Morning Report

Rules and regulations

Objectives of Morning Report

-The residents will learn how to prepare pertinent H&P’s with the help of his/her senior colleagues. Please follow the format given below.

-The morning report is an “exercise” of encoding diagnosis based on the symptoms given by the patient. You encode the diagnosis to be decoded by your peers and your attendings. It is also an exercise of differential diagnosis, one of the “prides” of internal medicine specialists.

-As much as possible, the presenting team should stick to the real presentation of the case, without “hiding” information. It is OK to hold information until requested by the audience.

-The goal is to learn from difficult and atypical patients but also to go over basic cases, we have to cover in our internal medicine curriculum as listed below.

-In many instances, the approach to symptoms and the analysis and synthesis of physical and laboratory findings and following the most cost effective sequence is the most valuable experience acquired in the morning report. Arriving at the right final diagnosis is, of course, ideal. In some cases, the final diagnosis might have not been reached yet. By following a systematic approach one can arrive at list of differential diagnosis by using categories such as Infectious (bacterial, viral, fungal, protozoa), Neoplastic, Vascular, Inflammatory non-infectious (vasculitic, collagen vascular diseases), Metabolic (endogenous or exogenous), Drug-induced, nutritional, congenital conditions. Be ready to present data ruling out the list of potential diagnosis.

Time: Morning report will start promptly at 7:30 am until 8:30 am

Location: Auditorium A unless otherwise specified.

Presenting team: The presenting team is the one on long call. ICU team will present their cases on Fridays. Cardiology morning report will be the third Thursday of the month.

Participants: PGY-I (Medicine and Rotating) residents, Senior Residents (PGY-II or PGY-III), Faculty leader of the team and guests faculty. Please contact specialists in advance if pertinent for your case. Make sure you discuss case with your senior resident and your attending before presentation. If there are mistakes or issues with the case, you do not want to be left alone. Have a scribe noting the most relevant information and suggested diagnosis on the white board as you are presenting. The post long call team is exempt of attending morning report.

Moderator: there might be a moderator such as a faculty physician, but in their absence the chief resident or the most senior resident takes over the discussion and asks questions to the audience that might be pertinent to the case or will illustrate a teaching point.
H& P Format for Morning Report

Chief Complaint: Pick one only, the one that will guide your case presentation. It’s OK to edit the patient’s words sometimes to make it more understandable e.g. patient might say “my kidneys hurt” it’s OK to say “Back or Flank Pain”. Look at ER triage sheet and see if that chief complaint makes sense. State duration of the complaint using time of admission as reference point. With this alone the discussion can start.

HPI: Start with the phrase: Age ____ year old male/female with history of (give up to three maximum chronic conditions relevant to patient’s condition). The patient was in his/her usual state of health until ________________ (hours/days/months) prior to admission when he/she experienced the ____ (sudden/gradual) onset of ____________. Then proceed to explain all the elements of the chief complaint be it pain, dyspnea, etc... Here you also need to add the Review of System of the affected system e.g. if cc is chest pain, include palpitations, dyspnea, exercise tolerance positives and negatives. Here you also ask questions to prove or disprove particular diagnosis mainly the most “dreaded” ones “diagnostic imperatives” that would kill or complicate your patient e.g. if cc was Headache, you could say “denied this being the worse headache of his/her life” which is commonly used to describe Subarachnoid Hemorrhage.

Past Medical History: Here you enumerate the diagnosis that the patient carries. Make sure you correlate with the medications he/she is taking e.g. if patient takes Levothyroxine, make sure Hypothyroidism is listed. When giving diagnosis such as chronic conditions such as Diabetes, Hypertension, CAD, CHF, HIV/AIDS, it is expected to have a description of the duration of these conditions, presence of complications if known or unknown and some indicators of their control i.e. Last A1c, CBG’s, BP numbers, Ejection Fraction if known, last stress test results if known, last viral load/CD4 count. Find out who their PCP is.

Past Surgeries: name of procedure and reason for it. If possible dates and locations

Allergies: state drug name and reaction and how long ago this happened.

Medications: use generics when possible with doses and frequency. Know reason why a med is given.

Social History: occupation is very important, even if currently unemployed or retired, list the occupation by trade. It’s useful to mention where patients come from, if not from El Paso. Describe use of tobacco, alcohol and “recreational” drugs. Last use, amounts and for how long. If they quit, state reason why they quit. Living situation e.g. single living alone, etc... Pets and if they are sick or not. If possible calculate alcohol intake in grams for the number of years used. If available here you can mention hobbies if ther are pertinent. Mention diet and caloric intake if possible

Family History: Know conditions that killed parents, ages and ask in particularly about Premature Coronary Artery Disease and any similar conditions currently affecting patient e.g. DM, HTN, CAD, Cholesterol. It is OK to present a genealogical tree if appropriate.
**Review of Systems:** Here you ask for at least 4 elements of every system x 12 systems. If it is already mentioned in HPI, you can say as per HPI. At the end always mention all others systems reviewed and found to be negative (if the patient stated that he/she did not have any other complaints)

**Physical Exam:**

**General Examination:** It’s OK to start with a opening statement describing general status of patient e.g. “Patient alert, oriented x 3 and in no acute distress, sitting on his hospital bed”

-Then give **Vital Signs**, add Pulse OX with amount of Oxygen received and Weight if known from ER admission sheet and BMI.

Always follow the sequence: INSPECTION, PALPATION, PERCUSSION AND AUSCULTATION at the end.

**HEENT:**

**Neck:**

**Chest:** Lungs and heart. If describing a murmur be specific with location, intensity, radiation, response to maneuvers.

**Back:**

**Abdomen:** Here it’s OK to auscultate before palpating and percussing.

**Genitalia and rectal exam:**

**Extremities:**

**Neurological:** Cranial nerves, motor, sensory, DTR’s and cerebellar

**Chest XRay:** it’s part of the physical exam and it rules out emergent diagnosis e.g. Pneumothorax, Dissecting Aortic Aneurysms

**Laboratory presentation:** Sequence of CBC and diff, BMP, LFT’s, Cardiac Enzymes, BNP, A1C, TSH Urinalysis. ABG’s if available.

**EKG:** Follow a systematic approach: rate, rhythm, axis, ST and T waves and PR and QTc intervals

**Other imaging studies:**

**Additional slides:** Hospital course if needed
Educational Presentation:

Brief didactic lecture on the topic you and your team selected, taking into account pertinence and usefulness for your colleagues and audience. Include material used in your MKSAP since that is what is absolutely needed to pass the Internal Medicine Board examination and you do not want to leave it out.

Internal Medicine Curriculum:

Use the list below to cover topics during morning report.

1. **Human Growth, Development, and Aging**: Adolescent medicine, Aging and Introduction to Geriatric Medicine, Management of Common Problems in the elderly.

2. **Preventive Medicine**: Principles of Preventive Medicine, Immunization, Alcohol and Substances Abuse.

3. **Principle of Diagnosis and Management**: Clinical Approach to the patient, Clinical Decision-Making, Interpretation of Laboratory Data.

4. **Cardiovascular Diseases**: Congestive heart failure, cardiac arrhythmias, hypertension, coronary heart disease, interpretation of EKG, interpretation of echocardiogram, nuclear medicine imaging, indication for cardiac catheterization.

5. **Respiratory Diseases**: Respiratory failure, COPD, asthma, pulmonary embolism, pleural effusion, interpretation of pulmonary function tests.

6. **Renal Diseases**: disorders of electrolytes and acid-base, acute renal failure, chronic renal failure, glomerulonephritis, tubulointerstitial diseases, vascular disorders.

7. **Gastrointestinal Diseases**: gastrointestinal bleeding, small bowel obstruction, large bowel obstruction, ischemic bowel diseases, pancreatitis, and diarrhea.

8. **Diseases of the Liver and Hepatobiliary Tract**: Viral hepatitis, cirrhosis and portal hypertension, and hepatic failure.

9. **Hematologic Diseases**: Anemias, interpretation of the peripheral blood smear, transfusion of blood and blood products, neutropenia, disorders of the platelets, disorders of blood coagulation.

10. **Oncology**: Acute leukemias, oncologic emergencies, lymphomas.

11. **Metabolic Diseases**: Hyperlipoproteinemias, gout.

12. **Nutritional Diseases**: Principles of nutritional support, parenteral nutrition.


15. *Infectious Diseases*: Septic shock, principles of antimicrobial therapy, pneumonias, UTI, soft tissue infections, osteomyelitis, infective endocarditis, bacterial meningitis, enteric infections, tuberculosis, fungal infections, HIV infection, treatment of AIDS and related disorders.

16. *Neurology*: The neurologic examination, radiologic imaging, cerebrovascular accident, dementias, sleep disorders, seizures