

Quality Dimensions of Educational Morning Report Sessions

Yazdani Sh, MD¹; Arab M, PhD^{2*}; Noghabaei G, MD³; Hosseini F, MD¹

¹ Department of Medical Education, Shahid Beheshti University of Medical Sciences, Tehran, Iran

² Preventative Gynecology Research Center (PGRC). Imam Hussein Medical Center. Shahid Beheshti University of Medical Sciences, Tehran, Iran

³ Gynecological Translational Research Center (GTRC, Shahid Beheshti University of Medical Sciences

Abstract

Morning report sessions had long-standing history in medical education. Morning report management is an important aspect of professional medical education.

To evaluate the contents of the morning report sessions, including management, staff training, deep learning, attention to learners at different level of education, record keeping, feedback, and final summarizing, direct observation of 73 sessions was conducted in five teaching hospitals in a medical university in Tehran.

The following scores were obtained: morning report management (91%), training faculty members (9%), residents' training (4%), direct learning by patient management instead of memorizing study material (88%), paying attention to the different educational levels of learners (28%), record keeping (36%), systematic feedback (48%), and a final summarizing session (26%).

Out of eight, five dimensions related to teaching in the morning report sessions need improvisation, specifically on the training of faculty members and residents, paying attention to different educational levels of learners, brief summary of all sessions, and record keeping.

Keywords: MEDICAL EDUCATION, MORNING REPORT, LEARNING, FEEDBACK

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Introduction

Morning report as an educational session has a long-standing history in medical education (1, 2). Participants believe that morning report sessions are more effective than lectures (3, 4). Participants in morning report sessions generally include faculty members and learners at different levels of education (5, 6). In a study, in which residents acted as teachers, development was observed after a short training course (7). Most often, chief residents become the managers of morning report sessions (8). In a previous study, in

which residents were asked about who they preferred as directors of the morning report sessions, 48% of the residents believed that the chief resident is most appropriate, 42 preferred guest faculty members, and the remaining 10% preferred their own faculty members (5).

The presence of the chairman of the subspecialty faculties influences the type of cases, although they are generally the managers of the morning report session (8, 9). Residents desire deeper understanding of concepts from few cases (2, 3, 5), and the faculty members follow different perspective and prefer review of all cases (10). A systematic review revealed that faculty members act as the leaders of the morning report sessions in 70% of the cases, while chief resident do so in 30% of the cases (2, 11-14). Another study reported that faculty

***Corresponding author:** Maliheh Arab, PhD student of Medical Education. Shahid Beheshti University of Medical Sciences. Professor of Gynecology-oncology. Preventative Gynecology Research Center (PGRC). Imam Hussein Medical Center, Shahid Beheshti University of Medical Sciences, Tehran, Iran.
Email: drmarab@yahoo.com

members act as manager, while the chief resident is responsible for case selection (6).

In order to improve the quality of morning report sessions, focusing on the training of faculty members and residents is important. In a study, residents played the role of teachers after training in a 3-hour workshop, which resulted in higher satisfaction of the learners (7). In another study, the attendants passing a training workshop provided increased satisfaction among learners, although it was not significant (15).

Traditionally, the main aspect of morning report sessions has been sharing of lectures, stories, and passive learning (1, 2). Practice-based learning is a basic dimension of proper patient care, which should be included in the curriculum (16). During the process of mental learning, discussion, and teaching by using case examples produces a database in the brain, which directs the reasoning and problem-solving activities to enable managing a specific case (17).

The existence of different levels of learners is another issue. Results of a previous study revealed that students comprise of 66% learners, but contributes to only 20% in terms of contribution to selecting and presenting the cases. About 40% of the residents believed that this companionship may improve their learning (18).

Record keeping is a challenging aspect of the morning report sessions. Record keeping follows education and evaluation goals (19-21). In a study, 23% of the morning report sessions are not recorded in the United States (8). Only one-third of the morning report participants are satisfied (6). Another study evaluated that incorporating the system of taking feedback can improve the satisfaction level from morning report sessions up to 77% (22).

Methods

The present study aimed to evaluate the quality dimensions of the morning report sessions in five teaching hospital of a medical university in Tehran. The study dimensions

included morning report management, training of faculty members and residents, deep learning instead of memorizing, paying attention to the educational levels of the learners, record keeping, giving feedback, and a brief conclusion at the end of the session.

For evaluation of the teaching time for learners at different levels of education, the ratio and discussion time with junior and senior learners was considered. In case the ratios were equal, the maximum score (100) is assigned, if unequal, the score is decreased based on the difference. For example, if 40% of the time was spent on juniors and 60% on senior learners, the difference was 10%, which was multiplied by 2, followed by 20% subtraction from 100%, giving a final score of 80%. In this regard, if the teaching time for learners at different levels of education was unequal, the final score of this dimension would decrease. The second dimension was including discussion about patient management instead of memorizing the educational material. A trained person calculated the percent of total time spent on discussion about patient management and found that time could be regarded as the index for scoring efficiency of patient management.

Morning report session management was the third dimension. The optimal situation was the case in which the chief resident or a faculty member would play the role of the manager. This dimension was evaluated by observation in addition to interviewing the ward director, where each obtained 50 scores from the total score of 100.

The fourth dimension was incorporating a brief conclusion at the end of the session by an attending trainee. Maximum score was achieved when summarizing was performed in 1 minute, with every additional minute over the optimal time (1 minute), 20% of the score was subtracted. For instance, if summarizing took 2 minutes, the score of this dimension was set at 80%.

Other dimensions included training of the faculty members and residents, record keeping, and obtaining systematic feedback

from the learners, which involved the directors and chief residents from each ward. The data obtained were analyzed by SPSS software (Ver. 18).

Results

Observation of 73 morning report sessions provided the score of 28% with respect to paying attention to different educational levels of learners, contributed 39% and 22% by the surgical and non-surgical wards, respectively. The score of patient management instead of memorizing content was 88%, including 82% from the surgical and 91% from non-surgical wards. A total score of the morning report session management was 91%, with 93% and 90% from the surgical and non-surgical wards, respectively. Score obtained after including the summarizing session was 26%, contributed by 29% from the surgical and 25% from the non-surgical wards.

In 4% of the studied wards, the residents participated in clinical education workshops. The corresponding percent for the surgical and non-surgical wards was 0% and 6%, respectively. Participation of the faculty members in the above-mentioned workshops was 9%, contributed by 11% from the surgical and 8% from the non-surgical wards. The score of record keeping of the sessions was 36%, contributed by 39% from the surgical and 35% from the non-surgical wards.

In the intensive care unit (ICU) and the psychiatric ward, the score for record keeping was 100%.

The total score from the systematic feedback was 48%, contributed by 44% from the surgical and 50% from the non-surgical wards.

Discussion

The levels of knowledge and clinical skills of the faculty members are significant factors contributing to the morning report sessions

quality. In the present study, review of 25 academic wards showed that 4% of the residents and 9% of the faculty members participated in a training workshops focusing on morning report. This result confirms the lack of a systematic training program for residents and faculty members, despite the importance of the issue.

A study involving 74 residents asked 44 questions regarding morning report sessions and found that 72% of the teachers were very competent. The most valuable traits expressed as the indices of competency were as follows: knowledge (90%), asking proper questions (86%), and good communication skills (84%) (8). However, in another study, participation in training workshops showed improved educational capacity after the morning report sessions (7).

In our study, the morning report sessions was managed by the chief residents or faculty members. Among these two, if the residents are appointed as teacher, their level of commitment to training and teaching would definitely improve. Teaching responsibilities of the residents is increasing in educational programs (7, 23, 24).

In the present study, the score of patient management discussions instead of memorizing factual material was 88%, which is acceptable. Problem-based learning is a well-known educational strategy (25, 26). Cognitive psychology studies have shown that learning by discussion improves the learning process and the long-term retention of learned topics (27-30).

In this study, the score of paying attention to the different levels of learners was 28%. Some studies have mentioned that this matter is a result of ignoring of junior learners and focusing more on senior learners (18).

In another study, it was revealed that structured morning report sessions, including a summarizing section, can influence the clinical decisions (31). However, in this study, only 26% of the scores was obtained after incorporation of the summarizing section, which is not significant. This could

probably be due to inappropriate structuring or conduction of the sessions.

Record keeping has been considered as an important parameter of these morning sessions (32). In the present study, the score of record keeping was 36%, which is not acceptable. Interestingly, the score in some of the wards, including ICU and psychiatry ward, was almost 100%. This difference may be due to the special care the directors of these wards exercise, since legal and problematic decisions are a normal issue for complicated cases in these wards. The results of the previous studies have confirmed that students tend to provide regular and periodic feedbacks on request (3, 33).

Conclusions

In order to improve the quality of medical education, morning report sessions should be incorporated in the course. The results of the present study revealed that some aspects of this session need improvisation. These weak dimensions include training of faculty members and residents, summarizing of the sessions, and record-keeping.

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References

1. Reilly B, Lemon M. Evidence-based morning report: a popular new format in a large hospital. *Amj med.* 1997;103(5):419-26.
2. Parrino TA, Villanueva AG. The principles and practice of morning report. *JAMA.* 1986;256(6):730-3.
3. Ways M, Kroenke K, Uma J, Buch D. Morning report: a survey of resident attitudes. *Arch Intern med.* 1995;155:1433-37.
4. Pupa LE, Carpenter JT. Starting the day right at the teaching hospital. *Amer Col phys. Observer.* 1982;z:1-2.
5. Grass CP, Donnelly GB, Reismann AB, Sepkowitz KA, Callahan MA. Resident expectations of morning report. *Arch Intern med.* 1999;159(13):1910-14.
6. Kadivar M, Hooman N. Rele and structure of morning children's teaching hospitals in Iran. *Medical journal of Islamic Republic of Iran.* 2011;25(2):94-8.
7. James MT, Mintz MJ, Mc Laughlin K. Evaluation of a multifaceted "Resident- as-teacher" educational intervention to improve morning report. *BMC.* 2006;20(6).
8. Schiff FJ. Morning report and work rounds: opportunities for teaching and learning. *Transitions of the American clinical and climatological association.* 1996;(107):275-86.
9. Malone MM, Jackson TC. Educational characteristics of ambulatory morning report. *J Gen Intern med.* 1993;8:512-4.
10. Battinelli D. morning report: chief residents manual. Handout distributed at: 1996 chief residents conference, American college of physicians Annual meeting; San Francisco, calf; 25-28. 1996;41-5.
11. Parrino TA. The social transformation of morning report. *J Gen Intern med.* 1997;12:332-3.
12. De-Groot LJ, Siegler M. The morning- report syndrome and medical search. *N Engl J med.* 1979;301:1285-7.
13. Brancati F. morning distort. *JAMA.* 1991;266:1627.
14. MC Gaghie WC, Engel JD, Wolf K, Smith AC. Morning report: a descriptive view from two different academic settings *proc. Annu conf res med Educ.* 1985;24:157-62.
15. Jouybari LM, cheraghali F, Padash L, Snagoo A. Effect of participation in the principles of the morning report case presentation workshop on clinical faculty member's performance. *Future of medical education journal.* 2012;2:1.
16. Ogrinc G, Headrick LA, Mutha S, Coleman MT, O'Donnell J, Miles P. A framework for teaching medical students and residents about practice- based learning and improvement, synthesized from a literature review. *Academic medicine.* 2003;78(7):748-56.
17. Mandim H, Harasym P, Eagle C, Vatanabe M. Developing a "clinical presentation" curriculum at the University of Calgary. *Academic Medicine.* 1995;70 (3):186-93.
18. Spickar A, Ryan SP, Muldowney JA, Farnbam L. outpatient morning report. A new conference for internal medicine residency programs. *J Gen Intern Med.* 2000;15:822-24.

19. Pupa LEJR, Carpenter JL. Morning report: a successful format. *Arch Intern med.* 1985;145:897-9.
20. Recht L, Kramer P, Schwartz W. Morning report in computer era: tradition meets technology. *Med teach.* 1995;17:327-31.
21. Wenger NS, Shprner RB. An analysis of morning report: implications for internal medicine education. *Ann Intern med.* 1993;119:395-9.
22. Ahaqwi AI. Importance and process of feedback in under graduate medical education in Saudi Arabia. *Saudi journal of kidney diseases and transplant.* 2012;23(5):1051-55.
23. Apter A, Metzger R, Glass Roth J: Residents perceptions as their role as teachers. *J med Edu.* 1988;57:854-9.
24. Weiss V, Need R. To teach is to learn twice: resident teachers learn more. *Arch pediatr Adolesc med.* 1998;152:190-2.
25. Wood DF. ABC of learning and teaching in medicine problem based learning. *British medical journal.* 2003.
26. Harden RM, Sowden S, Dunn DR. Spices model of educational strategies in curriculum. *(ASME) Medical education book let.* 1984;18.
27. Smith MK, Wood WB, Krauter K, Knight JK. Combining peer discussion with instructor explanation increases student learning from in class concept Questions. *CBG. Life sciences education.* 2010;10:55-63.
28. Smith MK, Wood WB, Adams WK, Wireman C, Knight JK, Guild N. Why peer discussion improves student performance on in class concept questions. *Science.* 2009;323:122-4.
29. Schwartz DL, Bransford JD. A time for telling. *Cogan Instr.* 1998;16:475-522.
30. Roediger HL, Agar PK, Kang SHK, Marsh EJ. Benefits of testing memory. *Best practices and boundary conditions in: new frontiers in applied memory*, eds. GM Davies and DB Wrights Brighton. UK: psychology press. 2010;13-49.
31. Kane GC, Holmzer C, Sorokin R. Management morning report: purpose, planning, and early experience in a university hospital residency program. *Seminars in medical practice.* 2001;27-36.
32. Cornville JF, Rubin DT, Humphrey H, Carson SS. Effects of billing and documentation requirement on the quantity and quality of teaching by attending physicians. *Academic medicine.* 2001;76(11):1144-7.
33. Torre DM, Simpson D, Sebastian JL, Elnick DM. Learning/feedback activities and high quality teaching during an inpatient rotation. *Acad med.* 2005;80:950-4.
- Al Haqwi AI, Molen HT, Magzoub ME, Schmidt HG. Determinants of effective clinical learning; A students and teacher perspectives in Saudi Arabian *aduc Health.* 2010;23:1-14.

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