The Oral Presentation

The purpose of the oral presentation is to provide other clinicians with patient information. This must be done in such a way that it tells the patient's story in a logical, clear and complete fashion yet is neither cumbersome nor too long. It is a difficult skill to master and is made more complicated by the fact that different clinical situations demand different types of presentations. For example, presentations given during morning work rounds (the time when the medical team briefly visits with each patient to review their clinical course and determine the plan for the day), are not the same as those given at formal patient management conferences. The first situation requires a focused presentation, with emphasis placed on reviewing new facts and data (e.g. test results, vital signs, changes in clinical course, etc.) and outlining the care plan. The second example calls for a much more detailed discussion. The presenter, then, must take into account the "environmental" factors which determine the type of presentation that is required. These include:

١. The audience to which you are presenting. A group of cardiologists, for example, are going to be most interested in the cardiac history.
٢. The purpose of the presentation (e.g. is it for work rounds, teaching conference, clinic etc.?).
٣. Time available to give the presentation. The longest, most complete presentation should take no longer then ٥-٧ minutes while shortened versions can be given in as little as ١٥ to ٣٠ seconds.
٤. Your familiarity with the case as well as associated pathophysiology.

For the purposes of this discussion, we will focus on the formal/complete presentation as it is probably the form which is most complicated and intimidating. You will find, however, that once you grasp the logic and organization of this process and have an opportunity to practice, your presentations will become both more effective and less anxiety provoking. Tips for presenting during work rounds are provided in the "Inpatient Medicine" section of the Clinical Guide.

In the discussion that follows, illustrative examples are frequently included and have been set off from the text by means of quotation marks and italics.

The Formal Presentation

Chief Complaint/Chief Concern:
The presentation begins with a one sentence description of the patient and the reason prompting their evaluation (i.e. the Chief Complaint). This is a teaser that sets the tone for the information to follow. It should not be too inclusive.

"Mr. H is a ٥٠ year old male with AIDS who presents for the evaluation of fever, chills and a cough over the past ٣ days."

History of Present Illness (HPI):
The HPI is presented in both a problem based and chronological fashion. That is, the dominant problem/complaint serves as the centerpiece of the history. If there is more then one problem, the presenter may try to link them together when appropriate. Information related to this main theme is presented in chronological order. This requires that the presenter go back far enough in time to cover any historical data that is relevant to the patient's main

complaint. Your ability as a presenter to know which past information is important and which superfluous will be based on both your clinical experience and understanding of pathophysiology. At the current time, this might be quite limited. For the above patient, a thorough description would include:
"Mr. H has been HIV + since ١٩٨٧; his CD٤ count in June of '٩٧was ١٥٠ and viral load approximately ٥٠،٠٠٠. Past opportunistic infections have included: PCP pneumonia ١٢/٩٥; CMV retinitis ١/٩٦; and Kaposi's Sarcoma first noted on his skin ١/٩٦. He currently takes ٣TC, AZT, and Indinavir, all of which he has been receiving for approximately one year. He also takes Bactrim Single Strength tablets on a daily basis, along with Fluconazole troches PRN for thrush. He claims to be ١٠٠٪ compliant with all of his medication. He is homosexual though he is currently not sexually active. He has never used intravenous drugs."
This information is not, in a strict sense, part of the present illness. However, it providescritical information that will have a direct bearing on the listener's interpretation of this patient's active problem. Your ability to determine which background to incorporate into your HPI will improve with time and exposure. The details of the patient's acute problem are then presented:
"Until ١ week ago, Mr. H had been quite active, walking up to ٢ miles a day without feeling short of breath. Approximately ١ week ago, he began to feel dyspneic with moderate activity. This progressed to the point that, ١ day ago, he was breathless after walking up a single flight of stairs. ٣ days ago, he began to develop subjective fevers and chills along with a cough productive of rust-colored sputum. There was associated nausea but no vomiting. He has spent most of the last ٢٤ hours in bed. He denies head ache, photophobia, stiff neck, focal weakness, chest pain, hemoptysis, abdominal pain, diarrhea or other complaints. There is no know history of asthma, COPD or chronic pulmonary condition. His current problem seems different to him then his past episode of PCP."

This section documents the course of the patient's most active problem. It concludes with a list of "pertinent negatives" that are meant to exclude, on the basis of history, other possible diagnoses that are known to have a similar symptom complex. In a patient with an HIV related illness, this review might actually be much more extensive than that provided above due to the diffuse, multi-organ system involvement that occurs with this disease. Note that the patient's baseline functional status is described, allowing the listener to gain some sense of the degree of impairment caused by the acute medical problem. If a patient is a poor historian, confused or simply unaware of all the details related to their illness, state this and move on. Historical information can be obtained from family, friends, etc. If this is the case, make sure that you note the source.

If, for example, a patient complains of both chest pain and shortness of breath, they may well be secondary to a single underlying process such as myocardial ischemia resulting in heart failure. When the problems are completely unrelated, the "dominant issue" (as determined by the presenter) is treated first, followed by a discussion of the secondary complaint. This can get quite complicated when multiple problems exist in parallel.

Review of Systems: The critical positive and negative findings discovered during a review of systems are generally incorporated at the end of the patient's history, as was done above. These questions are designed to uncover illnesses which might "travel with" the main problem and attempt to identify commonly occurring complications (e.g. hemoptysis can be a sequelae of pulmonary infection). The listener needs this information to help them put the remainder of the history in appropriate perspective. Any positive responses to a more inclusive ROS that covers all of the other various organ systems are then noted. The extent to

which this is repeated is left to the discretion of the presenter. If it is completely negative, it is generally acceptable to simply state, "ROS negative."

Past Medical History: Note is made of any other past medical problems which the patient has that are not related to the current complaint. Those items mentioned above are not repeated.

"The patient's past medical history includes:

١. *Hypertension x ١٠ years*
٢. *Gastro-Esophageal Reflux Disease*
٣. *Degenerative Joint Disease of the Right Knee"*

Past Surgical History: Any prior surgeries (along with the year in which they occurred) are noted.
"Past surgical history is remarkable for:

١. *Status Post Cholycystectomy ١٩٩٠*
٢. *Status Post Appendectomy ١٩٨٥*
٣. *Status Post open repair and internal fixation of left femur fracture, ١٩٨٣"*

Medications/Allergies: All current medications (along with dose, route and frequency) are mentioned:
"The patient takes the following medications:

AZT ٣٠٠ mg, ١ PO, BID
Indinavir ٧٥٠ mg, ٢ PO, TID
٣TC ١٥٠ mg, ١ PO, BID
Lansoprazole ٢٠ mg, ١ PO, BID
Lopressor ٥٠ mg, ٢ PO, BID
Clotrimazole Troches ١٠٠ mg, ١ PO TID PRN
Naprosyn ٢٥٠ mg, ١-٢, PO, BID PRN
He has no allergies"
Smoking and Alcohol (and any other substance abuse): Cigarettes and alcohol are highlighted because their use is so widespread and the deleterious effects associated with prolonged exposure well documented. Any additional substance abuse (e.g. cocaine use, intravenous drugs, etc.) should also be mentioned.
"Mr. H smokes ١ pack of cigarettes per day and has done so for ٢٠ years. He drinks approximately ١ glass of wine per week. He denies any other drug use."
Social/Work History: This includes a brief description of the patient's work and home environments. Sexual history, if relevant to the oral presentation would also be presented here. Any unusual work-related exposures should be noted.
"Mr. H works as an accountant for a large firm in Boston. He lives alone in an apartment in the city."
Family History: Emphasis is placed on the identification of illnesses within the family (particularly among first degree relatives) that are known to be genetically based and therefore potentially inherited by the patient. This would include: history of coronary artery disease, diabetes, certain neoplasms, etc.

"Both of the patient's parents are alive and well (his mother is ٧٨ and father ٨٠). He has ٢ brothers, one ٤٥ and the other ٥٥, who are also healthy. There is no family history of heart disease or cancer."

Physical Exam: This begins with a one sentence description of the patient's appearance along with their vital signs. In general, only '+' findings are noted. It is also reasonable to mention the absence of certain things that the listener will find helpful in excluding particular diagnoses. If, for example, a patient has shortness of breath secondary to asthma, the presenter might mention that rales, elevated jugular venous pressure and an S٣ were not present, indicating that congestive heart failure is an unlikely diagnosis. Some listeners expect the entire physical examination to be recounted, including "normal findings," particularly if the presenter is a student. The following exam is listed in more detail then is necessary. However, it should give you an idea of how abnormalities as well as "normal findings" are reported.

"Mr. H was seated on a gurney in the ER, breathing comfortably through a face mask oxygen delivery system. Breathing was unlabored and accessory muscles were not in use.

- *Vital signs were: Temp ١٠٢ Pulse ٩٠ BP ١٥٠/٩٠ Respiratory Rate ٢٠ O٢ Sat (on ٤٠٪ Face Mask) ٩٥٪*
- *Head, Eyes, Ears, Nose, Throat: Pupils equal, round and reactive to light; Tympanic membranes pearly gray with cone of light well seen; Sclera anicteric; No thrush was noted; Mucosa was dry and without lesions; There was no appreciable adenopathy; Thyroid non-palpable; JVP was less then ٥ cm.*
- *Lungs: Crackles and Bronchial breath sounds noted at right base. E to A changes present. No wheezing or other abnormal sounds noted over any other area of the lung. Dullness to percussion and increased fremitus was also appreciated at the right base.*
- *Cardiac: Rhythm was Regular. Normal S١ and S٢. No murmurs or extra heart sounds noted.*
- *Abdomen: Symmetric appearing; soft, flat, non-tender; no palpable masses; well healed Right upper and lower quadrant incisions at sites of prior apppendectomy and cholycystectomy.*
- *Rectal Exam: Brown stool in rectal vault, guiac negative; no masses; prostate small, smooth and non-tender.*
- *GU: Testes descended bilaterally; no masses; no hernia; penis without lesions.*
- *Extremities: No evidence of clubbing, cyanosis or edema; Dorsalis Pedis and Posterior Tibial pulses ٢+ and equal bilaterally.*
- *Skin: a ٢x٣ cm raised, purplish, non-tender, non-blanching area noted on left mid-shin; no other skin abnormalities identified.*
- *Neurologic Exam:*

  Mental Status: Awake, alert, appropriate and completely oriented.
  Cranial Nerves: ٢ thru ١٢ tested and intact.
  Motor: Strength ٥/٥ all extremities.
  Cerebellar: Finger to nose well done.
  Reflexes: ٢+ at ankles, knees, biceps and triceps
  Sensation: Intact to light touch and pin prick bilaterally; proprioception normal; vibration normal.
  Ambulation: Normal gait; negative Romberg."

Lab results, Radiological Studies, EKGs: In general, only lab values which are abnormal are mentioned. Similarly, if the interpretation of radiological studies and EKGs are directly relevant to the case, they are discussed.
"Mr. H's lab work was remarkable for: White count of ١٨ thousand with ١٠٪ bands; Normal Chem ٧ and LFTs. Room air blood gas: pH of ٧,٤٥/ PO ٢ of ٥٥/PCO ٢ of ٣٠. Sputum gram stain remarkable for an abundance of polys along with gram positive diplococci. CXR showed a dense right lower lobe infiltrate without effusion."
Impression and Plan: This is your opportunity to summarize the important aspects of the history, physical exam and supporting lab tests and formulate a differential diagnosis as well as a plan of action that addresses both the diagnostic and therapeutic approach to the patient's problems.
"Mr. H is an HIV + male with a low CD ٤ count and high viral load who presents with an acute pulmonary process. The rapid progression, focality of findings on lung exam and radiography, along with the sputum gram stain suggest a bacterial infection, in particular Streptococcal pneumonia. Other pathogens to consider include H Flu and, less commonly, Legionella. While he is certainly at risk for PCP, his presentation, compliance with PCP prophylaxis and statement that his current illness seems different then past PCP infection would argue against this as the etiologic agent. Mycobacterial infection also seems unlikely. Viral infections and neoplastic processes like CMV or Kaposi's Sarcoma of the lung do not generally give this clinical presentation. Furthermore, the data does not support the existence of either a primary cardiac or noninfectious pulmonary process.
The Current plan then is:

١. *Follow up on cultures of sputum and blood.*
٢. *Obtain sputum for silver staining to r/o PCP*
٣. *Begin treatment with IV cefuroxime; Hold off on empiric treatment for PCP.*
٤. *Continue O ٢,with goal to keep sats greater then ٩٢٪*
٥. *IV fluid replacement with Normal Saline at ١٢٥cc/H for next ٢٤ hours to correct mild hypovolemia, with plan to reassess volume status at that time*
٦. *If patient does not show improvement (or worsens) and cultures are unrevealing, consider bronchoscopy as a means of making more definitive diagnosis."*

A Few Practical Tips:

١. Practice, Practice, Practice. Mastering the oral presentation takes time and experience. This will not occur overnight. Early on in your careers, try to avoid presenting "on-the-fly" as it is obviously quite difficult to rapidly assimilate all of the relevant data and present it in a clear and cogent fashion. It's O.K. to use notes, though with practice and experience, this will eventually become unnecessary.
٢. Prior to presenting, think about what sort of picture you are trying to paint and then practice (while at home, walking to the hospital, in front of friends, etc.) doing this. Ask yourself and those listening to you whether the information that you have provided is in synch with the impression that you are trying to create. Are your listeners able to generate an accurate mental image along with a reasonable list of diagnostic possibilities?
٣. Listen to others when they present. Try to identify which elements distinguish concise presentations from those that are confusing or ineffective.
٤. Think about the clinical situation in which you are presenting so that you can provide a summary that is consistent with the expectations of your audience. Work rounds, for example, are clearly different from conferences and therefore mandate a different

style of presentation. Some services, in particular, general surgery and surgical sub-specialties, have very regimented presentation formats that are used for all patients. This is driven by the time constraints and high patient volumes seen on these services. Alternatively, some listeners demand that the presenter, particularly if that person is a student, recount the history in exquisite detail. They may, for example, expect you to list the entire physical exam, including both normal and abnormal findings, as well as the results of an extensive ROS. The only way for you to know what is expected is to ask beforehand.

٥. Try to be thorough without at the same time being long-winded or too detail oriented. Knowing what constitutes the "right amount" of relevant information will obviously take some practice and experience.

٦. Ask for feedback from your listeners. This will allow you to correct errors and improve subsequent presentations.