more than marginal or trivial. A carefully selected psychosocial M & M can serve the important educational function of highlighting for medical students and residents those situations in which the psychological, emotional, and family contextual dimensions make a profound contribution to the successful care of patients.

A psychosocial M & M can also accomplish another important task. The traditional M & M, while potentially of great educational value for the physician-in-training, does not always sufficiently alleviate the complex emotional reactions engendered by such disturbing patient care dilemmas. Too often, the subjective reaction of the student or resident is simply submerged, only to surface later, with

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greater intensity, under similar circumstances. The concept of a psychosocial M & M is designed in part to address some of the affective distress which arises in the physician-in-training in response to a difficult and painful case.

Thus, the goals of the psychosocial M & M are twofold: The first objective is to help residents and medical students understand in a graphic and detailed manner that the way in which they conceptualize and organize the patient's symptoms and problems is only one manner of defining the patient and that the social context of the patient, of which the physician-in-training and his or her interactions with the patient and family have now become a part, can be critical in providing essential insights into patient treatment. Secondly, the psychosocial M & M is intended to help residents move toward a resolution of some of the troubling feelings of guilt, anger, and loss of control which may be present during problematic patient encounters. The overall aim is to draw patient and physician closer together, to loosen the boundaries between them, and to enhance residents and students' abilities to perceive both their own humanity and that of their patients.[6] There is usually a striking synchronicity between these two goals,[7] ie, in understanding more about the patient from a psychosocial perspective, residents and medical students also begin to learn something more about themselves.

Theoretical Basis for the Psychosocial M & M

Medicine, like other social systems, is predicated on a certain set of assumptions and beliefs, a certain way of perceiving the world.[8] Despite strong advocacy in some quarters for the adoption of the biopsychosocial model,[9] by and large the more traditional biomedical model still prevails, especially in inpatient settings. In its philosophy, this model is rationalist and empirical; in its clinical practice, technological.[10]

Medicine uses this model to construct a framework within which to conduct its day-to-day business. The smooth functioning of the system depends on all participants (health care deliverers and recipients alike) sharing certain foundational assumptions and beliefs. When a participant (whether patient, family member, or physician) violates some or all of these assumptions, chaos can quickly ensue. The system responds by attempting to return the recalcitrant individual to the bounds of normalcy, according to its definitions. If this proves impossible, the system resorts to mechanisms of blame and punishment. In placing responsibility for undesirable outcomes on the individuals involved, the system conveniently avoids reexamination or challenge of its foundational premises. However, the physician-in-training often learns very little from such exercises in damage control. It is the belief of the authors that a more fruitful process is to examine and interpret the difficulty using a fundamentally distinct framework. Such reconceptualization of the problems, especially if formulated in interpersonal terms,[11] can open new pathways for change.

Rationalist, empiricist methods of analysis, which are exemplified in the biomedical morbidity and mortality conference, have been excellently summarized elsewhere.[12] Briefly, empiricism emphasizes the existence of an objective, verifiable, and unitary reality. Rationalism is more concerned with abstraction, in that it seeks to uncover the "deep structures" or foundational knowledge underlying the observable world. Both assume the possibility of adopting an objective, detached point of view to discover certain immutable laws which reflect predictable regularities in observable data. Thus, both rationalism and empiricism are oriented toward explanation and prediction, causality, hypothesis formulation and verification, and generality.[13]

The psychosocial M & M, by contrast, involves a discovery-oriented as opposed to a hypothesis-testing process.

> The whole basis for discovery-oriented (approaches) is the intention to learn more; to be surprised; to find out what one does not already expect, predict, or hypothesize. . .[14]

This model assumes that learners do not have unproblematic access to the meaning of a situation,[15] that meaning itself is not unitary, and that these meanings can most fruitfully be unraveled by using a hermeneutic or interpretive approach.[16] Using a systemic paradigm,[17] it argues that causality, such as it is, can only be understood in nonlinear and reciprocal terms. It also assumes that, rather than a single preexistent reality, realities are continually and mutually in the process of construction and that people's understanding of their world results from an ongoing communal interchange and dialogue.[18]

Thus, a discovery-oriented process is persistently interactional and relational as well as patient centered.[19] It attempts to understand what happens when the worlds of residents, medical students, patients, and faculty collide through the inevitable expression of differing agendas. It stresses the importance of discovering the interconnection between what the patient is doing and how the patient is being, and what and how other members of the system (including family members and health care providers) are doing and being. It is based on a kind of connected knowing,[20] which encourages learning through empathy as well as analysis. Rather than foundational knowledge, this approach seeks a point at which to enter the circle,[21] a starting place for inquiry.

In a discovery-oriented system, openness in the learner to several simultaneously existing interpretations does not lead to total subjectivism. Certain criteria of trustworthiness, such as credibility and confirmability, exist which limit the alternative ways of interpreting a given act. Thus, the rigor of a particular conclusion is based on the sense it makes to the participants, the agreement which can be achieved about the interpretation by other skilled observers, the degree of its "fit" with the social context from which it emerges, and its ability to withstand constructive criticism.[22]

The purpose of a discovery-oriented approach is to help learners get unstuck--to see the problem from a new vantage point[23]--and thus gain insights into potential alternative actions and behaviors. The aim is to get learners to acknowledge multiple coexisting realities, rather than making the assumption that their initial conclusions should inevitably determine the course of future interactions. Thus, the goal in a discovery-oriented approach is not prediction but a deepening appreciation for the particulars of a given situation--not a search for causes but a search for understanding, stemming from an interest in a different kind of knowing.[24]

Managing the Psychosocial M & M

Setting

The psychosocial M & M is usually convened at short notice, preferably within 48 hours after the need has been identified. Typically, it is held in the area normally used for morning inpatient rounds.

Participants include all individuals currently on the family practice inpatient service, ie, residents, medical students, and attending physicians and behavioral scientists. Other residents and faculty who have had either out- or inpatient experience with the patient are also encouraged to attend. Representatives of the nursing staff may also be invited as appropriate. Because the psychosocial M & M attempts to be patient-centered, at times it may even include the patient, so that agendas which have been previously ignored may be elicited directly. Alternatively, the participants may simply work with the health care personnel's previously acquired data base on the patient and family, making a significant effort to identify information which, according to traditional formulations, has been discarded as irrelevant or peripheral.

Process

As in most M & Ms, the resident with primary responsibility for the patient is asked to present the patient. Written documentation of salient aspects of the case is helpful. The resident is encouraged to reflect on his or her feelings in response to the patient, on indications of the patient's or family's subjective responses to illness and treatment, on relevant interactions and communications with the patient or family, and to integrate this information into the body of the presentation. Often, however, because of a lack of familiarity with this format and a reluctance to examine such psychologically threatening material, the resident is unable or unwilling to organize this type of presentation. At this point, it is the facilitator's responsibility to turn the discussion away from the more strictly biomedical aspects of the case.

In the authors' experience, the role of the facilitator falls primarily to the department's behavioral scientist. This is due in large part to the expectations surrounding the behavioral scientist's role. In point of fact, often the discussion is advanced significantly by contributions from the attending physician or resident. However, it is the responsibility of the behavioral scientist to organize the opening sally, to define the task at hand, and to move the discussion in an affective, relational, and interpretive direction. This is usually more easily accomplished when the physician faculty gives explicit and direct support to this process.[25]

Typically, a psychosocial M & M requires between 45 minutes and one hour to complete. At times, the process of the initial meeting will yield follow-up actions for the learners, either externally--in terms of negotiations and dialogue with patient/family/staff, or internally--in terms of continued reflection and shifting understandings, or some combination of external and internal actions. Thus, the primary facilitator may wish to schedule an additional summary conference. Any member of the participating group may also request such a meeting. These can usually be completed in approximately 30 minutes.

Topics

Given that the psychosocial M & M is primarily an exercise in reframing and interpretation, a pursuit of connected ways of knowing, it is arguable that any event which excites, piques interest, or invites taking a closer look merits such a conference. What, in a given situation, is out of the ordinary, different, exceptional, surprising, challenging, disconcerting, or distressing? What is hard to grasp, doesn't fit, or is hard to explain?

The realities of resident training, however, dictate the need for additional limitations. Thus, suitable topics might include persistent and debilitating doctor-patient problems generally classified under the category of "difficult patient" (eg, demanding, noncompliant, dependent, etc.).[26] Other topics to be considered for a psychosocial M & M are: chronic family problems which negatively affect the patient's health status; systemic failures in patient management (eg, an AIDS patient who leaves the hospital AMA); and unexpected or problematic patient death. This latter topic in particular represents an ideal candidate for the psychosocial M & M, because by its very nature it controverts traditional assumptions of the biomedical model[27] and almost inevitably engulfs the physician-in-training in a flood of doubts which are rarely admitted and less often explored in medical training.[28]

Role and Skills of the Discussant/Facilitator

The facilitator in the psychosocial M & M has diverse responsibilities. The first is to encourage the review of old material from new perspectives. This involves stimulating presenters to reinterpret commonplace conclusions and statements about the patient and family and to consider alternative explanations. Questions such as, "What was going on here?", "How did you experience this situation?", and "What was the patient feeling?" can help reorient participants' understanding. In addition, such questions can address a second goal, which is to bring to light new information relevant to the issue at hand. This can be accomplished by ensuring that the various informational bits and pieces held by the group as a whole are elicited. Very often, for example, a medical student may possess contradictory or paradoxical data which will have thus far been suppressed or ignored. It is up to the discussant to probe for and validate all such understandings.

It is also incumbent on the discussant to move the dialogue toward self-exploration for all participants. The link between understanding the patient and understanding oneself needs to be clearly established. Thus, the discussant should support and model feeling statements and self-disclosures. The facilitator must be able to help participants redraw the boundaries of the situation to include themselves as a vital component in the ongoing creation of the social context.[29] Particular attention should be paid to the interactional exchanges between health care personnel, patient, and family, since these contribute significantly to the construction of the idiosyncratic reality under examination.

Importantly, the facilitator is also responsible for moving the discussion toward resolution and closure. This statement does not imply premature or automatic solutions. However, it does mandate a sensitivity toward timely summarizing remarks. Clearly defining goals and objectives in the affective and interpretive realms at the start of the session will also enhance participants' sense of completeness by the conclusion.

The facilitator of the psychosocial M & M can be either a physician or a nonphysician behavioral science specialist (psychologist, social worker, clinical anthropologist). But whatever the professional training of the facilitator, he or she should have established expertise in group process. Since time constraints are operant in the psychosocial M & M setting, the facilitator must be prepared to confront and challenge participants in a direct way, asking questions

which dispute their conventional expectations and advancing interpretations which involve the participants directly in the process of the case, rather than leaving them comfortably outside the loop. At the same time, however, the facilitator must know how to be supportive and compassionate. A negative experience with a psychosocial M & M will virtually destroy all future possibility of this being a useful learning modality. By contrast, a skillful facilitator can extend acceptance and nonjudgmental understanding to participants who are suffering from guilt, rage, and anguish because of the ways in which they have become dysfunctionally entangled with their patients. The facilitator also needs to be ready to intercept highly critical and punitive remarks made by other group members by showing how those remarks reflect the speaker's own pain and anxiety.

Potential Difficulties

One of the most potentially unsettling aspects of a psychosocial M & M is that no ultimate authority exists to provide conclusive answers to the questions raised. There are no "correct" responses, no autopsy report to definitively resolve controversy. However, it is precisely accomplishing this shifting of psychological gears which is the goal of the psychosocial M & M. Participants involved in a psychosocial morbidity and mortality conference should not be searching for solutions so much as they should be seeking greater understanding and clarity. The psychosocial M & M is, above all, a psychological exercise in reframing, in helping the participants reach different and innovative understandings of the event at hand by entering into alternative perspectives and viewpoints. Participants who do not grasp and accept this essential assumption may end up confused and dissatisfied.

In a sense, this willingness on the part of conference participants to employ an alternative paradigm becomes the great challenge of the psychosocial M & M. Can physicians-in-training accept the value of an exercise whose purpose is not to solve but simply to illuminate? In the experience of the authors, the merit of such an experience becomes evident to the participants to the extent that it results in a reduction of their fears and anxieties and to the extent that it leads to new ways of approaching problematic situations with patients and families.

Addressing Learner Resistance

There is no easy answer for overcoming defensiveness and resistance in any individual, whether a physician-in-training, a patient or family member, or psychosocial M & M facilitators. Whenever one is asked to approach a sensitive and vulnerable area, unavoidable fears and anxieties surface.[30]

Many of the lessons of psychotherapy are relevant to this discussion.[31] For example, it is preferable to have the initiative for a psychosocial M & M come from a resident or other learner than from a behavioral scientist. Initiation on the part of the behavioral scientist risks creating push-pull scenarios, in which the learners adopt a strongly resistant biomedical stance while the behavioral scientist vainly pursues them with "touchy-feely" recommendations. However, it is often not realistic to expect residents or medical students to acknowledge their own anxieties. In these situations, the role of the physician attending is crucial. The physician faculty can act as a bridge between the strongly biomedical norms of the hospital and the psychologically minded, introspective, and relational world of the behavioral scientist. By modeling a willingness to cross the bridge, the physician attending creates an aura of normalcy and respectability for the process of the psychosocial M & M.

In the forum of the psychosocial M & M, resistance can be both normalized and confronted. In the former case, the faculty facilitator can emphasize the difficulty of examining the feelings of oneself and others, especially for physicians whose focus is generally solution oriented and concrete. In the latter case, resistance itself can be labeled and examined. Rather than making learners wrong for refusing to enter into the discussion, the process of avoiding the discussion can itself become an entry point. In either case, resistance from any participant, springing from fear and the desire to ignore that things have gone awry, is made explicit and safe.

Finally, as in other instances, learner resistance can be reduced through compassion and support from the faculty facilitator. Residents avoid situations like the psychosocial M & M in part because of their fears that they will be blamed and punished in this setting. One of the paradigm shifts which must occur in a successful psychosocial M & M is to convey to participants that neither of these has any part to play in the process they will be experiencing.

Comparison-Oriented Educational Modalities

The psychosocial M & M is not intended to supplant existing educational opportunities in the psychosocial realm. In the experience of the authors, these include the following: didactic lectures which touch generally and abstractly on the particular topic of concern; corridor consultations, in which there is little preformulated structure, in which biomedical and psychosocial issues become indiscriminantly mixed, and which generally have a specific problem-solving agenda; and one-on-one tutorials, which address psychosocial problems more systematically but generally in a dyadic fashion.

The psychosocial M & M complements existing educational modalities in that it is created in direct response to problematic situations which emerge from the ongoing experience of health-care delivery. While the psychosocial M & M has certain core members, it is primarily an ad hoc group, the membership of which is constituted on the basis of participation in the crisis situation at hand. Ideally, it brings together not simply one or two caretakers but a range of health care providers, all of whom represent a continuum of relationships with and perspectives on the patient.

In addition, the psychosocial M & M, while derived from a biopsychosocial model, radically changes the emphasis of most psychosocial consultations. In the normative consultation, biomedical concerns predominate, with psychosocial issues being treated as either secondary or tangential, although certainly relevant. The psychosocial M & M intentionally creates a drastically different perspective, in which primary attention is paid to the interpretive and relational ramifications of the case. The authors do not advocate that such an approach should become the standard model from which to view problematic patient situations. Rather, the psychosocial M & M is considered a strategic educational approach in that it directly confronts certain conventional biomedical forms and realities by self-consciously adopting a radically divergent point of entry. The purpose of this approach is to shake loose the learners' customary ways of

thinking and reacting, the repetitive patterns which can, at times, imprison them. In a dramatic and paradoxical fashion, it attempts to reveal to the learners that other interpretations coexist simultaneously with the neat and tidy way they have conveniently assembled the data.

Similarities and Differences with Balint Groups

In terms of certain goals--ie, helping the physician understand how his or her own intrapsychic issues may adversely affect patient care--[32] the psychosocial M & M and a Balint group have much in common. The authors have great respect for Balint-style groups and support their proliferation throughout residency training programs. However, residency programs frequently lack the resources to support ongoing groups. The psychosocial M & M has the advantage of being situation specific, as it is focused on an emergent case and convened for a very limited period of time.

Furthermore, while nothing in a Balint group prohibits an interdisciplinary approach, this is a requirement of the psychosocial M & M. Ideally nursing staff and other personnel involved in the patient's care are included, as well as patient and/or family members, when appropriate. However, at a minimum, because of the required involvement of behavioral scientists with family physician faculty, the social science perspective is guaranteed to be represented. In addition, the psychosocial M & M is especially well suited to incorporating individuals at different levels of training, from physician attendings to medical students. Balint groups often bring together physicians from different settings, who then share their problematic individual doctor-patient interactions. Even in a residency program,[33] all those assembled for a discussion may not have shared in the treatment of a specific patient. By contrast, the psychosocial M & M brings together only individuals who have direct involvement, albeit from varying perspectives and levels of responsibility, with the patient under discussion.

Most importantly, the goals of the psychosocial M & M are somewhat different from those of Balint-style groups in that they are based on a unique set of theoretical assumptions. They are, for example, more relational and interactional, focusing not only on the internal, subjective state of the physician but also on how the physician's interactions with the patient create a mutually constructed reality in a constant state of flux and change.

Outcomes of the Psychosocial M & M

While the psychosocial M & M is an exercise primarily in understanding and interpretation, rather than in problem solving, solutions will often emerge from the discussion. A special value of such solutions is that they are frequently located in the process arena and imply untangling interpersonal dynamics between patient and physician, or patient, physician, and family. For example, after a psychosocial M & M a resident may decide to elicit a patient's feelings regarding treatment, or a medical student may choose to pursue with a family member the idiosyncratic meanings he or she has attached to a do-not-resuscitate code. Other possible outcomes of the psychosocial M & M may include relief that other members of the treatment team are experiencing similar emotions, a reduction of anxiety resulting from an increased willingness to acknowledge sensations of guilt or inadequacy, and a lessening of anger toward the patient or other health care providers as a consequence of alternative interpretations of their behaviors.

At present, only anecdotal information exists regarding the efficacy of psychosocial M & Ms. However, informal feedback elicited from residents, medical students, patients, family members, and faculty indicate that these conferences have produced several positive outcomes. Participants often mentioned having a new understanding of the situation. They also reported feeling more aware of and resolved about their own feelings. In certain instances, residents reported a change of approach with patients and/or families, with what they considered to be improved outcome. Residents also indicated that participation in the psychosocial M & M demonstrated departmental interest in caring for the whole person--both the resident and the patient. Faculty members appeared appreciative that an innovative approach had been available to help them overcome a sense of educational impasse with residents and students. Patients and family members alluded particularly to a perceived sense of caring and concern following in the wake of a psychosocial M & M.

Several participants noted that the occurrence of the conference itself came to acquire symbolic value. In the constant press of ongoing responsibility, there can be an understandable tendency on the part of residents and faculty alike to indefinitely postpone analysis of or reflection on the psychosocial ramifications of a particularly difficult patient case. But busyness itself also becomes a way of insulating one from emotion, of reinforcing the individual's normal defenses. Saying "I can't deal with this now" can become a substitute for saying "I won't allow myself ever to deal with this." Simply providing curricular space for such a discussion appeared to communicate that pursuit of this type of understanding of patient, family, and self was considered to be as critical an educational endeavor as, for example, tracing the biological cause of death.

Another interesting insight to emerge from the anecdotal debriefings was that participants in the discussion often reflected different phases of responses, which could also be understood as different phases of each participant's own individual response. For instance, one participant might model self-disclosure, concern for family members, and awareness of his or her own intrapsychic issues. Another might remain silent and guilty. Still another might become preoccupied with rationalizing away the emotional effect of the situation. But as part of a group process, all these responses became part of a complete and satisfying whole. One participant could verbalize what another was afraid to say but desperately needed to hear. These differing responses were not viewed as right or wrong, better or worse, but as reflections of various aspects of potential response to the ambiguities and complexities of the situation under consideration--all of which could be helpful in deepening the understanding and awareness of the group participants. For example, prevalent feelings of guilt led to discussions of appropriate responsibility and purposiveness in relation to the alleviation of suffering. Similarly, feelings of anger made possible exploration of related issues, such as fairness and justice in the world,[34] while anxiety expressed in the group yielded acknowledgement of participants' simultaneous freedom and existential aloneness.[35]

Summary

The psychosocial M & M is designed as a complementary tool in the task of biopsychosocial training to facilitate an interpretive and relational construction of illness realities. It emphasizes the creation of a safe, albeit challenging environment, derived from the exigencies of particular problematic patient situations, in which to explore simultaneously held but potentially conflicting or controversial understandings. Its goal is the production of insights and interpretations which make sense in the social context of all participants, which are confirmed by multiple descriptions from a variety of sources, and which can withstand critical inquiry. At its best, the psychosocial M & M stimulates a unique way of looking at things that redraws the boundaries of experience to include patients, family members, medical students, residents, nursing staff, physician faculty, and conference facilitator, all within the circle of health and illness.

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