Oral Presentation Guidelines

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The Oral Case Presentation is an art form that requires concerted effort and repeated practice. Although the style of presentation may vary depending on the clinical setting, service, and time available, these guidelines are a good starting point for presentations during post call attending rounds and case conferences.

Principles

1. Purpose of the case presentation: to concisely summarize 4 parts of your patient’s presentation: (1) history, (2) physical examination, (3) laboratory results, and (4) your understanding of these findings (i.e., clinical reasoning)
2. Basic structure
   1. Identifying information/chief complaint
   2. History of present illness
   3. Other active medical problems, medications, habits, and allergies
   4. Physical examination (key findings only)
   5. Laboratory
   6. Assessment and plan
   7. Note: Sections covering family history, social history and review of systems are excluded from the case presentation. If a fact from the social history is relevant to the chief complaint (e.g., homelessness), it should appear in the “history of present illness” section.
3. Basic guidelines
   1. The oral presentation is brief. Its length is always <5 minutes, and ideally <3 minutes.
   2. The oral presentation is delivered from memory (it is OK to refer intermittently to note cards). Importantly, you should try to make eye contact with your listeners during the presentation.
   3. The oral case presentation differs from the written presentation. The written presentation contains all the facts; the oral presentation contains only those few facts essential to understanding the current issue(s).
   4. The oral presentation emphasizes "history of present illness" and "assessment and plan", and the listener’s attention is most acute during these sections (see below). Consequently, good presenters move as quickly as they can from the end of the "history of present illness" to the "assessment and plan" section.
Identifying Information/Chief Complaint

1. Content - contains 4 elements, expressed in a single sentence:
   1. The patient’s age and sex
   2. The patient’s active ongoing medical problems, mentioned by name only, and including only the most important, i.e., no more than 3 or 4
   3. The patient’s reason for presentation
   4. The duration of symptoms

2. Examples:
   "Mr Smith is a 42 year old man with diabetes mellitus and hyperlipidemia who presents with 3 days of intermittent chest pain"

   "Mrs. White is a 59 year old woman with prior diagnosis of breast cancer, rheumatoid arthritis, and hypertension who presents with 2 months of bilateral leg weakness"

   "Mr. Jones is a 48 year old man who is transferred from Juneau General Hospital for further evaluation of a left lung mass"

3. A litmus test for a successful introductory sentence is being able to answer "no" to the following question:

   "Do any surprises appear after this sentence?"

For example, if a presentation begins with "A 46 year old man presents with 2 weeks of dyspnea" but then reveals 2 minutes later that the patient is "HIV positive", your listener (who has been trying to solve your case from the initial sentence) will suddenly realize that all of his or her clinical reasoning has been flawed.
History of Present Illness (HPI)

The HPI is the fundamental part of the oral presentation and the source of 90% of correct diagnoses.

1. Content
   1. All "positive" elements (i.e., what occurred) precede all "negative" elements (what was absent)
   2. "Positive" statements:
      a. Are presented in chronologic order
      b. Are attentive to detail
         * Frequently used descriptors include patient's own words, whether intermittent/constant, duration, frequency, whether changing over time (progressive, stable, improving), aggravating/alleviating features, associated symptoms, prior episodes, attribution (i.e., the patient's own interpretation of his or her symptoms), and, if pain, quality, location, depth, radiation, severity (1-10 scale)
      c. If the current problem is a direct extension of a previous ongoing active medical problem, the HPI begins with a 1-2 sentence summary of that ongoing medical problem, using "key words"
         1. Date of diagnosis?
         2. How was diagnosis made?
         3. Current symptoms and treatment?
         4. Are any complications present?
         5. Are any objective measures of the chronic problem available? (e.g., a1c for diabetes, FEV1 for COPD)
   3. "Negative" statements – include 3 categories of findings that, although absent, are important to mention:
      1. Constitutional complaints (fevers, sweats, weight change)
      2. Symptoms relevant to organ symptom (if the patient has chest pain, report here which chest symptoms were absent, i.e., cough, dyspnea, sputum, hemoptysis, dysphagia)
      3. Important risk factors (ask yourself the question "what could my patient have been exposed to cause this problem?")
   4. Prior workup to date (e.g., if the patient is transferred from another hospital), and status on transfer.

   (Some presenters prefer inverting the order of #3 and #4...try both ways and see which sounds best to you)
2. Examples

Identifying information/chief complaint – no surprises after this sentence

Mr. Smith is a 62 year old man with coronary artery disease, diabetes, and hyperlipidemia who is transferred to our hospital for further evaluation of 3 weeks of episodic chest pain.

You believe his present illness is a direct extension of his prior CAD; therefore you begin with a 2 sentence summary of his prior CAD, using key words describing date of diagnosis, how diagnosed, and objective measure (perfusion scan)

Mr. Smith has a long history of coronary disease, originally diagnosed 5 years ago when he presented with crescendo angina was found to have 3 vessel disease and underwent 3 vessel CABG. A myocardial perfusion scan 2 years ago revealed no evidence of ischemia.

"Positive" elements, emphasizing (1) chronology and (2) attention to detail

He was in his usual state of health, without angina or other chest symptoms, until 3 weeks ago when he noticed the gradual onset of episodic chest pain and dyspnea. He describes his chest pain as a "tightness" or "vise-like" sensation, 3-5/10, occurring once or twice daily, usually lasting minutes at a time, located deep in his left chest without radiation, mostly occurring during exertion but also occurring at rest and waking him at night, and associated with dyspnea. This morning, while eating breakfast, he experienced a more severe version of the identical pain, 8/10, which did not resolve until 30 minutes after lying down and taking 3 nitroglycerin tablets.

"Negative" elements, including constitutional complaints, other organ-specific symptoms, and important risk factors

There is no history of fever, weight change, cough, sputum production, hemoptysis, dysphagia, or edema.

The patient is a diabetic and has a strong family history of coronary disease. He does not smoke and his LDL cholesterol 6 months ago was 82.

Workup for current problem but before he came to your hospital

The patient went to an outside emergency department this morning for evaluation. Although he was pain-free, his electrocardiogram revealed T wave inversion in leads 1, L, V5 and V6 which was new when compared to a tracing 1 year ago. His creatine kinase and troponin levels were normal and he was transferred to our service for further evaluation.
Other active medical problems, medications, habits, and allergies

1. Content
   1. Brief summary (using key words, see III-A-2-c above) of other active medical problems mentioned in your identifying information sentence
   2. Medications - Some teachers want to hear actual dosages; others do not. Ask ahead of time.

2. Example

   His other problems include a 10 year history of diabetes mellitus, without retinopathy, neuropathy or nephropathy. An A1c 6 months ago was 6.8. His current medications include his NPH insulin, glyburide, isordil, aspirin, metoprolol, lisinopril, and simvastatin. He does not drink alcohol and has no allergies.

Physical examination

1. Content
   o Begin with "general description and vital signs"
   o Include all abnormal findings
   o Among normal findings, include only those essential to the understanding of the chief complaint

2. Example

   On physical examination, he appeared in no distress and was pain free. His blood pressure was 120/80, pulse 80 and regular, respirations 18, temperature 98.4 and oxygen saturation is 98% on 2L. There is no goiter. His lungs are clear. Estimated central venous pressure is 8 cm water. There is no precordial pulsation or chest wall tenderness. There is a left ventricular S4 but no murmurs or rubs. His abdominal examination is normal and there is no edema.

Laboratory

1. Content
   o Include all abnormal labs, with comparison to previous value
   o Among normal labs, includes only those relevant to the chief complaint
   o Any labs presented should appear in traditional order (electrolytes/creatinine/glucose, complete blood count, other chemistries, urinalysis, CXR, ECG, gram stains and analysis of body fluids)

2. Example

   On laboratory testing, his chem 7 is normal except for a glucose of 160 and creatinine of 1.4 (his creatinine 6 months ago was 1.3). CBC was normal. CPK and troponin at admission and 8
hours later are normal. CXR revealed wires from his CABG, normal heart size, and clear lungs. ECG revealed the inverted T waves in the anterolateral leads as previously described.

Assessment and Plan

1. Content

   1. Begin with a positive statement of the patient’s problem, which is either a (1) symptom, (2) sign, (3) abnormal laboratory test, or (4) diagnosis.
   2. Ask yourself “At the moment I am presenting the case, what is the principal unresolved issue?”
      1. If the principal unresolved issue is diagnosis, your assessment focuses on differential diagnosis: (i) list the 3-5 most likely diagnoses, (ii) state which diagnosis is most likely and why, and (iii) state why other diagnostic possibilities are less likely (draw your evidence from the H and P you just presented).
      2. If the principal unresolved issue is therapy, your assessment: (i) states the diagnosis or problem, (ii) states which therapy you gave or plan to give, and why you made this decision, (iii) states which complications you might anticipate.
   3. If you are presenting the morning after overnight call, the case presentation usually ends with a 1-2 sentence summary of what happened overnight, after implementation of your initial decisions.

2. Example

   In summary, the patient has progressive episodic chest pain that is classic for crescendo angina because of its exertional nature and the patient’s known coronary disease. Pericarditis is less likely because of the absence of characteristic rub, pleuritic pain and ECG of pericarditis. Dissecting aortic aneurysm is unlikely because the pain is episodic and there is no pulse differential on examination and no widened mediastinum on CXR. Pulmonary embolism is unlikely because he has no risk factors and we have a better alternative diagnosis.

   We treated him overnight as unstable angina, using enoxaparin, aspirin, and metoprolol. He had no further pain and overnight telemetry revealed only sinus rhythm. This morning’s ECG is unchanged from admission. We plan to obtain cardiac catheterization later today to better define the etiology of his pain.

Delivery Tips

- Be aware of your posture.
- Maintain eye contact - glance at your notes only as necessary.
- Present with a clear, energetic, and interested voice. You have become a "storyteller", and are giving information of crucial importance in the life and care of another human being.
• Follow the outline of the OCP in a linear fashion - do not skip around.
• Keep your language precise.
• Use positive statements rather than negative statements: "Chest Xray shows normal heart size" is better than "chest Xray shows no cardiomegaly". "In summary, this patient's problem is acute dyspnea" is better than "the patient's problem is rule-out pneumonia".
• Do not rationalize or editorialize as you present, just tell the "facts" as they were obtained by you. Remember, you are telling the patient's story, not your own. Example: at the end of the History of the Present Illness, you would not say: "I would have gathered more information, but the patient's breakfast came and the nurse kept interrupting to change the patient's dressing, administer medications, and check vital signs."