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Morning Report Should Mirror Resident Experiences

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Morning report has become a common staple of resident education. Residents arrive at each level of training with varying degrees of experience. Tailoring morning report to multiple levels is the key to maximizing its learning benefits. Assessing the level of understanding, setting expectations, and evaluating competencies all require a sophisticated understanding of the trainee as a learner.¹ Resident work-hour restrictions have decreased clinical experience, making alternative strategies to enhance both the quality and efficiency of resident education necessary.² As a graduating resident and new chief, I bring a perspective to improving morning report in medical practice. One option to enhance morning report is to make it more dynamic and to mirror clinical experiences, thereby making it more relevant and applicable.

When an intern tiptoes into morning report for the first time, there is usually a sense of interest and urgency to learn as much as possible in order to avoid making mistakes on real patients. A few months into the year, overall enthusiasm, participation, and interest in morning report dwindle. The differential of what accounts for this is broad and includes burnout, monotony of cases, and the impending transition of first-year interns and graduating residents whose focus has shifted to their specialties.

Program directors, with the help of their chief residents, need to develop different strategies to keep morning report current, interesting, and beneficial for the residents and faculty. Like any presentation, keeping your audience interested and participating optimizes learning. In the beginning of the year, focusing

on bread-and-butter cases like congestive heart failure, pneumonia, and cirrhosis is essential. Critical cases with increased morbidity and mortality will grab the attention of an audience and are beneficial for new physicians. As the year progresses, residents anticipate more advanced or rarer cases that help keep them interested and involved. Finding "zebra" cases five days a week is usually difficult. However, techniques can be developed to maintain higher-level quality learning in more common cases as well.

In the beginning of the year, an entire session may be devoted to differential diagnosis. As the year progresses, developing a differential becomes redundant. Residents continuously spend a third of the hour asking the same simple review of system and physical exam questions. Labs and imaging are usually hidden from the residents until the end of the session to avoid "giving away" the diagnosis.

As a resident, I have realized that morning report follows a rigid structure that does not coincide with ward activities. In practice, ironically, a resident walks into the ER with a small differential already created. Labs are resulted, and imaging has already been done. In morning report, the first thing a resident often asks for is to "get a CBC." How ridiculous! All in attendance know that the team had reviewed the CBC before seeing the patient. It makes morning report feel unrealistic. This is repeated time and again.

Morning report should be used to target real practice scenarios. Making residents aware that a diagnosis made by the ER may not always be correct is essential to

avoiding tragic mistakes. Morning report could focus on the necessary process of confirming or replacing initial diagnostic impressions. Residents can discuss the process of the initial diagnosis and what they might have done differently. This process should be discussed as it is done with the labs, the history, and the imaging.

Creating resident teams at morning report may help stimulate thought in a manner similar to the wards as well. Learners can sit in resident-intern-student groups that mimic daily practice. This would allow learning to occur at different levels based on experience in much the same way it does on the wards. A question or task can be assigned to this group, and as a unit, they will have to come up with answers.

Another method we use in daily practice is to first see the diagnosis and then backtrack to see how the diagnosis was obtained. There is a lot to be learned from this method. You can see things that were missed on admission, like review of system questions and physical exam items, that should have been done and documented. You can see what may have delayed the diagnosis and then make practice improvements based on these mistakes. You can discuss treatment and see if there are better recommendations. You may even discuss unnecessary testing that could have been omitted. This form of retrospective critique could be quite valuable. All these things are difficult to do when you always start without a diagnosis.

Changing and declaring a theme for the day might also help focus learning. Some days could still be

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devoted to diagnosis and others to therapy. On the wards, patients often present with an interesting known diagnosis, and the physician must focus primarily on therapy. This shift in focus allows for different types of learning. After a brief case presentation, for example, a literature review could be performed in front of the residents to help with effective clinical searches. You may even choose to focus solely on basic science. Understanding the basic mechanisms behind disease pathology and its

therapy may help solidify an important teaching point. Our program session is often attended by the clinical librarian, who is a wealth of knowledge on improving these inquiries. Themes could also be related to ancillary services, such as physical therapy, occupational therapy, billing, and quality initiatives.

In short, if morning report mirrored what happened in clinical practice, it would become more relevant and much easier to duplicate in the hospital. It would refresh the conference and hopefully make at-

tendees feel as excited as new interns coming to morning report for the first time.

References

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