Societies Program: Doctor and Patient Course

Oral Presentations

The oral presentation is among the most important and most used skill that you will develop. The purpose of an oral presentation is to concisely present the patient’s history and physical examination, applicable objective data and your assessment and plan. You will use various forms of oral presentations to communicate health care information to other health care professionals in many different settings.

Basic Principles

• An oral presentation is a concise, edited presentation of your written H&P; not all of the detail contained in your written H&P need be presented.
• An oral presentation follows a basic structure, as discussed below.
• As you become familiar with oral presentations, decrease your reliance on notes. Do not just read your written H&P.
• There are different oral presentation styles depending on the clinical setting: work rounds, attending rounds, morning report and conferences, obtaining consultations, etc.
• During the first two years of the Societies Program, you will focus on formal presentations that will be appropriate for presenting a new patient to your attending physician for the first time during 3rd year in-patient clinical rotations.

Structure of an oral presentation

The basic structure of the oral presentation follows that of the written H&P. However, the review of systems is generally not part of the oral presentation (remember that pertinent ROS will be included in your HPI). Please refer to the document Writing a History and Physical.

Patient Identification, Source of Information, and Chief Complaint

Here you will simply state the above information.

• Example: “My patient’s name is John Smith; the medical history was obtained from Mr. Smith with input from his wife. His chief complaint is shortness of breath.”

History of the Present Illness (HPI)

The format of the HPI during a presentation is the same as that described for the written H&P. Remember that the first sentence should “frame” the patient and include pertinent past medical history.
Example: “Mr. Smith is a 58 year-old male with a past medical history significant for coronary heart disease, heart failure with reduced ejection fraction and chronic obstructive pulmonary disease who presented to the emergency department last night with a four-day history of worsening shortness of breath.”

The HPI may include some or all of the following (using OPQRST-ADA mnemonic):
- O = Onset; chronology of illness, relative to time of presentation
- P = Position or pattern
- Q = Quality of symptom
- R = Radiation
- S = Severity
- T = Timing; intermittent or constant
- A = Aggravating or alleviating factors
- D = Duration
- A = Associated symptoms
- Pertinent positives and negatives, including epidemiologic risk factors and exposures
- Previous evaluation/treatment for the presenting problem
- What the patient thinks is the problem (“Mr. Smith states that his current symptoms are identical to those he had last year when he was diagnosed with an exacerbation of his congestive heart failure.”)

**Allergies/Adverse Drug Reactions**
State as noted in the document *Writing a History and Physical.*

**Past Medical History (PMHx)**
For your oral presentation, briefly list the patient’s active medical problems, especially if they are major or contribute further to the chief complaint. You do not need to restate the pertinent PMHx that you included in the HPI unless you feel that more detail needs to be given about a particular disease. The following examples are based on Mr. Smith’s HPI started above. In the first example the presenter does not feel the need to elaborate on the PMHx mentioned in the HPI; in the second example, the presenter does feel additional information is needed.

- Example 1: “In addition to that already mentioned, Mr. Smith’s past medical history includes hypertension, Stage G3aA1 chronic kidney disease, and dyslipidemia.”
- Example 2: “Mr. Smith’s past medical history includes coronary heart disease; he has suffered two myocardial infarctions, the last of which occurred one year ago. He was subsequently diagnosed with heart failure and his left ventricular...
Ejection fraction is 30% according to an echocardiogram from 3/2016. His chronic obstructive pulmonary disease is oxygen dependent and he was intubated during an admission for a COPD exacerbation in 2003. His other past medical history is pertinent for hypertension, stage G3aA1 chronic kidney disease, and dyslipidemia.”

**Medications**
List the patient’s medications (using generic names) and doses. Include relevant over-the-counter and herbal medications.

**Social History**
Briefly describe the patient’s current social situation including place and duration of residence, education/occupation, living situation and relationship status, plus any additional information you feel is relevant to the patient’s current care.

**Lifestyle Behaviors**
If not mentioned in the HPI, summarize tobacco, alcohol and drug use (current and past). For past users, indicate duration of use and the quit date. Include any other lifestyle behaviors that are relevant to the patient’s current care.

**Family History**
Briefly describe any medical family history that is pertinent to the current chief complaint. If none is relevant state, “Mr. Smith’s family history is non-contributory to his current complaint.” Note: Your mentor may want you to practice presenting a full family history at first, even if it is not relevant to the chief complaint.

**Review of Systems (ROS)**
The ROS is usually not part of an oral presentation. Remember that pertinent ROS have already been covered in the HPI.

**Physical Examination (PE)**
Vital signs should be presented: blood pressure, pulse, temperature, oxygen saturation, weight and orthostatic blood pressure measurements if relevant. Provide a description of the patient’s appearance and comfort level.

- Example: Mr. Smith presents as a well-nourished male appearing his stated age. He is in moderate respiratory distress and is not able to complete full sentences before stopping for a breath.

Proceed to cover the physical exam in order, using a head-to-toe fashion. Describe all pertinent findings, both positive and negative. Describe what you found; do not
editorialize, diagnose, or make excuses for your physical exam skills. Remember, you are describing only what you found, not what you think you should have found.

- **Example (correct):** “Cardiovascular: Regular rate and rhythm; S1 and S2 are heard without an S3 or S4. There is a 2/6 crescendo-decrescendo systolic murmur heard best at the right upper sternal border and radiating to the carotids.”

- **Example (incorrect):** “Cardiovascular: Regular rate and rhythm. I thought I heard a murmur, but I’m not really good at cardiac exams…it probably isn’t there...”

Your mentor will want you to present the entire physical exam that was performed in order to gain experience. After your mentor is satisfied that you are able to orally present the physical exam, if a physical exam system is normal and not relevant to the chief complaint, you may state “normal” or “unremarkable;” do not do so until you and your mentor have mutually agreed this is appropriate. Additionally, if a system within the physical examination is relevant to the chief complaint, you should not say “normal” but rather describe the normal physical exam as a pertinent negative finding.

- **Example:** If your patient has liver disease but lacks jaundice, on the HEENT part of the physical exam, you would state “sclera are non-icteric” rather than “normal.”

**Objective Data**
Here you will present pertinent laboratory data, medical imaging studies, electrocardiograms, etc.

**Summary Statement**
Here you will provide a concise summary of the essential aspects of the HPI, PE, and objective data. Please find more information on the summary statement in the document *Writing a History and Physical*.

- **Example:** “In summary, Mr. Smith is a 58 year-old white male with a history of ischemic cardiomyopathy and COPD who presents with a four day history of worsening dyspnea. His exam is significant for elevated jugular venous pressure, bilateral lower lobe pulmonary crackles, and bilateral lower extremity edema. His chest radiograph is consistent with pulmonary edema.”

**Assessment and Plan**
Please see the discussion regarding the A/P in *Writing a History and Physical*. The only difference is that you need to be concise during your presentation. During the discussion, if the problem is undifferentiated, focus on the differential diagnosis and which of these you consider most likely.

**Common Mistakes during an Oral Presentation** (in addition to those discussed above)

- **Failure to use parallel reference points.** Relate time in hours/days/weeks prior to admission rather than “Last Thursday.”
- **Editorializing, diagnosing or “bleeding” between sections of the presentation.** There is a tendency to try to explain a physical exam finding or laboratory finding as soon as they are presented – avoid this. The place for your interpretation of the findings is when you discuss the Assessment and Plan.
  - Example: “There is a crescendo-decrescendo murmur...I think this is probably aortic stenosis.” Rather the exam should be described in the physical exam section and the possibility of aortic stenosis discussed during the Assessment and Plan. If the finding is already known (e.g., a patient has a known history of aortic stenosis) and/or is not going to be discussed in the Assessment & Plan, you may describe the finding and note that it is consistent with the known diagnosis. For example, “There is a 2/6 crescendo-decrescendo murmur heard best at the right upper sternal border and radiating to the carotids consistent with his known diagnosis of aortic stenosis.”
  - Example: “The white blood cell count is 23 thousand, which I’m sure is due to the patient’s pneumonia.” Rather the WBC should merely be stated, and the fact that it is elevated discussed as supportive evidence for pneumonia during your Assessment and Plan.
  - Example: “The skin exam showed psoriatic lesions on the elbows.” Rather you should describe the lesions during the physical exam section (“there were several 2 cm round plaques with silver scale distributed on the extensor surfaces of the elbows”) and then discuss psoriasis in your assessment and plan.
- **Reading your written H&P as your oral presentation.** As discussed above, these are not interchangeable.
- **Over-reliance on notes.** In the beginning this is expected. However, trusting your knowledge of your patient leads to a much smoother presentation than constantly looking down at notes to make sure you haven’t made a mistake or omitted information.

**Formal and Informal Oral Presentations**
In the Societies Program, you will present your patient formally one week after your initial interview. You will also present your patient informally to your Society Group immediately after your initial interview and exam. We hope that you will use the above principles during your informal as well as formal presentations. However, we do not expect polished oral presentations during your informal presentations. Rather, relax and have fun with it. As you will see during the course of your career, time and practice are keys to excellent oral presentations.