Residents' Morning Report in Psychiatry Training

Description of a Model and a Survey of Resident Attitudes

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A residents' morning report, adapted from the traditional internal medicine model, was introduced into a psychiatry residency curriculum to supplement bedside teaching for junior residents during inpatient service rotations by focusing on case presentations, clinical reasoning, and evidence-based decision-making skills. This paper describes the design of the report and findings from surveys of residents who participated in the report over a 3-year period. The surveys demonstrate high levels of satisfaction with the exercise and offer insight into factors that may optimize or impede learning in the morning report setting in psychiatry. (Acad Psychiatry 2002; 26:9–16)

In 1996, a group of faculty and residents in the Department of Psychiatry at the University of Rochester began to explore options for an educational experience that could augment clinical training for junior residents. Our objectives were to hone case presentation, clinical reasoning, and decision-making skills, and to train residents to critically appraise the literature by making these activities a more routine and prominent part of the culture of training and clinical care. The result was a teaching forum adapted from our internal medicine colleagues, a resident's morning report for PGY-1 and PGY-2 psychiatry residents that we launched as a new curriculum element in 1997. Our aims for this paper are to describe the design of the exercise and to report findings from a survey of residents that offer insights into factors that may optimize or impede learning in this setting.

Nearly all psychiatry programs concentrate the majority of inpatient services training in the first two years of residency training (1). As length of stay has declined on psychiatry inpatient services, educators are challenged to adapt training in these sites to optimize skill acquisition during these critical formative years of professional development. An entire text was recently devoted to describing the challenges of declining length of stay on psychotherapy training (2). Other authors have addressed the broader challenges that affect the educational climate in inpatient services and have offered suggestions to enhance training experiences in them (3). When we began to explore options for a new inpatient services training experience, the average stay on our inpatient training services ranged between 8 and 14 days (4). Case conferences, seminar series, and strong faculty preceptor and psychotherapy supervision systems complemented the bedside teaching on inpatient rotations. But a clear message was repeated in evaluations from both residents and faculty: circumstances conspired to reduce the amount of time routinely available to devote to honing residents' skills in case presentation and clinical reasoning. An examination of the issues revealed that residents, and their attending physicians, often did not have sufficient time to focus routinely on developing these skills. The residents

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wanted more of this attention and the attendings wanted help from the larger faculty with these time-intensive skill development tasks.

Simultaneously, residents were lobbying for more training in evidence-based medicine (EBM). EBM refers to the systematic practices of literature search and critical appraisal to find "best evidence" on which to base clinical decisions (5,6). Although these activities are not new to excellent clinical practice, renewed efforts to train medical residents in the practice of critical appraisal and informed decision making emerged in the 1990s (6,7) and spread to psychiatry (8,9). The psychiatry curriculum offered little systematic instruction in EBM before initiating the morning report exercise.

Our internal medicine colleagues encouraged us to consider a resident's morning report as a vehicle for meeting our objectives. A MEDLINE search from 1966 to 2000 revealed no publications on the use of a residents' morning report in psychiatry training, but its use in internal medicine residency programs appears to be nearly universal (10,11). A 1993 survey of all internal medicine training programs ($N=124$) found that at least 93% (115 of 117 responding) had an active morning report (10). In its traditional form, morning report is a daily (weekday) gathering of junior and senior internal medicine residents rotating on inpatient services. Participants typically include the chief resident, who is responsible for organizing and leading the report, and the chief of service or a designated faculty member who shares teaching roles with the chief. The usual aims are to assess and improve diagnostic and clinical reasoning skills by presentation and discussion of new admissions and critical events on the service. Formats differ between programs depending on a number of cultural factors, including service demand and leadership styles (10–13), and have changed over the years with contemporary educational objectives (14).

Although some authors have questioned the educational value of morning report (12,15,16), a larger literature expresses enthusiasm for it as well as suggestions to improve on the traditional report format (10,11,14,17–21). Recent reports of innovations designed to emphasize evidence-based medicine (22,23) and the care of outpatients (24–27) reflect an increasing and more generalized acceptance of this teaching method. Three recent surveys of internal medicine residents' attitudes about morning report (13,22,28) confirm that it is alive and valued, and offer insights into what learners find most important in the format, focus, and activities of morning report in the internal medicine setting. Ways and colleagues (13) reported on a survey of internal medicine residents offering detailed information about optimizing the format and function of morning report. These findings guided the development of our morning report, and we adapted their survey instrument for use in our examination of psychiatry residents' attitudes and opinions about the exercise.

A MORNING REPORT FOR PSYCHIATRY RESIDENTS

Participants

Residents in postgraduate years 1 and 2 in the general and combined internal medicine and psychiatry program, and PGY-3 residents of the combined program, are required to attend morning report during rotations on inpatient and consultation-liaison services. Residents who are rotating on medicine, neurology, and emergency services do not attend the Department of Psychiatry's morning report. The chief resident leads the meeting and provides feedback about case presentation, clinical reasoning, and EBM skills to more junior colleagues. A faculty discussant provides a source of more advanced knowledge and clinical experience. The residents select faculty discussants for one-month rotations with input from the program director.

Frequency of Sessions

The report meets Tuesdays, Wednesdays, and Thursdays at 7:30 A.M., prior to the start of service-based activities. A three-day-per-week format allows residents to spend Mondays evaluating new admissions and reassessing continuing patients to determine which cases they wish to present in report on Tuesday morning, and it also avoids competition and distractions from end-of-week tasks on Fridays. This daily, midweek schedule has been sustained with excellent resident attendance and enthusiastic faculty participation.

Activities in Sessions

Each report includes a 30-minute period for presentation and discussion of one or two new cases, and, if time permits, brief follow-up of cases that were discussed on previous occasions. One day a week an additional 30 minutes is scheduled to present and discuss findings from an evidence-based literature review focused on a clinical question raised in a recent morning report. A resident is preassigned the tasks of formulating a clinical question raised in the care of a patient; searching the literature for the "best evidence" with which to answer the question; and presenting the findings to the group. If the selected source is a research report, the presentation includes a critical appraisal of methodology and a discussion of whether the findings from the study apply to the patient example before the group. The chief resident and the faculty discussant use a portion of this time to teach and reinforce decision-making skills that incorporate research-based evidence.

SURVEY METHODS

Residents in the general and combined programs were surveyed for 3 consecutive years. The first survey was conducted 2 months after the end of the first year of the report. The second and third surveys were taken at subsequent intervals about 12 months apart. Respondents who participated in at least 1 month of morning report were included in the data analysis. The response rates by survey year were 77% (17/22); 95% (20/21); and 75% (18/24). Residents rotating in internal medicine and neurology services at the time of the surveys accounted for the majority of nonresponses.

The survey instrument was adapted from a questionnaire used by Ways and colleagues to investigate attitudes about morning report in an internal medicine program (1995 [13] and personal communication). It consisted of 17 items, including short answers, multiple-choice options, ordering rank, and open-ended questions that required 5 minutes to complete. Several areas of interest were examined: 1) trainee characteristics; 2) attitudes, preferences, and satisfaction with the format and activities of the morning report sessions; 3) factors that facilitated or impeded learning; 4) the value of morning report in comparison to other educational forums currently used in the training program; and 5) the extent to which participation in morning report enhanced knowledge, skills, and attitudes. (The survey instrument is available from the author on request.)

Because of the relatively small number of subjects in each year of the survey ($n = 17, 20, 18$, respectively) no comparative statistical analysis of the results was conducted.

RESULTS

When results are presented, numbers will refer consecutively to the years of the survey unless otherwise noted.

Trainee Characteristics

Table 1 shows the characteristics of respondents at each survey interval by year of training, age, gender, and the length of time that respondents had participated in morning report. Respondents were not asked to quantify months of participation in survey year 1, but all residents included in the analysis had completed at least 1 month of report. In survey years 2 and 3, 78% and 90% of respondents, respectively, reported at least 3 months of participation in the re-

TABLE 1. Characteristics of psychiatry residents surveyed regarding attitudes about morning report

	Survey Year		
Characteristic	**1 (1997–1998)**	**2 (1998–1999)**	**3 (1999–2000)**
N	17	20	18
Number of residents by PGY class (1–5)	1 = 5 2 = 3 3 = 6 4 = 3 5 = 0	1 = 5 2 = 4 3 = 3 4 = 7 5 = 1	1 = 3 2 = 6 3 = 5 4 = 3 5 = 0 ? = 1[a]
Age, mean years (range)	32.6 (25–41)	30.6 (26–42)	31.6 (27–43)
Gender, % female	29%	40%s	53%
Months (range) of participation for all respondents and % participating for ≥3 months	Not assessed, all >1 month	(1–10+) 78%	(1–10+) 90%

[a]One did not identify PGY year.

port; 50% and 60%, respectively, had at least 7 months exposure.

Format and Activities Preferences

Frequency and Duration of Sessions: The majority of respondents at each survey interval favored a 3-day-per-week session frequency (76%; 55%; 67%). Thirty minutes was the most frequently endorsed session duration (47%; 45%; 56%), but the majority of respondents in survey years 1 and 2 (53%; 55%) and a significant minority in survey year 3 (44%) indicated a preference for longer sessions of either 45 or 60 minutes.

Leadership: In survey years 1 and 2, residents indicated a strong preference (71%; 81%) that the chief resident lead the report. Preferences were more evenly divided between chief (42%) and faculty (58%) leadership in survey year 3.

Case Selection and Time Allotment: The survey inquired about preferences for the number and type of cases presented (new vs. old), and the amount of time that should be allotted to them. A majority of respondents in each survey year favored a format where one new case (88%; 89%; 78%) is presented briefly (5–10 min; 71%; 65%; 56%) with the remainder of time used for discussion.

Discussion Format: The majority in each survey year (65%; 55%; 54%) preferred that one case be presented briefly (5–10 minutes) yet comprehensively (covering all relevant areas of the presenting problem, history, and examination findings) without interruption, followed by an interactive discussion facilitated by the chief and faculty discussant with open-ended questions (e.g., "What do people think about diagnosis?" "What treatment recommendations would you make?"). Preferences for formats requiring more directed discussion, where individuals are selected to offer answers to specific questions or the presentation is interrupted for questions and answers, were endorsed by significant minorities of residents in each survey. A case presentation followed only by faculty commentary was consistently the least favored format.

Residents were asked to grade preferences for teaching activities commonly used in the report on a three-point scale of high, medium, or low importance. The average grade for each activity was used to rank preferences. Listing differential diagnoses, reviewing patient management, discussing appropriate tests and studies, and reviewing ethical issues ranked consistently among the top three activities (certain activities tied in rank order) in each survey year. Reviewing the results of tests and studies and writing information on the board to organize the discussion were uniformly ranked as the least valued activities. In each survey year, a majority (88%; 70%; 71%) preferred that presentation of critical literature appraisals be limited to one session per week.

Faculty Attributes

Residents were asked to grade the importance (high, medium, low) of 12 faculty attributes to facilitate learning in morning report. Attributes were ranked in importance by calculating the average grade received. Six attributes—flexibility of style, fund of general psychiatric knowledge, ability to expand residents' differential diagnosis, clinical wisdom, skill in asking effective questions, and interpersonal skills with house staff—were ranked in the top three positions (certain activities tied in rank order) in each survey year. Of these, fund of general psychiatric knowledge consistently ranked in the first position. Subspecialty knowledge, sharing anecdotal information from case experiences, and discussion of basic science were consistently among the lowest-ranked attributes.

Perceived Educational Value

Enhancement of Residents' Knowledge, Skills, and Attitudes: Residents were asked to rate on a three-point scale (none, moderate, or high) the degree to which eight selected groups of knowledge, skills, and attitudes were enhanced by participation in morning report. Ratings were averaged to determine a ranking of these groups. Knowledge base, differential diagnosis skills, and problem-solving skills ranked among the top three most enhanced areas in each survey year. Tendency to search the literature for evidence on which to base decisions ranked in the top three areas in the first two survey years but ranked fourth in survey year 3. Four groups—history and evaluation skills, critical literature appraisal skills, at-

titudes toward patient care, and attitudes toward teaching—did not achieve a top-three ranking in more than one survey.

Comparison With Other Teaching Forums: When asked to compare the educational importance of morning report with that of five other teaching forums, 73% or more of respondents in each year of the survey rated morning report as equal to or more important than case conference, inpatient work rounds, seminars, and independent readings. Individual sessions with teaching faculty (e.g., mentoring, psychotherapy supervision) was the only offering that received strong support as being more important than morning report.

Most Valued Learning Experiences and Obstacles to Effectiveness: Two open-ended questions prompted residents to cite the most valued learning experiences and the factors that created obstacles to the potential effectiveness of learning in the report. In total, 77 responses were cited as most valued learning experiences and 76 were cited as obstacles. Responses were aggregated into themes and ranked by the frequency (percentage) at which each theme was cited over the three years of the survey.

Discussion of cases was most frequently cited as the most valued learning experience (56% of 77 responses). In descending order of frequency, development of presentation skills (17%), development of differential diagnosis skills (10%), and faculty input (8%) were named as valued experiences. Nine percent of responses could not be neatly categorized into a theme. Several responses commented on the safe and collegial nature of the report environment to practice skills and expose weakness and uncertainty.

Time was cited as the major obstacle to learning effectiveness in each survey year (76% of 76 responses). The majority of time comments expressed a desire to have more time during each report for case discussion; others focused on the time of day (too early) or the frequency (desiring more times per week) of the report. Twenty percent of responses named poor resident performance (e.g., inadequate preparation, tardiness, and lack of focus or motivation), and 17% referred to poor faculty performance (e.g., monopolizing discussion, interrupting, and lecturing) as other most common obstacles. Thirty percent of responses could not be neatly categorized into a theme.

DISCUSSION

Many factors determine the success or failure of any curriculum offering. Among the most critical are sufficient alignment of learner expectations with actual outcomes and a convergence between the attitudes and motivations of the learners and attributes of the teachers that facilitate a positive learning environment. Learner satisfaction itself has emerged as a critical factor in producing good educational products and is now measured as an educational outcome of primary significance. The three years of survey results reported here offer insight into activities that psychiatry residents prefer and factors that influence a satisfying educational experience in the morning report setting. These findings may be helpful to educators considering adopting a morning report for their residents or seeking to improve the quality of an existing report.

Our psychiatry residents consistently find a morning report, based on the internal medicine model, an effective and valued educational experience. They rate it of equal or greater importance to nearly all other formal educational offerings in our curriculum, the sole exception being individual time with teaching faculty. This learner-centered forum offers junior residents frequent opportunities to discuss cases with each other, with senior colleagues, and with faculty while learning to make effective oral case presentations, struggling with clinical management decisions, and learning to make decisions based on the best available evidence. These forms of learning are offered in a reliably available and collegial environment. Here one may be more willing to risk exposing weaknesses as knowledge and skills develop.

Residents prefer to focus on a single case, with at least two-thirds of the allotted time available for discussion, so that they can take away immediately relevant ideas to apply in the evaluation and management of their patients. Opportunities to expand differential diagnosis, think through strategies for patient evaluation and management, and explore ethical issues are particularly valued. Residents emerge from the morning report experience more confident in their knowledge base and their differential diagnosis and problem-solving skills.

Certain faculty attributes appear to be more important than others in facilitating the exercise. Interpersonal skills, flexibility, and skill in guiding discussion through effective questioning invite participation and interactive discussion. A command of general psychiatry and knowledge gained from clinical experience are valued more than subspecialty or basic science knowledge. The residents clearly want an interactive forum, more resident than faculty driven, yet they do greatly value the input of the faculty in both leadership of the report and contributions to discussion and problem-solving. They are not interested in being lectured to in this setting. These findings may help guide the selection, orientation, and training of faculty participants. Harris (10) has reviewed critical faculty training issues relevant to morning report that may be of interest to readers.

Time factors are perceived as the chief obstacles to the effectiveness of the report. Most residents want to lengthen each report session to allow for fuller case discussions. But other findings suggest that allowing more time may not be a risk-free solution. The timing of the report already imposes certain conflicts with service activities. It also seems that certain resident and faculty behaviors such as tardiness, lack of preparation, monopolizing discussion and lecturing, can distract from discussion time. If these behaviors could be effectively reduced, more time might be available for the kinds of interactive discussions that residents value without actually lengthening the sessions.

Providing an opportunity to learn and apply EBM skills was among the original primary objectives of the report. Residents value these skills but want to limit the time allotted to them. Participation in morning report appears to have influenced residents to look to the literature more often for evidence on which to base clinical decisions. However, confidence in their critical literature appraisal skills apparently has not been consistently enhanced by the report exercise. We believe that inconsistent training of report leaders in critical appraisal skills and residents' disillusionment with the lack of empirical research on which to base clinical decisions has contributed to differing expectations about the rigor of EBM exercises. This may have resulted in a loss of focus on critical appraisal skill development in the report setting.

The findings of our survey of psychiatry residents closely mirror those in three previous surveys of internal medicine residents regarding their experience of morning report (13,22,28). Common findings among these three surveys include high levels of satisfaction with morning report. Nekhlyudov et al. (22) found particularly high levels of satisfaction among junior residents with a report focused on EBM. Certain preferences and opinions about the morning report exercise were remarkably similar between internal medicine and psychiatry residents. These groups agreed about the purpose and optimal function of the report exercise, leadership of the exercise (28), and ratings of faculty attributes seen as of high value (general medical knowledge, effective questioning style, and good interpersonal skills with house staff) or of low value (discussions of basic science, anecdotes and subspecialty knowledge) (13) for optimizing learning in the morning report exercise.

How does one account for such positive attributions being placed on the morning report experience by both residents in medicine and trainees in psychiatry? We believe the answer lies in the particular characteristics of a morning report that make it immediately relevant to the residents' daily lives, as they confront patient care responsibilities, uncertainty, and the challenges of developing excellent communication and critical thinking skills, and as they strive to develop a practical strategy for continuing professional education. When properly developed, morning report provides a learner-centered educational experience that couples attentive senior resident and faculty mentorship with both the peer support and the competition necessary to develop a sense of mastery and confidence. While these characteristics are not unique to morning report, it is one example of a well-described vehicle to deliver this kind of an educational experience that may be particularly valuable for junior psychiatry residents at a critical stage in professional development.

There are limitations to our survey methodology that should be considered in interpreting the results. These include a small sample drawn from a single program's residents, some of whom were surveyed on more than one occasion. The choices to preserve anonymity of the respondents and to survey all residents each year about their experience of morning report led to methodological limitations in measuring longitudinal change in the knowledge, skills, and attitudes that were propagated in morning report. Future research with larger samples, multiple sites, and

more sophisticated educational research designs would allow fuller examination of factors that facilitate positive educational outcomes and would permit an exploration of trends.

Ethnographic observations may help us tease out just what are the critical factors to providing not only a satisfying and educationally valuable morning report but also quality educational offerings in general (12). One example is the potential for different educational outcomes depending on the format of the report exercise. In the survey by Ways and colleagues (13), internal medicine residents expressed a preference for using up to one-third of the session for a "comprehensive" case presentation, to be followed by an interactive discussion guided by open-ended questions. Our psychiatric residents endorsed the same format, while those in the survey by Gross et al. (28) favored an interactive presentation intentionally interrupted with questions and discussion. Arguably, these differing formats meet different educational objectives. One format values case presentation skill building; the other, teaching clinical reasoning through "iterative hypothesis testing" (29). Understanding the outcomes of format differences is an area for further study.

We also need to understand more about how best to teach and incorporate evidence-based decision making in psychiatry and how to determine whether a morning report is an effective vehicle for this. How time may be optimized without forever expanding it is another important matter to resolve as we strive for educational efficiency, the proper balance of didactic and clinical experiences, and the best use of faculty resources. Morning report has been adapted for ambulatory training in internal medicine (24–27); this option should be explored in psychiatry training.

Ultimately, educators are interested in finding sustainable didactic experiences that are immediately relevant to trainees, that maximize the efficient use of resources, and that reward both the learners and the teachers with satisfying and sound educational outcomes. We believe that morning report is one example of such an experience, and we encourage psychiatry educators to consider experimenting with this exercise for their trainees and joining in the evaluation of it.

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