Assessment of Morning Report Sessions: Experience from Department of Surgery, Addis Ababa University

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Abstract

Background: The term ‘‘morning report’’ is used to describe case-based conferences where residents, attending physicians, and others meet to present and discuss clinical cases. Morning report (MR) session is one way of delivering clinical teaching. It is case based approach, designed to teach residents and medical students from the actual patients managed in a hospital. The primary goal of the morning session is improving and monitoring the patient care given by the faculty. The objective of the study is to assess the perception of general surgery residents, faculty and the medical director about morning report sessions and look for their suggestion on areas of improvement in TASH, the main teaching hospital of Ethiopia.

Methodology: This study was conducted using qualitative research methodologies and thematic analysis. Focus group discussion was conducted with the residents. Semi-structured Interviews were done with selected instructors and the medical director of the hospital. Purposeful sampling of third and fourth year general surgery residents was used to recruit study participants. Selected faculty members were interviewed using a convenience sampling technique. The Medical Director of Tikur Anbessa Specialized Hospital (TASH) was also interviewed.

Results: The FGD and interviews were transcribed and translated by the principal investigator. Three major themes emerged from the study. These are: 1) Importance of MR; 2) Challenges encountered and 3) Areas for improvement. Its role in teaching and learning and impact in quality of patient care were mentioned as an importance of MR. The main challenges were poor attendance, unfavorable environment, inadequate scientific discussion, failure to address logistical and administrative issues and time inconsistency. Participants also suggested three major areas for improvement. These included using resident as a moderator, digitalizing presentations, and restructuring the sessions, subspecialty unit level MR, sharing responsibility amongst the different levels of trainees, and enforcing stricter timing and duration of MR.

Conclusion: MR is a vital teaching and service activity of the department. It has a role in the development of varied components of teaching and learning in the residency program including learning from cases, assessment of resident’s performance, acquiring leadership skills and enriching the communication and presentation skills of a resident. Despite all the mentioned advantages, MR is not without challenges. Poor attendance especially by faculty, inappropriate feedback, and time inconsistency are major drawbacks. The majority of the participants have suggested valuable areas of improvement to benefit maximum from MR.

Keywords: Morning Report Session; Program Evaluation; Focus Group; Interviews; Surgical residents

Abbreviations

AAU-Addis Ababa University

CHS-College of Health Sciences

TASH- Tikur Anbessa Specialized Hospital

MR- Morning Report Sessions

LOS- Length of Stay

ICU – Intensive care unit

IRB- Institutional Review Board

EMA- Ethiopian Medical Association

SSE – Surgical Society of Ethiopia

COSECSA- College of Surgeons of East, Central and South Africa

Introduction

Statement of the problem

Morning report (MR) session is one way of delivering clinical teaching. It is a case based approach, designed to teach residents and medical students from the actual patients managed in a hospital. The primary goal of the morning session is improving and monitoring the patient care given by the faculty. Other purposes of morning report include evaluation of residents and quality of services, detection and reporting of adverse events, non-medical issues, inspiring clinical research and social interaction.

The term ‘‘morning report’’ is used to describe case-based conferences where residents, attending physicians, and others meet to present and discuss clinical cases. The term includes resident reports, morning or house staff conferences, and morning sessions but excludes work rounds or teaching rounds. In a typical morning report, the team on duty during the night presents recently admitted patients, followed by a general discussion of the cases and related topics (1).

Historically the traditional MR system in the US was developed as a way of enabling each hospital’s Chief of Medicine to be updated on patients admitted overnight, but eventually it became established as a major teaching session, consistently stated as being one of the most highly regarded educational activities by junior and middle- grade staff (2).

Despite the lack of a clear definition in the literature, morning report represents a scientific formal meeting in which residents and faculty educators interact and exchange case-based clinically oriented information. In a time that calls for innovation and attention to time and financial costs, programs should tailor morning report to their specific needs. Frequent scrutiny is necessary to ensure that it meets the academic and nonacademic goals of our new generation of residents

There is a significant body of research on MR, most of it conducted in North America, designed to maximize the benefits of MR both as a teaching tool and improving quality of care to the patients, which is described in the literature review below.

The morning report sessions in the Department of Surgery at Addis Ababa University are conducted daily except for Wednesdays which is dedicated for radiology session and clinical audit. The sessions are moderated by one of the consultant surgeons unlike the sessions in other departments which are led by chief residents.

Each day the duty senior resident presents the cases, including who was admitted, operated on and died. The process of the diagnosis and management of the patients are discussed thoroughly with an intention to oversee the care of the patients and to teach and learn from the cases managed. Activities in the outpatient department, wards and intensive care unit (ICU) are also reported and discussed accordingly.

Although MR has been in practice since the inception of the department, little attention has of yet been given to its benefits, uses and potential areas for improvement. There has not yet been

research done examining this important aspect of the activities of the department. Despite consensus on the importance of morning report sessions, recently residents, staffs and the medical director have suggested that the sessions are not up to their expectations. Residents have commented that the sessions are becoming less educational, and the faculty express that the role of MR in monitoring patient care is not meeting their expectations. The Ministry of Health has stated that too much time is currently allocated to MR to the detriment of actual service delivery to the patients.

Review of literature

The term ‘‘morning report’’ is used to describe case-based conferences where residents, attending physicians, and others meet to present and discuss clinical cases. The term includes resident reports, morning or house staff conferences, and morning sessions but excludes work rounds or teaching rounds. In a typical morning report, the team on duty during the night presents recently admitted patients, followed by a general discussion of the cases and related topics (1).

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Despite the lack of a clear definition in the literature, morning report represents a scientific formal meeting in which residents and faculty educators interact and exchange case-based clinically oriented information. In a time that calls for innovation and attention to time and financial costs, programs should tailor morning report to their specific needs. Frequent scrutiny is necessary to ensure that it meets the academic and nonacademic goals of our new generation of residents (3).

The various purposes of morning report are presented according to five subheadings: education, evaluation of residents, quality of services, detection and reporting of adverse events, and non-medical issues and social interaction (1). There are valuable teaching objectives that are achieved by a well-conceived, well-run Morning Report conference. However, a new day is upon us, and we may need to restructure Morning Report for our times (4)

Kolb’s experiential learning theory postulates that experience and knowledge are intertwined and that experience creates knowledge (5).

Several new approaches to morning report have been described, including the use of morning report as a sign-out meeting after implementation of a night float system in surgery residency (6). The intervention mitigated 2 of the unintended consequences of resident work hour limitations—the fear of disrupted continuity of care and the concern that the night float residents would have substantially limited interaction with faculty members (4,6).

Though there is evidence that discussing patients at morning report can improve patient outcomes such as length of stay, the primary purpose of morning report across centers has been education (7). In a study done by Gross to the expectation of residents about MR, they were asked to rate a list of goals for the over-all purpose of morning report on a 5-point scale, with 5 being most important. Conveying medical knowledge was rated as the most important purpose of morning report mean rating, followed by promoting camaraderie, inspiring clinical research, and evaluating house staff performance. Trends were similar after stratifying by program. Conveying medical knowledge, for example, was ranked highest by residents in all 13 programs, while evaluating performance received the lowest ranking by residents in 10 of 13 programs (8).

Luciano and et al have identified the role of MR as evidence based medicine as follows. Morning report has become an important component of most of the residency training programs. It provides

forum for academic discussions, resident evaluation, and several non-medical issues. In recent years evidence based medicine (EBM) has been utilized in several teaching activities including morning report. As an evidence-based learner it is important to realize that practice of EBM starts with assessment of the patient, asking question, acquiring updated knowledge, analyzing evidence, applying that evidence to the patient and eventually reassessing the patient (9).

Perhaps one of the key successes of MR is that it has developed a unique environment where junior doctors feel that they can speak freely, with the support and encouragement of senior consultants. The processes that we have demonstrated are easily replicated, and we would strongly encourage others to establish MR meetings within their own hospital trusts. It has been said that 'it is not teaching but learning that leads doctors to change their practice: with the development of the MR we demonstrate that focusing relevant clinical teaching is possible in a hospital environment, and, as such, we aim to encourage and motivate doctors to learn throughout their careers, with the ultimate out- come being high quality patient care (10).

Additionally, residents indicated that morning report should mainly be educational and not a venue for knowledge evaluation or faculty judgment (6).

Over the past several years, numerous challenges have occurred to the classic paradigm of surgical education. Change has been driven by many factors, including the economic needs of hospital systems and individual residents, workforce issues, resident lifestyle expectations, and a continued move toward specialization within general surgery (11). Many challenges have occurred to the way in which surgical residents and students are traditionally trained. Training must occur in a shorter work week, and residents must demonstrate proficiency in specific competencies. In a study conducted in University of Virginia Health System, a departmental MR was instituted to ensure patient continuity of care within a new system. Serendipitously, MR has become an integral educational tool for the surgery residents and students at the University of Virginia Health System. It is an opportunity for residents to exercise and improve their knowledge, leadership, presentation, and problem-solving skills. MR not only serves the dual purposes of enhancing patient care and medical education, but it also provides evidence of learning and assessment of the general competencies (11).

According to the findings of the study done in Research and Development Center, Sinai Hospital, Imam Khomeini St, Tehran, most participants considered morning report sessions held in their hospital to be effective in the way it is. They claimed that these sessions accurately focused on case presentation and the participants suggested that these sessions provided them with efficient educational information especially in terms of clinical approach, differential diagnosis and treatment of a case and provoked the need for self-directed learning. In other words, with the short time available for studying the case before the session along with the fact that every participant is encouraged and sometimes forced to contribute in the discussions, residents try to study harder and improve their knowledge in diverse topics. It was also recommended that issues such as communication skill, Emergency Department (ED) management, critical thinking, ethics, professionalism and evidence-based medicine be included in the discussions (12). MR is a powerful educational intervention that may decrease patients' length of stay (LOS) and cost of care. MR, in association with an online literature search and retrieval of relevant information, provided an up-to-date approach to the medical problems of patients and a significant reduction in

median LOS for patients hospitalized on the internal medicine service. A larger study is warranted to confirm these changes and to better identify reasons for this success (13). Medical residents participate in a wide range of educational activities during the training process. Morning report, a traditional educational venue for academic medical centers in which residents, faculty, and others meet to discuss clinical issues, is regarded by many residents as the most important educational conference of their training. A variety of approaches to morning report across institutions have been de- scribed, and suggestions have been offered regarding such issues as who should attend, how structured a format should be used, what topics should be covered, and how interactive the sessions should be. (14,15).

The person leading morning report was either a faculty member (70%) or a chief resident (30%). (2) Many openly criticized the role of the leaders and the tone they set during morning report (16).

In one study done on the culture of MR, they noted residents have gained EBM skills, senior residents have assumed leadership roles. They facilitate the discussion, help to involve more junior residents, and explain relevant technical issues. The senior residents lead the conference and attendings add clinical or statistical pearls as appropriate (17).

Although this may represent publication bias, the researchers feel this observation lends credence to the idea that the most important contributor to a successful morning report is the willingness to constantly reevaluate the effectiveness of the conference style coupled with the flexibility to adapt to the changing needs of students and residents. They suggested that education leaders must remain open to experimenting with even their most well-established institutional traditions (17)

In a study done to know resident's attitude, they noted a gradual shift in the format of morning report to de-emphasize the authority figures of the department chairs and program directors in favor of a focus on learner-centered approaches and the principles of reflective learning (2). Other changes in the culture of morning report include moving away from scrutinizing residents to resident education, nurturing, and encouraging participation (16). In the past, morning report was used to monitor clinical services and performances (18); more recently, the emphasis has been on condensing learning into take-home points (19). The third shift has been a change from a focus on the short-term care of newly hospitalized patients (2) to the general principles of patient care, critical thinking, evidence-based decision making, as well as improvement of residents' skills and confidence (20)

In one study done in Pakistan the frequency of morning report was fairly uniform across programs. Most were held on a regularly scheduled basis, with 80% of internal medicine programs holding morning report five times or more a week. Only a handful of pro- grams held morning report less than three times a week. Morning report usually began before 9 AM and lasted for an hour. Some programs (4%) actually held ''morning'' report during the afternoon. In most programs, work rounds preceded morning report to facilitate data collection prior to morning report. Schiffman et al. argued that conducting morning report afterward rounds may be more useful because attending physicians can contribute significantly to the quality of the session (21).

The availability of computers enabled many programs to use the data from morning report for a variety of purposes. Rouan et al. described a computer program to generate information from

hospital admissions. They used the information for patient follow up, patient distribution among house staff, residents' evaluation, and quality assurance (22). Recht et al. also described a computerized data management program and its use in clinical research and quality assurance (23).

Several new approaches to morning report have been described, including the use of morning report as a sign-out meeting after implementation of a night float system in a surgery residency (6). The intervention mitigated 2 of the unintended consequences of resident work hour limitations—the fear of disrupted continuity of care and the concern that the night float residents would have substantially limited interaction with faculty members (6). In another innovative approach, cases presented used blinded, scripted presentations taken from published medical journals (18). Residents competed for the diagnosis, with bits of information given at specific times to allow for discussion, and the first group who answered correctly won. The new format resulted in a 30% to 40% increased attendance with this method (18).

There has been a lot of research conducted on the various aspects of MR including the relevance, importance, the timing, structuring and its contents in the developed world but as of yet none from Africa and specifically none from Ethiopia. This study will try to fill this gap. The findings from this study will also be used as a springboard for future research in the subject matter.

Research question

In this qualitative research we will be trying to address the following research questions.

1. What are the perceptions of AAU CHS Department of Surgery senior residents, faculty and the medical director of challenges of morning report as currently practiced?

2. What potential changes to morning report sessions do these participants identify?

Objectives

General Objective

- To describe the Morning Report Sessions in the Department of Surgery, College of Health Science, Addis Ababa University

Specific objectives

To describe:

- the perception of residents about morning report sessions
- the perception of Faculty about morning report sessions
- the perception of the medical director about morning report sessions
- the gaps of the morning report session in their present format

Significance of the study

Morning report sessions are one of the modalities of clinical teaching in all clinical departments. Ethiopia has been expanding medical schools rapidly. The residency programs in general surgery were very few a few years back. Recently there is rapid expansion of the programs in the country. It has a significant impact in the training of both undergraduate and post graduate trainings. Apart from its role as a venue for medical education, MR has a significant role in monitoring the quality of care provided and helps in one format of evaluating the performance of both undergraduate and postgraduate trainees.

There has been a lot of research conducted on the various aspects of MR including the relevance, importance, the timing, structuring and its contents in the developed world but none from Africa and specifically from Ethiopia. This study will try to fill this gap. The result of this study will also be used as a spring board for future research in the subject matter.

Methodology

Qualitative research approaches were used. Two focus group discussions were conducted with residents for a duration of 51 and 64 minutes respectively, to gather information about resident perceptions of the benefits and purpose of morning report. The residents critically looked into the relevance and importance of the session in helping them achieve the expectations of the surgical residency program. Drawbacks of the morning session as it is currently practiced in the department of Surgery were also discussed. The residents were also asked to provide suggestions on how to improve the format to achieve the desired goals. Semi-structured interviews were conducted to selected instructors and the medical director on the same topics which were discussed by residents.

Study Area

The study was conducted in Department of Surgery, School of Medicine, College of Health Sciences, Addis, Ababa University. The Department of Surgery is one of the biggest departments in the University. It has around 70 Faculty members. It is involved in both undergraduate and post graduate training, and has more than 10 programs. The general surgery residency program started in 1980. For many years, it was the only post graduate surgery program in the country. Over Since the last decade, more than 10 new surgery residency programs have opened across the country. The AAU surgery department is still the source of majority of faculty members for serving in these new programs. Recently there has also been an expansion of fellowship and residency programs in the different subspecialty units of the AAU Surgery Department.

Study Population

The target study population for this research project are third and fourth year general surgery residents. This is because it is during these years of residency that trainees are given somehow a full responsibility in taking care of patients. More over the activities of the off duty hours are reported by the most senior resident which could be either third or fourth year surgical residents. In addition, selected group of faculty in the department of Surgery were included as participants to get information on the perception of the Faculty about MR. The medical director of Tikur Anbessa Specialized hospital (TASH) was also included in the study to get and administrative perspective.

Sampling Technique

Purposeful sampling technique was used to pick 7 fourth year residents and 10 third year general surgery residents. Focus group discussion was conducted to this group. The FGD was conducted on Wednesdays. This day was selected because Wednesdays are allocated for teaching activity of the week. Almost no elective surgery is done on this day. Convenient sampling methods were used to select a faculty and six faculties were interviewed at which time saturation is achieved.

Data Collection Instrument

Focus group discussion (FGD) were conducted with third and fourth year residents who come for Wednesdays session. The FGD were done in two separate 51 and 64 minutes' sessions for third year and fourth year residents separately. They were run by one of the Health Science Educations master degree trainees. The FGDs were conducted in English. Participants were also encouraged to use Amharic language if they preferred to do so in order to express their ideas accurately. The place of FGD was Department of Surgery Seminar room. The principal investigator was not involved in FGD to avoid power issues. Training had been given to the person who led the focus group discussion.

Semi-structured interviews were conducted with the faculty. It was conducted in English. Amharic language was used as an optional whenever the participants preferred to use it. The interviews ranged between 8 to 18 minutes with an average duration of 12 minutes. It was conducted by the principal investigator as he doesn't have a leadership position in the department. A semi-structured interview was also done with the medical director of TASH by the principal investigator. It was conducted in medical director office and it took us 20 minutes. Both the FGD and interviews were recorded using electronic voice recorder. Data was transcribed and translated by the principal investigator.

Data Collection Technique

Data was collected via semi-structured interviews and FGD with participants. The residents were given the opportunity to air their perception of the MR. Their suggestion was also entertained using the FGD. Semi-structured interviews were used to extract information from the faculties and the medical director. Open ended semi-structured questionnaire was prepared and it was pretested. Almost the same questionnaire was used both for the interview and FGD. (See Appendix C and D) Informed consent was obtained from each participant after a short briefing about the intent and purpose of the interview and FGD accordingly

Research design/paradigm

This research project used a qualitative study design. Situated learning theory is the theoretical framework of the research. Situated learning theory holds that knowledge should be delivered in an authentic context. Beginning learners should be involved in authentic settings of daily practice, applying knowledge, and making use of artefacts in productive but low-risk ways. This usually requires social interaction and collaboration within the "community of practice". However, learners gradually move away from this community to become engaged in more dynamic and complex activities, and transition into the role of the expert. Morning report sessions provide residents the opportunity to get the real clinical scenario exposure in the presence of guidance from

senior faculty. That make Situated learning theory to be a useful and relevant theoretical framework for this study

Data analysis

The FGD and the interviews recorded and were encoded. Analysis was done using Thematic analysis method. Interviews lasted from eight to eighteen minutes. Two FGD were conducted with third and fourth year residents lasting 51 and 64 minutes respectively. It was conducted in English. Participants were encouraged to use Amharic language whenever they want to. FGD and interviews were recorded using a digital voice recorder. The FGD and interviews were translated and transcribed by the principal investigator. The transcribed verbatim was checked against the recorded interviews for accuracy. After the data were prepared for analysis, the data was analyzed using content analysis method. The following themes and sub-themes emerged after the analysis

Themes and Subthemes

Theme 1: Importance of morning report Session
- Subtheme 1: MR in Teaching and learning
  - Learning Clinical decision making skills
  - As method of continuous assessment
  - Practicing leadership
  - Develop communication and presentation skill
- Subtheme 2: MR in the improvement of patient care
  - Optimization of patient management
  - Clinical audit of the emergency activities
- Sub theme 3: Balancing the clinical and the academic mandate of a faculty

Theme 2: Challenges encountered in MR
- Subtheme 1: Poor Attendance
- Subtheme 2: Inappropriate feed back
- Subtheme 3: Inadequate scientific discussion
- Subtheme 4: Failure to address Logistic and admin issues
- Subtheme 5: Time inconsistency

Theme 3: Suggested areas of improvement
- Subtheme 1: Resident as a moderator
- Subtheme 2: Digital presentation
- Subtheme 3: Restructuring MR
  - Subspecialty unit level MR
  - Sharing responsibility
  - Strict timing

Result

Thematic Analysis of the encoded data resulted in three main themes with sub themes and categories under each. The three themes emerged are Importance of morning report Session, challenges encountered in MR and areas of improvement.

Theme 1: Importance of morning report Session

All study participants i.e. residents, faculty and MD have agreed that MR is an essential and vital activity in the department. The MD has described out the importance of MR as follows

"...*I think MR is vital activity of the department. It is useful for handing over patients; helps continuity of patient care; based on the discussion from the cases it also is used as a forum for education and for training a better work force. Especially if all faculty attends it facilitates the hand over process..." MD*

Subtheme 1: MR in Teaching and learning

The study participants believe that the major importance of MR as the teaching and learning method in the residency program.

Each case helps in the development of clinical decision making skill. This was witnessed from the following quotes

"...Every case is Case for education for all interns, residents and consultants. The presentation of the cases, the way patients managed the suggestion and comments made are important. It addresses evaluation, investigation, diagnostics and management of each case. All aspects of patient management can be learned from the discussion..." F1

"...We are spending most of our time in training our trainees develop clinical skill. This includes for example when one takes history he shouldn't take it traditionally. In fact, when someone takes from the patient he is calculating a probability. Therefore, for the trainee to play that mind game we can train him in the MR. Is the history taken by the trainee substantive? Has he configured the important facts and key points? When we talk about clinical decision making, there are nodal points. Having gathered the information, based on these evidences, we will say this is likely and this is not likely diagnosis. We can also teach trainees to do focused physical examination. Selection of appropriate investigation is also another area of training. Sending unnecessary investigation can lead to false positive result and might end up in misdiagnosis. The tying of history, physical examination, and investigation to reach at specific diagnosis can be taught in MR. MR session is case oriented and case study from teaching and learning perspective..."MD

MR is also a valuable way of progressive evaluation of residents. It was mentioned by one of the residents as

"...It is clear that what we reporting is what we have done in the last 24 hours of our duty. So the report reflects the residents' different skills. Does he know when and when not to do surgeries? Does he really know his limitations? How is his decision making skill? What are the leadership qualities of the resident? I feel that it is the major aspects of assessment..."4B

MR helps the residents to acquire and practice leadership skills. This was witness by one of the participants as follows

"...The duty team is comprised of senior residents, junior residents, interns and other professionals. Next to the duty surgeon the senior resident is second in command. It is the duty of

this senior resident to lead the whole group. Hence it also helps us develop our leadership capability..."3B

Development of communication and presentation skills are the other components of teaching and learning in a residency program identified by most study participants.

"...Helps in the development of communication skills and we acquire the skill in making a presentation in front of a bigger crowd..."3F
"...When we start reporting MR, we had difficulty but later we developed confidence in reporting..."4E

Subtheme 2: MR in improvement of quality of patient care

Majority of the study participants have a feeling that MR has great role in improving especially emergency case management. This has been mentioned both in the interviews and FGDs. This was mentioned by the MD as follows

"...As far as honest discussion is conducted, it helps. It has a role in treating patients in a team. MR help fill the the management missed to the patient. If there is mismanagement, it can be rectified following a discussion in the morning session. Really if there is case oriented and problem oriented discussion, it has superior advantage to patient management..."MD
One of the faculties has strengthened this point as follows
"... Patients admitted on semi-emergency and emergency basis are discussed in MR. Appropriate management will be suggested to those who are not managed yet. Even in those who are managed expert opinion and suggestions are helpful in improving the care and amending the management Additional intervention or change in the management will be incorporated..." F1
"...The management given to the patient may not be optimal one or there might also be a different way of treating the patient. Hence the comments given by these different experts will increase the quality of service rendered..."3B

The 24-hour emergency activity of the department can also be audited using MR. This has been raised both in the interviews and FGDs

"...Evaluation of emergency surgical care rendered by the department..." F4

"...Helps the hospital to assess itself as service provision institution. The amount and kind of and quality of service is audited..."4D

Sub theme 3: Balancing the clinical and the academic mandate of a faculty

MR are also a good venue in striking a balance between the clinical and academic mandate of a faculty. There is always a debate about what should be the primary activity and what proportion of our time should be spent in each of these. As has been emphasized by the MD MR has great role

"...As a faculty in a teaching hospital, we have three duties and responsibilities teaching, clinical service and research, we need to balance our role in teaching and service provision. Teaching and service aspect overlap. Consultants should walk the talk. MR is a good venue for delivering the knowledge and attitude part. It lacks the delivery of the skill part. The skill of history taking, physical examination and doing procedures can be taught to trainees while providing clinical service. We have to come to center stage. We can't stand on the extremes of the service and teaching aspect. We should be able to say I would teach while giving service and do while teaching. If we do that the patient will get a better a care and the trainees will benefit more. We have to integrate. MR is a vital and a good venue for both..." MD

Theme 2: Challenges encountered in MR

Despite the agreed consensus on the importance of MR, it is not without challenges. A lot of challenges have been mentioned.

Subtheme 1: **Poor Attendance**

This problem has been picked by the residents, faculty and the MD. It is serious issue as has been mentioned by the MD in the following manner
"...The major gap is Senior consultants are not attending the session regularly and they are not also in their assigned work places. This is improper. These senior faculties are not present in both these places. This in turn trickle down. If seniors are not attending, residents will follow their footsteps and are not attending the session fully. The same holds true for interns too... "...When we allocate time for MR, it is given because it is a valuable session..." MD
"...External bodies have evaluated the situation. They took the total number of faculty and have compared it with number of those attending the session. They have witnessed a significant gap ..." MD
One of the faculty has raised this issue as follows
"...We are facing low attendance by interns, residents and consultants..." **F6**

One of the residents have described the issue in the following manner

"...The attendance of the consultant is not full. More attendance means more participation and that will increase what we gain out of the session..."4F

Subtheme 2: Inappropriate feedback giving method

The atmosphere of the morning session is not favorable for the residents. This was the observation of most of the study participants.
The commonly mentioned reason is the inappropriateness of the feedback given to residents especially when they make mistakes. There is a tendency for fault finding and blame game. This was stated by one faculty as follows

"...Some faculty have fault finding mentality. They tend to blame residents rather than helping them to learn from their mistakes. This also forces residents to report some facts which are not genuine for the purpose of bypassing this mentality..." F2

Residents have cited their experience in the following manner

"...There is a sort of blame game. When we are preparing the report we are preoccupied by what intimidating comments might come during MR by some consultants. Rather than thinking about what I might get from the session I feel scared. Residents are trainees and sometimes the session forgets that component and focuses on the blaming. This doesn't mean that all consultants are the same. There are some good ones..."3C

This has been noted by the MD and he has stated his observation as follows
"...I know residents fear MR for different reason. First you will be held accountable for whatever you did. The other is you don't want to be exposed when you don't know the questions you are asked in front of a crowd. Our communication skill should improve. Mistakes can be picked and feedback can be given without affecting the emotion of the resident..."MD
"...We are aware that MR are equated with a court room where residents are interrogated..." MD

Subtheme 3: Inadequate scientific discussion
Residents and faculty feel that the intended purposes of MR are not achieved fully. Especially academic components are not given due attention. Most of the discussion focuses on the routine patient care. The scientific discussion is not up to their expectation. This has been mention by faculty and residents as follows

"... Residents should be asked the scientific basis of their management of the cases. This encourage them to read and learn from the cases presented..." F3
"...The session focus on the report of routine activity. We are asked what we did. It doesn't give the opportunity for residents to explain the scientific basis they used to reach at a specific decision..."3E

Subtheme 4: Failure to address logistical and administrative issues
There is a clear difference in emphasis given to failure to address logistic and admin issues from resident and faculty perspective. Almost all residents feel that this part is neglected and not raised. Even if these issues are raised little effort is made to address them. Little has been said by the faculty
"...The admin issues we are raising are not given due attention. During the duty hour we face shortage of supplies, electricity, water, drapes needed for operation and the like. Though we are reporting this whenever we get the opportunity they are not taken seriously and not solved..."4G

Subtheme 5: Time inconsistency
Time inconsistency is one the challenges not by most participants but the emphasis given to it by the MD is immense. This one area where admin people complain about. It affects other activities of the hospital. It was stated by the MD as follows
"...Time inconsistency is also a serious issue. It should start on 8 am and finished at 9 am. Timing of MR has an impact on the other activity of the hospital..."MD

Theme 3: Areas of improvement
Participants have suggested certain recommendation for the challenges they noted with regard to MR.

Sub-theme 1: Resident as a moderator
MR are moderated by one of the senior faculty in the department of surgery. This is peculiar to the department because in other departments the sessions are moderated by senior residents preferably by chief residents. Most would prefer sessions to be led by senior resident. They have sited reasons for their preference
"...If a senior resident moderates it will help him develop the leadership capabilities and coordinating character to attain confidence. If a resident leads the session. I feel that I am presenting to a colleague. It makes me comfortable as opposed to if I present to a consultant. It decreases the burden on me and eases the environment. I feel more confident..."3F
"...Leading a morning session is all about facilitation, communication and leadership. The decision is not the most important part of moderating the morning session. The chief residents can bridge the gap between the consultants and the residents. MR can be moderated by the chief residents. In the time of difficult and challenging cases, the responsible consultant can be invited to comment and share his experiences. Even in the presence of the senior consultant as a moderator, he is not the ultimate source of decision. He asks the experts from the different subspecialty unit to comments and decision. Even the consultant moderator is the source of expertise in his subspecialty field only..."4E

Subtheme 2: Digital presentation
Digitalizing the presentation was suggested to be started in the department. Residents have brought their experience from orthopedics department in introducing power point presentation in MR. Besides some have justified their stand by mentioning the automation of patient chart initiated in the hospital. One of the resident has said the following

"...Power point presentation is good. It will be helpful for clinical audit and research purpose too. Data is documented well and we can retrieve it whenever we want it. It helps us in alleviating the missed information of the manual documentation we are using..."4I
"...The time needed for preparing the power point shouldn't be an issue. Somehow we spend time for the preparation of the paper presentation too. The power presentation has great role in incorporating the intraoperative images and video, and radiologic studies. This will have great role improving the educational values of MR. Using this audiovisual instrument is very good. The presentation will be legible and accessing data will be easier. It is valuable both for the patient care and the educational purpose. Especially for the rare cases, the pictures of the actual pathology and the imaging will be more informative and educational both for the residents and consultants. After all hearing is not a good way of knowledge transfer as using audiovisual aides. When we are attending the verbal presentation, attentions can be distracted easily..."4E

Subtheme 3: **Restructuring MR**

Subspecialty unit level MR
One form of restructuring MR is introduction of subspecialty Unit level MR. The ria a clear

difference in the opinion of residents and consultants about this issue. Residents feel that this can affect their general surgery residency training as is stated by one of the residents as follows
"...Now the different units of the department have started their own MR. Neurosurgery, Urology, and pediatric surgery units have started their own session. Especially the departure of the Pediatric surgery unit from the MR will create gap in in my future carrier. We are expected to manage many pediatric surgical cases in the future. The skills and knowledge we get from our placement in the unit can't replace all what we used to get when the unit was presenting its activities in the general surgery MR..."4B

Most faculty feel that this is a good opportunity to have detailed and deeper discussion about the cases managed. The following the quote from one of the faculty
"...The session should be geared towards more focused and deeper discussion. Patients should be managed by relevant subspecialty unit and the sessions be conducted at the unit level. This won't affect the general surgery training qualities the residents will have the opportunity to participate these sessions when they are attached to the specific units..." F5
This unit level MR is inevitable and it is beyond the authority of general surgery residency program as the units have started their own training programs and they want to conduct the sessions by themselves. Hence theses unit level sessions should be one are of change coming.

Sharing responsibility
In the department of Surgery, it is the most senior resident who shoulders the majority of the responsibility. That has made tremendous burden on senior resident. This shouldn't continue like this from now on according to most residents as has been mention by one of the residents as follows
"...In Surgery almost all responsibility lies on the shoulder of final year resident. Junior residents are excused. If it is possible Responsibilities should be shared by the junior resident too. Any wrong doing by the junior should be the responsibility of the respective resident. The OPD activity for example is covered by the junior resident and he should be accountable for all the activities of OPD. The senior resident should act as the overall team leader..."3B
"...The junior resident can be involved in the preparation of the power point presentation. The senior resident will do his usual activities. This makes the junior resident to be involved in the care of the patient in a responsible manner..."4I

Strict timing
MR should have strict timing as suggested by the MD and stated as follows
"...As a manager of this teaching Hospital we have reached at the following consensus

1. *All the sessions shouldn't take more than 1 hour*
2. *It should start exactly at 8 am and end at 9 am. Department heads should focus to implement this because all the staff should be deployed to their assigned places at 9 am.*
3. *MR has main actors. The majority are audiences. Early starters need to leave the session at 8:30am and start the clinical service. This makes the clinical service to be started early lessening the discomfort for the patients. After 9 am everybody should be at his / her assigned work place..."MD*

Discussion

In a review of literature in academic medicine, various purposes of morning report are described according to five subheadings: education, evaluation of residents, quality of services, detection and reporting of adverse events, and non-medical issues and social interaction (1). The purposes of MR perceived by residents, faculty and the medical director (MD) can be grossly put under the above categories. These were listed under the theme "importance of MR" in our research. One disparity between the findings of this research project and the international literature is that detection and report of adverse events is not listed in the present study. In our setting, a striking finding about the purpose of MR is that administrative and logistical issues are perceived to have been given insufficient attention by the faculty members and MD. They are one of the most important purposes mention in both FGD with third year and fourth year residents. Residents feel that though these issues are raised almost daily, the attempt to alleviate the problems encountered by residents during duty hours is negligible.

In one study published in Qualitative health research in 2004 the authors identified that by interacting with peers and role models, residents and students learned the culture of medicine and develop their professional identities. Similar findings were mentioned by our residents and it is line with experiences in the other part of the world (24).

Almost all study participants stated that these purposes of MR are not achieved fully. In a narrative review published in Journal of Graduate Medical Education in 2013 the researchers examined the evidence for the value and effectiveness of MR in graduate study (25) education was rated the most important purpose of MR. One of the main reasons for our study participants to have reservations about the achievement of the intended purpose of MR (both faculty and residents) is that they state that the educational aspect of MR was not achieved well. This finding in our setting is different from the findings of the narrative review.

Perhaps one of the key successes of MR is that we have developed a unique environment where junior doctors feel that they can speak freely, with the support and encouragement of senior consultants (10). The finding in our study contrasts with findings from studies in other parts of the world. Here in our setting resident mention the MR environment to be unfavorable. They incriminate the behavior of some faculty in creating discouraging environment. But this doesn't mean that it is peculiar to our setting. In another study published in JAMA in 1991 residents indicated that morning report should mainly be educational and not a venue for knowledge evaluation or faculty judgment (16).

Over the past several years, numerous challenges have occurred to the classic paradigm of surgical education. Change has been driven by many factors, including the economic needs of hospital systems and individual residents, workforce issues, resident lifestyle expectations, and a continued move toward specialization within general surgery (11). In line with challenges mentioned in the above study, the expansion of subspecialty programs and the start of MR at Subspecialty level has been mentioned as one of the challenges of MR in general surgery residency program. Contrary to the above perception by residents, this has been mentioned by some faculty as a positive move.

The most important challenge mentioned by the resident, faculty and MD is less attendance mainly by the faculty to a lesser extent by residents and interns. This was mentioned to affect the educational input from the experience of the consultants. The MD feel that this is a serious malpractice as this can bring an issue of good governance.

One of the major challenges identified by all stake holders is the unfavorable environment of the MR. There were lots of negative words used to describe this scenario. Residents, faculty and even the MD used the words like blame game, a court room scenario, fault finding mentality and inappropriate feedback giving methods. This should be taken seriously and should be worked hard to rectify it. This contrasts with what has been identified in other settings where researchers mention as a key success of MR is that they have developed a unique environment where junior doctors feel that they can speak freely, with the support and encouragement of senior consultants (10).

According to the findings of the study done in Research and Development Center, Sinai Hospital, Imam Khomeini St, Tehran, most participants considered morning report sessions held in their hospital to be effective in the way it is. They claimed that these sessions accurately focused on case presentation and the participants suggested that these sessions provided them with efficient educational information especially in terms of clinical approach, differential diagnosis and treatment of a case and provoked the need for self-directed learning. In other words, with the short time available for studying the case before the session along with the fact that every participant is encouraged and sometimes forced to contribute in the discussions, residents try to study harder and improve their knowledge in diverse topics. It was also recommended that issues such as communication skill, Emergency Department (ED) management, critical thinking, ethics, professionalism and evidence-based medicine be included in the discussions. (11) Though this research is done in emergency department, these all purposes were mentioned in detail both by the faculty and residents in our study. This makes the finding of our study to be line with the studies done Iran.

MR are led a senior faculty in the Department of Surgery here TASH. This is not uncommon in other parts of the world. In one study done in Pakistan they have found out that 70 % of the sessions are led by faculty and 30 % by chief residents. Apart from Department of surgery sessions are led by chief residents in other departments of TASH. Researches support that if the session is led by residents, they will gain EBM skills, senior residents have assumed leadership roles. They facilitate the discussion, help to involve more junior residents, and explain relevant technical issues. The senior residents lead the conference and attendings add clinical or statistical pearls as appropriate. Most residents and some faculty suggest the MR in the department should be led by residents to achieve the aforementioned benefits. This has been found in one study which stated that Peer-led education has been shown to be highly effective in the promotion of in-depth, long- term learning for those responsible for teaching, as well as for those being taught, both at a student and postgraduate level (26).

Digitalizing the session is one of the points raised by most residents and few faculties. Lots of advantages of this has been mentioned both by the study participants and in literatures. The following are the findings of these different studies. The availability of computers enabled many programs to use the data from morning report for a variety of purposes. Rouan et al. described a computer program to generate information from hospital admissions (22). They used the

information for patient follow up, patient distribution among house staff, residents' evaluation, and quality assurance. Recht et al. also described a computerized data management program and its use in clinical research and quality assurance (23).

Conclusion

MR is a vital part of the activities of our teaching hospital. It has great role both in the teaching and learning activities and quality of patient care. It is helpful in the development of resident's clinical decision skills; Assessment of resident's knowledge and attitude; practicing leadership, and development of communication and presentation skills. It is also a good venue for optimizing patient's management and as a clinical audit for the emergency activity of the department. MR are also good venue for balancing the clinical and academic mandate of faculty in a teaching hospital like ours.

However, this session is not without challenges. The challenges identified include poor attendance mainly by the faculty and to some extent by residents and interns. The MR environment is unfavorable. The way the feedback is given is not appropriate and sometimes intimidating and scary for the residents. The intended purposes of MR are not achieved fully especially the academic part with little emphasis to the scientific basis of the diseases treated.

Though residents want the administrative part and the logistical problem encountered during the duty hour to get due the attention, the reverse is what is happening. The shortages and challenges encountered during the emergency hour are not discussed well and not addressed in timely manner. The other most important challenges noticed especially by the medical director and some faculty and residents is the time inconsistency. Sometimes the sessions take more than an hour. This can have negative impact on patient care by compromising the time needed for other activities of the department.

Recommendation

Senior residents especially chief residents are used a s moderator in other departments. This is not the case in the department of surgery. Most residents and faculty feel that the session should be moderated by senior residents. This somehow can make the session to be less scary as the residents have a better understanding and insight about MR. Besides the moderation by the residents can make the discussion to be trainee centered by emphasizing what residents want to be discussed.

Digitalizing the session is another recommendation. In the present era of computer and high technology using a paper presentation should be discouraged. This will help retrieving data very easy both for monthly audit and research purpose. The hospital is introducing computerized patient recording system. This in turn make the demand for digitalizing MR sessions timely.

Restructuring the session is another area of improvement. Subspecialty unit level MR one of the recommendation. Here the opinion is different both from the residents and faculty perspective. Residents feel that these sessions are compromising the general surgery residency training. On the other hand, the faculty feel this should be the right direction. This looks to be the natural course which is expected. The subspecialty programs have started their own residency and fellowship

programs; hence they will start their own MR programs·

Another potential area of change is in sharing responsibility. The MR in the department of Surgery puts all responsibility on final year residents. According to the suggestions by most residents and some faculty the junior residents should take responsibility on the activities they are involved and the in the preparation of the soft copy if the digitalizing the session to be realized.

Strict timing is the last field which needs improvement. As recommended by the medical director, the MR session should not take more than one hour. Early starters of the clinical activity should leave after 30 minutes, and the rest should finish by one hour.

Ethical clearance

Data from the residents will be collected using focus group discussion. The Focus group discussion will be conducted by a colleague to avoid power influence on the data.

Ethical clearance will be obtained from IRB of the Department of Health Science Education, CHS-AAU. Informed consent will be obtained from individual participants. The participant will be told that they have the right to be involved or not to be involved in the study and that their non-involvement will not affect their study. The names of the participants are not going to be made public or written within the research paper.

Knowledge translation

After completing thesis dissertation, the result of the study will be communicated to the members of the department and the medical director office and the Ministry of Health. The study will also be published in a reputable journal (peer reviewed journal) so that it will be available for those scholars interested in the field. The finding will be presented in annual conference of College's research day, EMA, ESS, COSECSA and other local and international conferences

References

1. Steward D, Amin Z, Guajardo J, Wisniewski W, Bordage G, Tekian A, et al. REVIEW PAPER Morning Report: Focus and Methods over the Past Three Decades.
2. Ways M, Kroenke K, Umali J, Buchwald D. Morning report: A survey of resident attitudes. Arch Intern Med [Internet]. 1995 Jul 10;155(13):1433–7. Available from:http://dx.doi.org/10.1001/archinte.1995.00430130127013
3. Parrino TA. The social transformation of medical morning report. J Gen Intern Med. 1997; 12:332–3.
4. Trachtman H. Morning Report: Is the Time Ripe for a Change? Teach Learn Med. 2012;
5. Kolb DA. Experiential Learning: Experience as the Source of Learning and Development. Englewood Cliffs, NJ, Prentice-Hall, 1985.
6. Stiles BM, Reece TB, Hedrick TL, Garwood RA, Hughes MG, Dubose JJ, et al. General surgery morning report: a competency-based conference that enhances patient care and resident education. Curr Surg. 2006;63(6):385–90.
7. Daniels VJ, Goldstein CE. Changing Morning Report: An Educational Intervention to Address Curricular Needs. 2014; Available from: http://dx.doi.org/10.1155/2014/830701
8. Gross CP, Donnelly GB, Reisman AB, Sepkowitz KA, Callahan MA. Resident expectations of morning report: A multi-institutional study. Arch Intern Med. 1999;
9. Luciano GL, Visintainer PF, Rothberg MB. Ambulatory Morning Report: A Case-Based Method of Teaching EBM Through Experiential Learning. 2016;108–11.
10. Layne K, Nabeebaccus A, Fok H, Lams B, Thomas S. Modernizing Morning Report: innovation in teaching and learning. THE CLINICAL TEACHER 2010; 7: 77–82 2010;77–82.
11. Moharari RS, Soleymani HA, Nejati A, Rezaeefar A, Khashayar P, Meysamie AP. Evaluation of morning report in an emergency medicine department.
12. Banks DE, Shi R, Timm DF, Christopher KA, Duggar DC, Comegys M, et al. Decreased hospital length of stay associated with presentation of cases at morning report with librarian support. 2007;95(October):381–7.
13. TA P, AG V. The principles and practice of morning report. JAMA [Internet]. 1986 Aug8;256(6):730–3.Available from: http://dx.doi.org/10.1001/jama.1986.03380060056025
14. Amin Z, Guajardo J, Wisniewski W, Bordage G, Tekian A, Niederman LG. Morning report: focus and methods over the past three decades. Acad Med. 2000 Oct;75(10 Suppl):S1-5.
15. West CP, Kolars JC, Eggert CH, Kennedy CC, Ficalora RD. Changing Morning Report: Evaluation of a Transition to an Interactive Mixed-Learner Format in an Internal Medicine Residency Program. 2004;
16. Brancati F. Morning distort. JAMA. 1991;266:1627.
17. Hill RF, Tyson EP, Riley HD Jr. The culture of morning report: ethnography of a clinical teaching conference. South Med J. 1997;90(6):594–600.
18. Huffman MD, Kaufman SR, Saint S. A new approach to resident morning report: introducing ‘‘VAVUM.’’ Intern Emerg Med. 2010;5(1):81–82.
19. Harris ED Jr. Morning report. Ann Intern Med. 1993;119(5):430–431.

20. Sanfey H, Stiles B, Hedrick T, Sawyer RG. Morning report: combining education with patient handover. Surgeon. 2008;6(2):94–100.
21. Muhammad Tariq, Shahab Abid, Wasim Jafri. Morning Report is an effective teaching Activity: Faculty and Residents Perspectives. Journal of Surgery Pakistan (International) Vol. 9 (2) April - June 2004: 38- 42.
22. Rouan G, Marks E, Tuchfarber B, Redington TJ, Lorenzi N. Development, effects, and educational outcomes of reporting from a clinical database. Med Decis Mak- ing. 1991;11:S80–9.
23. Recht L, Kramer P, Schwartz W. Morning report in computer era: tradition meets technology. Med Teach. 1995; 17:327–31
24. Apker J, Eggly S. Communicating professional identity in medical socialization: considering the ideological discourse of morning report. Qual Health Res. 2004;14(3):411–429.
25. Matthew McNeill, MD Sayed K. Ali, MD Daniel E. Banks, MD, MS Ishak A. Mansi, MD. Morning Report: Can an Established Medical Education Tradition Be Validated? Journal of Graduate Medical Education, September 2013; 374-384. DOI: http://dx.doi.org/10.4300/JGME-D-12-00199.1
26. Weiss V, Needlman R. To teach is to learn twice. Resident teachers learn more. Arch Pediatr Adolesc Med 1998;152:190–192.

Appendix A: Consent Form for Residents

Centre for Health Science Education College of Health Sciences, Addis Ababa University

The purpose of the study is to assess the perception of residents, faculty and the medical director about Morning Report Sessions in their present format. It will also try to identify the gaps and look for possible suggestions by study participants.

I agree to take part in the assessment of morning report sessions in the department of Surgery, College of Health Science, Addis Ababa University. I have read and understand the study purpose as described above. I understand that agreeing to take part means that I am willing to:

1. be involved in focus group discussion

2. allow the discussion to be audio-taped

I understand that my participation is voluntary and I can withdraw at any stage of

the project without being penalized or disadvantaged in any way. I understand that any data that the researcher extracts from the focus group for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

Participant's name: _____

Signature: _____

Date: _____

Appendix B: Consent Form for Faculty and Medical Director

Centre for Health Science Education College of Health Sciences, Addis Ababa University

The purpose of the study is to assess the perception of residents, faculty and the medical director about Morning Report Sessions in their present format. It will also try to identify the gaps and look for possible suggestions by study participants.

I agree to take part in the assessment of morning report sessions in the Department of Surgery, College of Health Science, Addis Ababa University. I have read and understand the study purpose as described above. I understand that agreeing to take part means that I am willing to:

1. be involved in Semi-Structured Interview

2. allow the Interview to be audio-taped

I understand that my participation is voluntary and I can withdraw at any stage of

the project without being penalized or disadvantaged in any way. I understand that any data that the researcher extracts from the focus group for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

Participant's name: _____

Participants Role in the department_____

Signature: _____

Date: _____

Appendix C: Questions for Focus Group Discussion with students

1. What do you think are the purposes of morning report sessions?

2. How do you think the morning report sessions in its present format is achieving its intended purpose?

3. What role do morning report sessions have in the improvement of quality patient care?

4. What educational values do morning report sessions have?

5. What are the gaps you noticed in the morning report sessions in its present format?

6. How do you think the format of the morning sessions can be improved?

Appendix D: Questions for semi-structured interview with faculty members

1. What do you think are the purposes of morning report sessions?

2. How do you think the morning report sessions in its present format is achieving its intended purpose?

3. What role do morning report sessions have in the improvement of quality patient care?

4. What educational values do morning report sessions have?

5. What are the gaps you noticed in the morning report sessions in its present format?

6. How do you think the format of the morning sessions can be improved?

Appendix E: Encoded Data from Interviews of Medical director and Faculty

Transcribed verbatim: Medical director Interviewer: What do you think are the purposes of MR? I think MR is vital activity of the department. **MD**: It is useful for handing over patients; helps continuity of patient care; based on the discussion from the cases it also is used as a forum for education and for training a better work force. Especially if all faculty attends it facilitates the hand over process. I know there were different perceptions about MR like MR is not necessary and people were also recommending to change the timing to be in the afternoon. MR is not peculiar to Ethiopia. It is conducted in the other part of the world too. They are conducted in the morning. I have seen it being conducted in USA and Europe especially in Germany. But we can make it more efficient. As a manager of this teaching Hospital we have reached at the following consensus 1. All the sessions shouldn't take more than 1 hour 2. It should start exactly at 8 am and end at 9 am. Department heads should focus to implement this because all the staff should be deployed to their assigned places at 9 am. 3. MR has main actors. The majority are audiences. Early starters need to leave the session at 8:30am and start the clinical service. This makes the clinical service to be started early lessening the discomfort for the patients. After 9 am everybody should be at his / her assigned work place We have audited the activity of TASH. 82 % of the activity is conducted in the morning. Only 18 % of the activity done in the afternoon. We have tried to redistribute this to 60 % to 40%. 60 % should be done in the morning. This helps in avoiding spill over to the next day. If there is a spillover from the morning activity, it can be addressed in the lunch time. By doing this we are able to make the spill over rate to be nil. Since the morning is used to execute 60 % of the daily activity, we should be strict in the timing of MR. More or less the MR is achieving its purpose. But there are gaps we noted. The major gap is Senior consultants are not attending the session regularly and they are not also in their assigned work places. This is improper. These senior faculties are not present in both these places. This in turn trickle down. If seniors are not attending, residents will follow their footsteps and are not attending the session fully. The same holds true for interns too. External bodies have evaluated the situation. They took the total number of faculty and have compared it with number of those attending the session. They have witnessed a significant gap. This finally will lead to the issue of good governance. We have customers and they need the service. We trainees and they need training. Besides we have other duties to do. When we allocate time for MR, it is given because it is a valuable session. Time allocated for MR is not a French leave. We have	Patient hand over Continuity of patient care Making MR more efficient Partial achievement Poor attendance Lack of good governance Reinforcing measure Training in team Feeling ashamed Accountability Learning from mistakes MR as Court room Time inconsistency Non Participatory Session

to work hard to improve this. Especially the department heads should strive to rectify this. If there is a need, staffs should be encouraged to attend MR. If this fails, one should try to implement reinforcing measures.
Interviewer: What do you think are the role of MR inpatient quality care?
MD: As far as honest discussion is conducted, it helps. It has a role in treating patients in a team. MR help fill the management missed to the patient. If there is mismanagement, it can be rectified following a discussion in the morning session. Really if there is case oriented and problem oriented discussion, it has superior advantage to patient management.
Interviewer: How about the educational value of MR?
MD: Are you doubting it?
Interviewer: No I am not
MD: It has educational value from different perspective. We are spending most of our time in training our trainees develop clinical skill. This includes for example when one takes history he shouldn't take it traditionally. In fact, when someone takes from the patient he is calculating a probability. Therefore, for the trainee to play that mind game we can train him in the MR. Is the history taken by the trainee substantive? Has he configured the important facts and key points? When we talk about clinical decision making, there are nodal points. Having gathered the information, based on these evidences, we will say this is likely and this is not likely diagnosis. We can also teach trainees to do focused physical examination. Selection of appropriate investigation is also another area of training. Sending unnecessary investigation can lead to false positive result and might end up in misdiagnosis. The tying of history, physical examination, and investigation to reach at specific diagnosis can be taught in MR. MR session is case oriented and case study from teaching and learning perspective. MR is also helps to train residents in team. Every physician has different impression about one specific patient presentation. In addition, the diagnostic acumen of the individual consultant varies. The diagnostic skill of a physician even if it follows a logical sequence it has also fussy logic component. If clinical medicine is one plus one equals two, there should not be a need in training manpower and doctors could have been replaced by machines long before. Residents learn from the contribution of every consultant.
Clinical decision making skill has its own peculiar dimension. It has both art and science component with variable proportion. MR is good way of teaching this skill. It is also a forum to discuss both the analytic and didactic component of clinical medicine.
I know residents fear MR for different reason. First you will be held accountable for whatever you did. The other is you don't want to be exposed when you don't know the questions you are asked in front of a crowd. Our communication skill should improve. Mistakes can be picked and feedback can be given without affecting the emotion of the resident.
We are aware that MR are labeled as a court room where residents are interrogated. We are also aware that residents compliant for being

asked by a consultant who has spent the whole night on those who have spent working the whole night. We should work hard to bring a cultural shift and bring about the positive aspects of MR. Interviewer: What other gaps did you notice in the MR? MD: As I have tried to mention it before, poor attendance by all stakeholders is the major one especially by consultants. The other is the structure of the MR. All our activities are done traditionally. We don't have written document about the structure of MR. MR are not well organized. Sometimes the session becomes a place for argument. It is also dominated by few individuals. Time inconsistency is also a serious issue. It should start on 8 am and finished at 9 am. Timing of MR has an impact on the other activity of the hospital. There are three defined roles in MR. These are the roles of a presenter and the audience. Sometimes the moderator tries to fill the gap between the two. The majority of the participants are passive. There should be a mechanism to bring the majority of participants to active participation. It is clearly known who is seating in the front line, some are sleeping, and there are participants who tend to pick the comical aspect to use it for fun after the session. Here I see the impact of our culture. If you the communication skill in other part of the world, people communicate freely, respectfully but openly. We tend to be quite. The reason could be out of respect for senior staff or out of fear of the authority. **Interviewer: Any other thing you want to add?** **MD:** As a faculty in a teaching hospital, we have three duties and responsibilities teaching, clinical service and research, we need to balance our role in teaching and service provision. Teaching and service aspect overlap. Consultants should walk the talk. MR is a good venue for delivering the knowledge and attitude part. It lacks the delivery of the skill part. The skill of history taking, physical examination and doing procedures can be taught to trainees while providing clinical service. We have to come to center stage. We can't stand on the extremes of the service and teaching aspect. We should be able to say I would teach while giving service and do while teaching. If we do that the patient will get a better a care and the trainees will benefit more. We have to integrate. MR is a vital and good venue for both.	

Interviewer: What do you think are the purpose of MR? F1 MR has two major purposes. These are Academic and service. Junior residents learn from the sessions. Different ways of patient management are discussed from resident's perspective, from what the senior residents do, and as well as from comments and suggestion from consultants. Residents also learn from patients admitted and operated overnight. Comments and suggestion will be forwarded on cases admitted and operated by different consultants. Missed management and important interventions will be added to the patient. It also helps also for progressive assessment and evaluation of residents on their patient evaluation and clinical judgment. In most instance it is achieving the intended purpose. The challenge I noticed is lower attendance from consultants. Due to this, the valuable suggestion from different specialties will not be obtained. It should be worked hard to improve the attendance of the consultants from different sub-specialty units. There is also low attendance from residents and interns. Attendance should improve **Interviewer: What is the role of MR in the care of the patient?** Patients admitted on semi-emergency and emergency basis are discussed in MR. Appropriate management will be suggested to those who are not managed yet. Even in those who are managed expert opinion and suggestions are helpful in improving the care and amending the management Additional intervention or change in the management will be incorporated. It also gives opportunity for the specialist to know the cases managed, which otherwise, would be difficult for them to see. Every case is case for education for all. Interns, residents and even consultants learn from cases admitted and managed. The presentation of the cases, the way patients managed the suggestion and comments made are important. It addresses the history taken, the physical examination, investigation and management of the patients who are admitted during the duty hours. are addressed during the sessions.in short it addresses all aspects of patient management Apart from what has been said a lot is gained from the imaging study done to the patient **Interviewer: What gaps did you notice in MR in its present format?** Lack of attendance is one of the gaps of MR I noticed. Timely intervention from the decision made during the session is not achieved. Whatever is discussed and decided should be accomplished in timely manner. Delay in addressing what is decided in the sessions should be taken seriously.	Importance of the session Peer learning Improved patient care Part of learning and teaching Success of MR Gaps identified Recommendation for improvement Poor Attendance Assessment and evaluation of residents Appropriate management Improved patient care Optimizing patient management Learning from cases Lack of attendance Delay in optimal treatment Different format in different hospitals Resident as a moderator Practicing leadership Continue with the format

The format of MR is different in TASH and the other affiliated hospitals like Zewditu Memorial Hospital (ZMH), Yekatit 12 Hospital and Minilik II Hospitals In Tikur Anbesaa Specialized Hospital(TASH) the session is led by the senior consultant or the department head. It is different in the affiliated hospitals where the sessions are led by residents. This mix up is good. Whatever they noticed in TASH MR they will practice it whenever they go in the affiliated hospitals. They learn how to lead a session in TASH and practice it in the affiliated hospital. **Interviewer: Do you think the format of MR be changed?** The format should be kept as it is. It has good arrangement. Strengthen MR and make it more functional. Interns involvement in the session should be taken seriously. They should be given the opportunity to report and encouraged to tell what they know and be given responsibilities Residents are prospective surgeons and senior faculty. They should be given the opportunity to lead sessions as they will do it when they finished the residency program and somehow it helps them practice they future leadership role. Detailed discussion on the management of specific cases should be included otherwise it will loss its academic purpose	

F2 **Interviewer: What do you think are the purpose of MR?** **It is the r**eport of 24 hrs. emergency surgical activity, helps in reaching at diagnosis on those preoperative cases and follow up of postoperative patients. On top of that based on the discussions arising from the sessions residents and even a senior faculty learn from the cases. **Interviewer**: **Do you think MR session has achieved its purpose?** As to the achievement of the intended purpose I have mixed feeling. Some of the purposes are achieved liking reporting the activity and follow up of patients **Interviewer: Any gaps you noted?** The gaps noticed include the following. In some of the sessions, there seems to be a sense of fault finding by some senior faculty. This makes residents to report some facts which are not genuine for the purpose of bypassing this mentality **Interviewer**: What Educational Values do MR have? Residents are surgeons on training with low level of expertise. Listening what the different expert's comments and suggestions based on the evidence obtained from residents is one way of learning. It helps residents to learn from the clinical judgment skills of their role models. Generally, I noted the following gaps. Lack of commitment from some consultants, Poor attendance by the faculty, Fault finding mentality, blaming rather than helping residents to learn from their mistakes **Interviewer**: Should the format of MR be changed? Yes, it should be changed. Residents should take the moderator role preferably the chief residents should lead. The feeling is shared by the residents. The role of the consultants should be giving comments. Sessions led by residents will give them the empowerment and responsibility. This helps them read on the subject matter. When new and challenging cases are found short presentation on the subject matter will improve the education values of morning report for the residents. It helps the consultant himself to update on the current approach and updates in the management of the cases presented	Emergency surgical activity Case based learning Purpose not achieved Fault finding Unreliable report Sound clinical judgment Lack of commitment Poor attendance Blame game Resident as a moderator Empowering residents Short presentation

Interviewer: What do you think are the purpose of MR? **F3** The purpose of MR include the followings. It helps improve the quality of patient care; Helps improve the reporting capacity of residents; Have impact in hospital service. It is also a media to teach residents how to manage emergency surgical cases. It is also one form of assessing and evaluating residents **Interviewer**: **Do you think MR session has achieved its purpose?** It is achieving its purpose partly. It has lack of feedback to the resident on their reporting style and their way of management. The management plan after the report is not clearly stated and implemented. It also lacks some of its teaching elements. **Interviewer: Do you think the format of MR be changed?** It should be started earlier especially on Mondays where there will be an activity report of 3 days, the report is long so that the team will start their surgical activities earlier. It should be conducted on daily basis to address the management of emergency cases timely. Interns should be encouraged to be involved more. Scientific basis of the cases should be asked to encourage residents to read on the cases presented. It should be led by consultants on rotation rather than few specific consultants permanently. Inclusion of 10 minutes' short presentations on challenging and new cases will improve the educational role of MR	Quality patient care Develop communication skill Residents assessment Deficient feed back Low educational purpose
Interviewer: What do you think are the purpose of MR? **F4** It is a forum for learning for all levels of residents, interns and consultants. Clinical decisions are made using different ladders of experts. Evaluation of emergency surgical care rendered by the department. Timely measures are taken in the management of patients by junior staff It also helps predict the complications and prevent complications Preoperative preparation, intraoperative, Post op care of the patients are also discussed. MR is also a social venue for the faculty from different subspecialty units of the department to meet and exchange ideas.	Teaching junior doctors Clinical decision making Optimum Care Venue for socialization Resident Assessment Intended purpose not met More about patient care Short presentation Unit level MR

Senior residents are evaluated by the way they present, their clinical decision, how they carried out the procedure and their post-operative follow up of the patients Most cases are managed off duty hour where most senior faculty are not around. The care may not be optimum and these sessions help in rectifying care to the optimum level I don't feel that these sessions are meeting all their intended targets The duration is short with lots of cases from different subspecialty units. The discussion is not intense and consultants are not providing their reflection on the cases presented due to the shortage of time and other reason It has become a sort of daily audit in contrary to the intended educational uses of the session **Interviewer: Do you think the format of MR be changed?** Short presentation on uncommon cases in the following day The subspecialty units should split and cases must be discussed in some detail at the unit level	
F5 MR helps to know the 24 hr. emergency activity of the department and helps me in planning the daily activity It is also helpful to communicate with the residents and consultants. I use MR to know who is who. Who is more important in caring the patient It has achieved it purpose partially. But recently it has lost its momentum. This could be probably due to increased patients and short duration. The residents and consultants who avail themselves are passive in the discussion. Some of the residents may not be listening what is being discussed MR has a role in improving prioritizing and triaging of patients The residents have the opportunity to learn how to take care of patients The educational purpose is compromised and it is not a good media for skills training Helps also in the development of communication skill and shaping the attitude of the residents towards patient care in compassionate and respectful fashion Helps in addressing the logistics and administrative issues The format should change because the service is expanding , academic and post graduate training is expanding. The session should be geared towards to more focused and deeper discussion. Patients should be managed by relevant unit and the sessions be conducted at the unit level. This won't affect the general surgery training qualities the residents will have the opportunity to participate these sessions when they are attached to the specific units Short presentations on uncommon cases The sessions should be conducted with due respect for the residents and consultants	Report of emergency activity Social venue Achieving purpose partially Discussions not heard Less participation in discussion Patient prioritization Poor venue fro skill transfer Communication skill development Attitude development Role modelling Addressing Logistic and admin issues Compromised educational purpose Deeper and focused discussion Subspecialty MR Short presentation Due respect for residents and consultants Improved attendance from residents and consultants

Consultants from different subspecialty units should avail themselves to increase the benefits from the discussion	
F6 Purpose The purpose of MR for me is more of teaching residents and interns. It is also a kind of daily audit to know the 24 hr. emergency activity the department. It also helps in handing over management left overs. I feel that it has achieved these purposes partly. We are facing low attendance by interns, residents and consultants. The decisions made during the session are not passed to the responsible body on time. Like shortages and admin challenges faced are not addressed on time It has a role in patient care quality. The consultant will have the chance to be informed about the cases. That in turn helps in optimizing the patient care by including additional treatment options and changing those which are not helping the patient. As a teaching hospital I feel that the teaching role of the MR is more than the service. Most patient who present during the emergency hour are managed by residents. The treatment may not be optimal and in rare circumstances the patient could be mismanaged. Residents will have the chance to learn from the discussion during MR. The MR we are conducting is more of traditional. We are conducting just the way We saw our seniors had been doing. It is not innovative The working condition during the duty hours is not conducive. Residents are challenged with lots of shortages. The session is also intimidating for some residents. These days we are having lots of residents with few exposures. They may not be confident when they present during the session. The feedback given by some consultants can make the resident feel uneasiness. MR can also be used for research purposes. The format of the session be changed. It should be conducted in the form of discussion rather than a report and moderator format. Many feel it is long especially on Mondays where there is a three day activity report	Primarily educational Daily emergency activity audit Handing over emergency left overs Partial fulfillment of it purpose Low attendance of interns, residents and consultants Betterment of quality of patient care Optimum patient care Adding treatment and amending mismanagement Traditional not innovative MR Suboptimal working condition Uneasiness of the MR environment Higher number of residents with limited exposure Lack of confidence Negative feedback

Appendix F: Encoded Data from Third and fourth year general surgery residents Focus group discussion

Evidence from the participant	Codes
Moderator: What do you think are the purposes of morning session?	24-hour duty activity report
3A. Reporting on what has been done in the last 24 hours. And it doesn't have educational purpose.	Not educational
3B. It has a role in the quality of patient care. The residents are the front line doctors and the respective consultants are also on duty. The session is meant to check and recheck the patient care provided by residents. It also helps in assessing the residents level of knowledge and skill. To check the standard by watching what the residents are doing. It is also a venue for the exchange of opinion and helping to reach at the consensus for challenging cases	Monitoring patient care Assessment of residents Management of challenging cases
3C. I agree to what has been said by colleagues. During the duty times it is not only the residents but also the seniors are also duty. The main issues are the academic purpose. We learn from what we did right and from our mistakes. Additional options of patient management are also discussed. Administrative issues are also discussed. In one of the peripheral hospital where we attach there is one consultant who is assigned and he regularly asks us the administrative problems we face.	Mainly academic Learning from mistakes Other option of management
3D. In some hospitals occasionally the admin people do attend the session. In TASH Department of surgery, we discuss about the admin issues usually once per month during the monthly audit session and we submit the summarized document to the admin people.	Logistic and admin issues raised Can be used for research
3G. It also helpful for a research purpose. Though the MR activity is documented manually it also helps in the research purpose. What is documented can be utilized for research purpose. It is also assessing other members of the team. Surgery is a team work. It comprises anesthesia team the nurses and other supporting staff. Generally, it is helpful in evaluating the hospitals activity	Assessing the performance of other members of the team Evaluation of the hospital service
3F. Helps in the development of communication skills and we acquire the skill in making a presentation in front of a bigger crowd.	Development of communication skill
3B. In general, I expect what has been mentioned. We acquire knowledge from the different consultant while they are sharing their experience.	Presentation skill development
3D. Cases which are challenging and complex get a good decision during the MR. All the senior contribute and share their experience and we benefit out of these discussions and get knowledge which may not be readily available from reading books. It is also a good opportunity to learn from consultants whom we may not have the chance to meet in rounds, operation theatre and other activities of the department.	Learning from senior's experience Opportunity to gain from other consultants
3B. The duty team is comprised of senior residents, junior residents, interns and other professionals. Next to the duty surgeon the senior resident is second in command. It is the duty of this senior	

resident to lead the whole group. Hence it also helps us develop our leadership capability 3E. Increases our skill in presentation Our style and way of presentation gets improved from day to day 3C. Makes us more responsible for whatever we are doing 3G. It will help us defend what we did based on the scientific basis of the management	Developing leadership capabilities Improvement in presentation skill Executing responsibility
Moderator: What is the role of MR on the quality of patient care? 3B. Different consultant from different subspecialty attend the session. The management given to the patient may not be optimal one or there might also be a different way of treating the patient. Hence the comments given by these different experts will increase the quality of service rendered 3A. Clinical judgment and decision making skill of the residents will be augmented from the suggestion of the different consultants 3B. It has great role in management of patient care which can increase patient satisfaction. 3C. Helps to fill the gap in the information exchange between the resident and consultant. Patient information is communicated well both horizontally and vertically 3A. Helps in the assessment of resident's performance Moderator: Should the format be changed? 3E. The format of the morning session is ; One of the consultants moderate the session; The duty senior resident will present the procedures done; The junior residents will report what is done in the emergency OPD, the wards and ICU. The interns also present the inpatient activity during the 24 time. I feel that the educational purpose is not achieved. Rather than teaching it has a sort of blame game It doesn't give the opportunity to learn from the mistakes committed. The consultant also tells you the management decision needed for the patient. They won't tell you the approach they used to reach that decision. The session focus on the report of routine activity. We are asked what we did. It doesn't give the opportunity for residents to explain the scientific basis they used to reach at a specific decision. Adequate emphasis is made with regard to the patient care. The duty consultants will go and evaluate those patients who need special attention. That increase the patient satisfaction 3A. I agree what my colleagues have said. We got the opportunity to see the morning session in the department of Orthopedics. It is different there and I have learnt a lot from them. The session there offers an academic opportunity which we lack in the department of surgery. 3F. In the format there is a space to document the referred and kept patients. There should be a space for reasons for referring patients to other hospitals. That is more important than documenting the number only. It will help in rectifying the reason behind the referral.	Contribution from different Subspecialists Optimizing patient management Increased quality of care Clinical judgment Decision making Patient satisfaction Filling communication gap Resident's assessment Team work Blame game Learning from mistakes Process of decision Routine activity Scientific basis Good patient care Opportunity for treatment by consultants Better academic environment Changing the format

3C.	It is not achieving the educational purpose. The Session gives emphasis only in reporting what is done. There is a sort of blame game. When we are preparing the report we are preoccupied by what some consultants might criticize us. Rather than what I might get from the session I feel scared. Residents are trainees and sometimes the session lacks that component and focuses on the blaming. This doesn't mean that all consultants are the same. There are some good ones	Not academic Blame game Uneasy environment
3E. 3F. 3D. 3F 3C. 3D. 3B.	The MR in the department of surgery in TASH is being divided into more subspecialty units. Neurosurgery, Urology, pediatric surgery has started their own session. This has affected the quality of general surgery training. Even though we may not do the activities and surgeries done by these different subspecialty units especially the pediatric surgery activity, we used to learn a lot from what they were reporting when they were presenting in the general surgery MR. It would have been good if the MR is not split and conducted together There should be a joint session at least ones in a week by the different subspecialty units for those cases which might need a joint decision. The session is different in different hospitals. In Minilik II Hospital the attendance is mandatory and is more educational. In TASH it looks that the attendance is not mandatory. The educational component is not attractive. There should be a mechanism to make it educational and more attractive There are many consultants who are friendly and teach us in the morning session. The approach from some of the consultants is not friendly and it makes the session to be unease. Rather than emphasizing on the weakness and wrong side of the residents it would be good if emphasis is made on area of improvement. This can create a communication gap between the residents and the consultants. Residents will not have the motivation to communicate their concern about the patient management The frequency should be on the daily basis. Making it infrequent will make the session long and that in turn can affect the other daily activities like the referral clinic and the operation theatre schedules. The Monday MR is a good example where we report 3-day activity and the session sometimes will be finished after 9:30. No problem in the format of the reporting paper. It is helpful in reporting It is helpful in doing research. I don't have a problem with frequency. It is good it should continue like that. The area of improvement is the communication with consultant and making it more academic	Unit level MR affects the training Joint MR Reinforcing Attendance Unfriendly environment Emphasizing on the weakness of the resident Gap between resident and consultant Daily session Better communication with consultant Improve the educational component
3E.	I share the previous speaker's idea. Use of power point presentation is also another option. We are using manual documentation. It is a possibility. I think it will not significantly affect the MR.	Digital presentation

	Preparing the power point presentation is an extra burden to the senior resident.	Difficult to implement the digital presentation
3G.	Digital documentation is a good idea. Moving from paper documentation to the digital is good idea. But I don't think it will be applicable. We have difficulty in retrieving the images with the present status of internet connection. It can affect the patient management. If we have good internet connection it is a good idea.	Attempted but didn't work
3A.	The digital Presentation was tried in our department too. It complicates the Life of the resident. It is time consuming. It need to be simple and fast and applicable to our setting	Consultant as moderator
3B	Especially in TASH. We have a good moderator.	Good if resident lead MR
3G.	A consultant leading the session doesn't have negative impact.	Not audible
3C.	The consultants leading the session is good. He is more experienced in every aspect.	Scary environment
3F.	If a senior resident moderates it will help him develop the leadership capabilities and coordinating character to attain confidence. If a resident leads the session. I feel that I am presenting to a colleague. It makes me comfortable as opposed to if I present to a consultant. It decreases the burden on me and eases the environment. I feel more confident. There are times when we feel the consultant should lead the session like when we have challenging cases	Shared responsibility
3B.	The main issue is the intention of the moderator. If residents are leaders of the session, since he wants to learn more He will try to make the session as educational as possible as opposed to a senior who may try to shorten the session because he has some other commitment	
	Moderator Any comment on the modification of the format? How about the duration?	
3A.	It should depend on the number of cases and the number of days of activity	
3G.	It shouldn't be more than 1 hour if it is a 3-day report, if it is more than that it will affect the other activities If it is 1-day report the presentation and the teaching activity should not be longer than 30 minutes	
3B.	To improve the academic activity makes the session more educational. It will increase the interest of the residents. Sometimes the discussion will be between the presenter and the consultant. It may not be audible and the other residents will have difficulty in following the discussion. In some departments they use loud speaker and we can adopt that too. Generally, the atmosphere of the MR in the department of surgery is not as frightening as other departments from what we hear from our colleagues in other department In other department the starting time is early like 7: 30. That will be difficult to adopt in our department because of the transport and other issues	
3E.	The atmosphere of MR in TASH is scary. When you report, you will be distracted by the criticizing comments from consultant in front of the crowd. That can affect your confidence. In other	

affiliated hospitals like ZMH we present without any tension. the consultants are friendly and whatever comments they have they give you the comment in private without intimidating you 3B. In Surgery almost all responsibility lies on the shoulder of final year resident. Junior residents are excused. If it is possible Responsibilities should be shared by the junior resident to and any wrong doing by the junior should be the responsibility of the respective resident. The OPD activity for example is covered by the junior resident and he should be accountable for all the activities of OPD. The senior resident should act as the overall team leader	
Moderator: What do you think are the purposes of MR? 4A. I understand it in two ways. The first is transferring the skills from what we have done the 24 duty time to other residents and seniors. The other is to acquire knowledge and use it when we face other patients. To learn from the mistakes, we made. It has educational purpose too. Helping patient management and skill transfer. 4B. It has two main purposes. The first is academic. Since we are in a medical school, where both undergraduate and post graduate trainees are there. The second is patient management. The duty team present case during the session. Discussion will be made on Whether the cases are managed rightly or wrong, and to fill the gap and decide on the future management of the patient what should the to come up with the best management of the patient The third is administrative issues. The deficiencies and challenges are reported and discussed and will be acted upon accordingly. 4C. MR, generally be it academic hospital or nonacademic it is conducted wherever there is clinical service. In Nonacademic it is report of the 24 our report of clinical activity and the management of the cases will be discussed In Academic institution it has three purposes The first is h Reporting what was done. The second is how was it done, the way of management this is the academic part The third is administrative purpose and the last one is decision making. The decisions done on individual level will be discussed more options of management will be included that will help the management of the patients 4D. Helps the hospital to assess itself as service provision institution. The amount and kind of and quality of service is audited. 4E. It is also the venue for the development of the communication skill of the resident. .	Activity report Learning from mistakes Academic and patient management Admin issues Emergency activity Admin issues Decision making Evaluation of hospital activities Communication skill development
Moderator: Does MR is achieving its intended purpose? 4A. We are trainees and have attachment in other affiliated hospital of the department like Minilik II hospital Yekatitit12 Hospital and	No space for admin challenges

	Zewditu memorial hospital. Are you asking us our experience from TASH or the experience also includes our experience in other affiliated hospitals too.	Academic purpose achieved Admin issues not emphasized Academic not achieved Admin issues in monthly audit No detail for consultation and referrals Chief resident can lead Moderating is facilitation Daily MR is advantageous
Moderator:	It should be your overall experience be it here or in the other affiliated hospitals	
4F.	The response to this question is different for the different hospitals. The format is different. In other hospitals the space itself is not adequate and the format is different The form we are using has no space to report the admin challenges we facing during the duty hour except for patient service and the academic aspect. The form doesn't have space for other admin challenges we face during the duty hours in TASH the academic purpose is achieved. In other hospitals like Yekatit 12. It has lost its academic purpose. There we do only report the patient care service.	
4G.	The admin issues we are raising are not given due attention. During the duty hour we face shortage of supplies, electricity, water, drapes needed for operation. Though we are reporting this whenever we get the opportunity they are not taken seriously and not solved. The academic component of the MR is not also achieved fully.	
4B.	The admin issues are not discussed daily. They will be raised once in a month usually during the monthly audit sessions. OR tables are not working, no porter and the like. These issues are not addressed timely. Even if these are discussed during the audit session, they are not addressed. It would be good if the admin people are attending the session	
4I	Consultations and referrals are also documented. But there is no detailed information about each.	
4A.	I have reservation on documenting on all cases who are referred. It is not feasible. Kept and referred patients are discussed even though it is not documented	
4D.	The duration varies. We can't make a specific duration for all the sessions. It should be dependent on the number of duty days and the cases operated	
4A.	In TASH there is one specific consultant as a moderator most of the time. This has to be encouraged. It helps the follow up of patients reported and reduces the time needed to report in the subsequent days. This has to be encouraged in the other hospitals too. Even if it is not possible to assign one consultant permanently, it would be good if somebody is assigned for a longer period in rotation to achieve the above advantages	
4E.	The chief residents can lead the MR. They have a better insight about scenario	
4A.	The condition in surgery is different from other departments. There are different units and services given. It would be difficult for the resident to handle the discussion	
4B.	The moderator of the session should have the capacity of teaching. There are times when feedback and corrections given to	

	the consultant. This will make the MR difficult to be moderated by a resident. The most experienced consultant should lead the session. It facilitates the teaching and provision of feedback. Imaging is discussed well especially in TASH. This can be augmented by displaying the intraoperative finding which might help both residents and consultants to learn from the cases presented.	
4C.	MR is led by chief residents in other departments. The presenters in these department are junior residents which make the moderation by senior residents easier. In surgery the presentation is done by the most senior member of the duty team and this should be moderated by experienced surgeon.	
4E.	Leading a morning session is all about facilitation, communication and leadership. The decision is not the most important part of moderating the morning session. The chief residents can bridge the gap between the consultants and the residents. MR can be moderated by the chief residents. In the time of difficult and challenging cases, the responsible consultant can be invited to comment and share his experiences. Even in the presence of the senior consultant as a moderator, he is not the ultimate source of decision. He asks the experts from the different subspecialty unit to comments and decision. Even the consultant moderator is the source of expertise in his subspecialty field only	
4D.	MR is conducted 4-5 time per week. I feel that it is unnecessary. I don't see the benefit of this daily session. It affects the referral clinic and other activities of the department. It also interferes the OR times. Sometimes there is a long and unnecessary discussion for a routine and common cases. It should be done thrice per week	
4C.	Conducting the sessions daily has immense advantage. It makes the joint decision made to the patients to be timely. It helps patients get proper decision in less than 24 hours I don't feel that it affects the other activities of the department. It is done 3X week in other departments but they have different kind of cases. In fact, making it infrequent will interfere in the daily activity of the department by increasing the time spent in each session. Daily sessions facilitate the flow of information and follow up of the patients. The duration of the session can be adjusted by the moderator by making the discussion to focus on more important and rare cases.	
4H.	I agree. The daily frequency has no disadvantage. Rather making sessions infrequent makes the individual sessions to be long	
4I.	Making the session every other day is advantageous. Making the presenter to get prepared on the cases he managed during the duty hour and facilitate the educational values of the session. On the other hand, making it daily will have a great help in the patient care and follow up.	
4J.	Sometimes those patients who are admitted on Friday may wait till Monday for some decision. It would have been good if consultants spend the duty in the hospital and even can conduct the MR during the weekends. So I prefer sessions be conducted daily i.e. 7 times in week	

4A. I don't agree with this. There are duty consultants daily and are involved in the patient management timely. 4D. For a short duration of 20- 30 minutes, there is no need to make it infrequent	
Moderator: What do you think are the role of MR in the improvement of quality of patient care? 4I. The joint decisions will bring the experience of the different consultants together. That really increases the quality the department is providing. It helps in evaluating the care given by the hospital. Discussing the admin problem also help improving the care the hospital is rendering 4B. MR means right management, right decision and best follow up which will at the end improve the quality of care we are giving 4E. Residents are the first line doctors who are managing patients. If there is mismanagement or the management is not optimal, presentation of the cases during these sessions helps in optimizing the care being given from the suggestions of the more experienced surgeons 4A. In addition to what has been said, patients managed overnight will visited by the duty consultant right after the MR. This will in turn increase the patient satisfaction and will let the patient to get access to the most experienced surgeon	Joint decision Admin issues Optimizing management Right management, decision and follow up Patient satisfaction
Moderator: What educational values do MR have? 4B. The best I get from the session is the decision skill. The theoretical gain I got is not that much. The contribution from the different consultants can be applied when we face similar cases in the future. 4C. Helps to learn the updated and recent management recommendation from the attending 4D. We get management experience for our setting. We can read and get theoretical knowledge from the developed world. The context specific options of management of our patients can be obtained from the experience of the consultants 4A. The experience of the senior surgeons helps us how to manage patients in resource constrained setting like ours 4G. Some of the surgeons have been practicing surgery before we were born. Reporting on what I did in front of these giant surgeons builds my confidence	Decision making skill Updated management option Context specific management Learning from experience Alternative options not discussed well Leadership skill Scientific basis of care given

4C. I feel that the alternative options are not discussed well. Moreover, the scientific basis of the cases we managed is not given due attention 4F. Surgery is a team work. The senior surgical resident has a leadership role. If there is a gap in the team work, indirectly the leadership capabilities of the senior resident will be questioned 4A. It is clearly documented in the evaluation form of the resident what the components of the assessment of are. MR has a clear role in the evaluation of resident 4B. It is clear that what we reporting is what we done in the last 24 hours of our duty. So the report reflects the residents' different skills. Does he know when and when not to do surgeries? Does he know his limitations? How is his decision making skill? What are the leadership qualities of the resident? I feel that it is the major aspects of assessment	Team work Resident assessment
Moderator: What gaps did you notice in the current format of MR? 4B. There is no space for documenting the administrative problems we face. There are many times where we face lack of supplies? Electricity, water, etc. These should be documented and communicated to the responsible body 4F. The attendance of the consultant is not full. More attendance means more participation and that will increase what we gain out of the session. 4B. Now the different units of the department have started their own MR. Neurosurgery, Urology, and pediatric surgery units have started their own session. Especially the departure of the Pediatric surgery unit from the MR will create gap in in my future carrier. We are expected to manage many pediatric surgical cases in the future. The skills and knowledge we get from our placement in the unit can't replace all what we used to get when the unit was presenting its activities in the general surgery MR.	No space for Admin issues Less attendance Subspecialty MR
Moderator: Should the format be changed? 4E. The paper format we use should not be changed. It is concise and to the point. 4J. The paper format can be changed. It lacks the space to document the details of the consultations made. Whom and when was the consultation made, the name of the consultants consulted? The details of the procedure and the accidents encountered during the surgery is not documented in the present format. 4F. We can take the experience of the department of orthopedics. We can digitalize the presentation. This can avert what we were mentioning as a deficiency of the paper format. 4D. There was an attempt in our department to use power point presentation during MR. But couldn't continue long. It is tiresome. Rather we can make the reporting paper to be 2 pages and include those missed parts of the MR	Lacks space for details Digital presentation Enhances audit and research Audiovisual is better than hearing alone Catches the attention Junior resident prepares the power point Electronic chart keeping

4I.	Power point presentation is good. It will be helpful for clinical audit and research purpose too. Data is documented well and we can retrieve it whenever we want it. It helps us in alleviating the missed information of the manual documentation we are using.	
4E:	The time needed for preparing the power point shouldn't be an issue. Somehow we spend time for the preparation of the paper presentation too. The power presentation has great role in incorporating the intraoperative images and video, and radiologic studies. This will have great role improving the educational values of MR. Using this audiovisual instrument is very good. The presentation will be legible and accessing data will be easier. It is valuable both for the patient care and the educational purpose. Especially for the rare cases, the pictures of the actual pathology and the imaging will be more informative and educational both for the residents and consultants. After all hearing is not a good way of knowledge transfer as using audiovisual aides. When we are attending the verbal presentation, attentions can be distracted easily.	
4H.	I have reservation in the copying what is done in orthopedics. The scenario there is different from the scenario of general surgery. There the surgery is done by the final year resident and reporting by the third year resident. Their patients have a short history and the imaging they use is usually x rays. Here in general surgery the history is long and the imaging we use are mostly CT scans. This makes preparing power point presentation tiresome and time consuming.	
4I.	Responsibility can be given to the junior resident in the preparation of power point presentation.	
4E.	In addition to what I have said, the hospital is introducing the electronic chart keep system. Whether we like it or not we are heading towards using the digital system in reporting MR too	
4J.	Last time when I was preparing the monthly audit I got serious problem in retrieving the documents. Had it been documented digitally, it would have been easy. In the present day of electronic world, we have to start using this power point presentation.	
4A.	If that is the case, we can still use the paper format for the presentation and later we document it in soft copy	
4I.	The junior resident can be involved in the preparation of the soft copy. The senior resident will do his usual activities. This makes the junior resident to be involved in the care of the patient in a responsible manner	
4B.	We have to prepare the power point in a short format. We need not write the details of history and physical examination finding	
Moderator:	Any comment on the role of MR on the development of communication and social skill?	Confidence development Communication skill
4E.	When we start reporting MR, we had difficulty but later we developed confidence in reporting	

4A.	When we are on duty we have to communicate with different members of the duty team. We have to communicate with resident, Nurses, and other supporting staffs, Hence MR has good role in developing our communication skills	Punctual Disciplined
4E.	It helped us to be punctual.	
4D.	It has also made us more disciplined	