EDITORIAL

The Social Transformation of Medical Morning Report

In 1981, Feinstein and Petersdorf published a brief report that discussed the idea of "medical sociology."[1] Medical sociology can be characterized as the study of daily medical events—events that could indicate the status of some aspect of the profession. As far back as the 1950s, observational studies of medical students at Kansas and Columbia served as useful and interesting windows on the way young doctors began their clinical indoctrination. In an earlier critique of the problem-oriented record, Feinstein argued that no paper document could substitute for close supervision of housestaff by dedicated faculty physicians.[2] Feinstein described a system of morning work rounds and afternoon chart rounds that gave housestaff regular access to their professors as they planned case management.

Lewis Thomas, in recounting his own internship,[3] described the highly structured hierarchy in the public hospital of the 1930s. In this hierarchy, the service chief had broad responsibility for the health and safety of service patients, and morning report existed to provide the information necessary to achieve this level of oversight. Bosk explained this review process in a remarkable social analysis of a surgical service, titled *Forgive and Remember: Managing Medical Failure*.[4]

Morning report was an anxiety-provoking experience in those days. The meeting was brief and focused. In most places, the junior residents, who were officially responsible for the conduct of the medical service overnight, would gather to report on admissions, discharges, and transfers under the stern eye of a chief resident. The chief resident, of course, had gone through every medical record to make sure that the blood smears, stool guaiacs, and urinalyses had been satisfactorily completed. These residents would make their reports and return to the wards with "feedback" for the interns who had done those workups and scut work. Sometimes one intern would be summoned by the chief resident for a word of congratulation, or just as often, "constructive criticism." We interns imagined that a score card was maintained somewhere in the precincts of the front office and was readjusted daily to reflect our most recent accomplishments or transgressions as reported by our junior residents. Having no control over what went on in that meeting, we interns came to call it "morning distort."

The morning report that we knew in those days was a product of the public hospital training system. In this system, patients were usually admitted without attending physicians (public hospitals had "visiting physicians" who made rounds 3 or 4 days a week), and the hierarchy of management went from intern to resident to chief resident. We all felt that the Service Chief needed to know about every case, since we thought he was ultimately responsible for everything that happened. Therefore, a pronouncement that a lumbar puncture "should have been done" in a particular case could galvanize us into a flurry of unnecessary spinal taps in ensuing days and weeks. A suggestion by an "expert" at morning report that the best way to make a diagnosis of an unlikely but possible disease was to send a plasma specimen on ice by taxi across the city at midnight (or by jet to California) would result in a sudden upturn in the use of taxicabs (or airborne courier services) for that purpose.

During recent years, several papers have described some aspect of the process of postgraduate medical education. The medical chief residency, grand rounds, attending rounds, and various other institutions have come under scrutiny. Perhaps the most interesting of these has been morning report. We now have about 10 analyses of some aspect of morning report available. The first of these, by DeGroot and Siegler,[5] observed that morning report exemplified what were then new trends in medical education: the retreat from the bedside to the conference room and the overlaying of a social context on a meeting whose purpose had originally been for the service chief to test the pulse of the organization.

By the time DeGroot and Siegler published, there was an apparent softening in the atmosphere of morning report. They described a setting where residents would "eat doughnuts and engage in graduate medical education"—education that accentuated unusual and interesting cases and that was much less focused on oversight and surveillance and much more upon enlightened discussion of interesting topics. The role and function of morning report had shifted from one of quality control and supervision to something else.[6] But what was that?

Several authors suggested that morning report should center on a curriculum in which a distribution of cases should be presented to assure that residents would be exposed to a complete survey of common medical problems. This educational theme was extended with suggestions that cases be held over for discussion for several days, when imaging studies could be brought and expert consultants assembled for exhaustive discussions of a disease and its management. What we have in our hospitals today are variations on that theme.

In this issue, Ramratnam et al. present a useful update on the evolution of morning report from a brief, fo-

cused quality-assessment device to a central role in daily resident education.[7] In a 3-month analysis of case selection for morning report, they found that residents prefer cases that involve interesting or challenging diagnostic or treatment problems. There remains a disconnect between the basic clinical elements of the bedside examination and the "show and tell" atmosphere of morning report. This change is probably inevitable when case information must be transported from hospital room to classroom. With the decline in popularity of grand rounds, the declining availability of autopsy information, and the altered role of attending rounds, morning report has become indisputably the center for the most important daily socialization and didactic instruction on medical service. Case discussions provide a context in which key faculty can also assess the morale and level of compensation of the housestaff (individually and collectively) and address incipient problems before they become serious.

In *The Social Transformation of American Medicine*, Starr recounts the evolution of the American hospital from a community charity into a component of a huge industry.[8] In the modern hospital, the business of maintaining throughput has relegated clinical teaching to a secondary role, in which housestaff may have to learn from structured case studies rather than at the bedside. Ramratnam et al. give perspective to the role of the conference in a changing health care system. In providing "a minimum daily requirement" of medical education and moral support to housestaff, morning report assures that lessons learned about case management are generalized and shared. The authors argue that this particular aspect of morning report—its role as a survey course in clinical management—should be appreciated, strengthened, and made more consistent in its coverage of important subjects. In this viewpoint, we see a continuing movement of the conference away from supervision and constructive criticism to didactic instruction and exercises in clinical problem solving.—**Thomas A. Parrino, MD,** *VA New England Healthcare System, Boston, Mass., and Brown University, Providence, RI.*

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