1. Introduction: The Morbidity and Mortality (M&M) reporting, review and presentation process is one that exists in most clinical departments but there is very little information that documents its effectiveness and impact [1]. The opportunity exists for M&M programs to collect valuable information describing morbidity, close calls and emerging trends but what would the impact be of any developments or changes to current M&M practices [2]? With this in mind we developed and disseminated a questionnaire-based survey amongst Ontario-based Anesthesiologists with the purpose of: Documenting current M&M processes in Ontario Anesthesiology Departments; examining barriers to M&M rounds and voluntary safety reporting, examining the importance of M&M rounds on ongoing professional education, and, examining emphasis on morbidity and ‘close calls.’

2. Methods: Following institutional Research Ethics Board approval, we conducted a web-based survey of Anesthesiologists registered with the College of Physicians and Surgeons of Ontario. Descriptive statistics were used to analyze data.

3. Results: Of 441 anesthesiologists surveyed, 171 responded (38% response rate). Education and improved patient care are seen as the most effective accomplishments of M&M rounds but rounds occur irregularly, rarely discuss morbidity and do not effectively disseminate teaching points and recommendations beyond the meeting itself. Blame is seen as the biggest barrier to self reporting and the lack of reliable data collection is seen as the biggest barrier to effective M&M rounds. Despite poor utilization of safety reporting databases where they are available, M&M programs rely almost exclusively on voluntary safety reporting for case identification and respondents to this survey cited the lack of such databases as the largest barrier to effective M&M rounds.

4. Discussion: The data identifies education and improved patient care as major foci of M&M rounds and confirms that these foci should be maintained through any developments or changes to the M&M process. One would need to address the ‘culture of blame’, encourage the dissemination of review findings and recommendations beyond M&M rounds to non-attendees and colleagues outside of the specialty, and regularly recirculate important reviews and recommendations to educate new arrivals and reinforce best practices. Morbidity should be reported and reviewed more frequently in conjunction with near misses, close calls and potential for patient harm (eg as categorized by the NCC-MERP Index). While incident reporting is identified as the most likely way to improve the effectiveness of M&M programs, we need to be aware of the limitations of even the most efficient incident reporting database, and indeed, any QA or M&M program that relies solely on incident reporting for its data collection.