**Oral Presentations: New Patient**

**(Adapted from Green, Hershman, DeCherrie, Greenwald, Torres-Finnerty, Wahi-Guruaj, Boston University with input from CDIM and COMSEP guidelines)**

**General Concepts**

* Make a convincing case for the important problems, the differential, and the plan.
* Make it structured, organized and targeted, as it should take only 3–5 minutes.
* Determining what is relevant is a sophisticated skill that comes with experience. It can be helpful to ask the house staff ahead of time if you are in doubt of something’s relevance.

**Opening Statement**

* Brief statement of chief complaint and why patient was admitted.
* Include name of the patient’s PCP and site of care. (Good habit, though at UF usually under other history)
* Source, if other than patient
* If the patient cannot give reliable history, briefly note why.

**Present Illness**

* The differential diagnosis you considered should guide what you include.
* Consider starting with: “…usual state of health until…”
* ***Be chronologically organized and clear without analyzing***.
* Remember to include the 7 cardinal features of a symptom: Onset, Location, Timing, Quality, Palliation, Provocation, Associated Symptoms
* Include elements of past history (with supporting studies and therapeutic interventions), meds, family history, social history (including

psychosocial factors) that ***specifically contribute*** to the Present Illness.

* Pertinent positives and negatives to make the listener understand your ddx.

(Pertinent = relevant to the differential diagnosis and management considered)

* Only include ER course if it ***significantly*** affects/alters triage or immediate treatment decisions prior to coming to your unit. (Report facts and events, NOT E/R diagnoses.)
* For ICU or other transfers, summarize course using problem list.

***Other History***

* Important PMH with supporting history/data.(Important= will be addressed during hospitalization)
* Exclude minor diagnoses without impact on current care.
* Important meds with doses of relevant ones. Omit unimportant medications\*.
* Allergies
* Focused FH/SH/ROS. Usually critical information was covered in HPI. Do not repeat previously stated information.

**Physical Exam**

* Always include general appearance and specific vitals.
* Include pertinent (to present illness) elements of exam and any abnormal findings\*.
* Remainder may be noted as “noncontributory.”

**Labs/Data**

* Include pertinent or otherwise significant labs/studies\*.
* Start with basic blood tests first. CBC → Chem → Coags → Urine → ECG → Rad → Other
* OK to mention other tests as being “normal.”

**Assessment/Synthesis**

* Start with a 1-2 sentence synthesis that includes epidemiology, key features (most useful data), semantic qualifiers (e.g. acute vs chronic), **and your working diagnosis**
* Assess and synthesize, don’t summarize and regurgitate.
* Demonstrate your thinking about the patient specific differential diagnosis.
* If multiple issues present, weave together or discuss lesser issues in problem list below.

“Needs Improvement”

55-year-old woman with diabetes and hypertension who presented to the ED with severe chest pain that was diagnosed as unstable angina. Physical exam notable for hypertension initially but otherwise unremarkable. Labs essentially normal with CPK 100, troponin < 0.01. CXR normal; EKG with anterior TWI.

“Good”

55 y.o. woman with 2 cardiac risk factors and progressive 3-day history of chest pain suggestive of acute coronary syndrome

**Enumerated Diagnosis-Oriented Problem List**

* Start with most important problem first.
* Use most specific diagnosis for the problem you can.
* NEVER label a problem solely by its system.
* Include your understanding of the cause of the problem.
* Include a specific plan for addressing it.

\*If in doubt of how much to present, simply ask. (E.g. Would you like to hear the doses or just the list of meds? Would you like to hear all the labs or just the pertinent ones?)

**Oral Presentations: Follow-up Visits (daily rounds)**

**Subjective (This section differs the most from a new presentation.)**

* One sentence reviewing why the patient is here and how they feel this morning. (If everyone on the team already knows the patient, you can simply say how they are feeling.)
* A brief summary of any significant events that occurred since the team last met. (If nothing happened, do not feel the need to say something. “No events overnight” will suffice.)

**Objective (Guidelines for new presentations generally apply here as well.)**

* Pertinent physical exam (Vital signs and general appearance are always pertinent.)
* Any lab data that is pertinent to the main problem(s) and data peripheral to the main issues but that needs to be addressed (e.g. minor electrolyte abnormalities, glucose monitoring)

**Assessment and Plan (guidelines for new presentations generally apply here as well.)**

* Review the major problems (framed as diagnoses) and how each is to be addressed that day.
* Conclude with a comment about therapeutic endpoints (e.g. patient with pneumonia, no longer requiring supplemental O2, able to eat without vomiting) and discharge planning (when appropriate).

**General Tips**

* A daily presentation should take 1-2 minutes, followed by discussion.
* Avoid reading from notes and make good eye contact.
* If you are unsure whether to present something, omit it.
* If you are unsure how much detail to present, ask.
* Be aware of the context (e.g. if the team is very rushed and the patient is stable plan to be very brief; if a new members have joined the team, plan to provide more details).

**Additional Pearls**

**Story: Identifies and describes complaints**

* Think of the oral case presentation as building a case as an attorney would

in a court of law. You are providing information to allow others to come to

the assessment and plan you did. You are also providing enough information

to have them help you care for your patient.

**Organization: Facts are where listener expects**

* Starting with the chief complaint orients your listeners and prepares them for what follows.
* "Don't eat the dessert before the salad" - never change the basic format of the

presentation - it is always the same. (ID, HPI, PMH, MEDS, ALL, SH, etc.).

* Use standard headings to keep your listeners oriented. The relevant past medical history is,.. On physical exam I found... In summary..,
* If you put family history, social history, or parts of the review of systems into the history of present illness, there is no need to repeat it later in presentation

**Argument: Makes the case for the assessment and plan**

* An oral presentation is supposed to be a bedtime story not a suspense thriller.

Everything is designed to support an assessment and plan that shouldn’t ever be a surprise.

**Pertinence: only includes information relevant to the assessment and plan**

* If you're not sure if a detail is relevant, leave it out of the oral presentation. Your listener can always ask for more.
* Think of the oral presentation as the "Cliffs notes" version of the written H&P -

it includes all the details you need to understand the plot but not much more.

**Speech: Fluent, well-spoken, not read**

* Practice your presentation at least once before giving it.

**General**

* If you lose people's attention, think about what part of the presentation lost them.
* If preceptors keep asking for the same types of information after your presentation, then include it next time.
* The assessment and plan is a wonderful opportunity for you to demonstrate your clinical reasoning and medical knowledge. Don't miss this chance to shine!
* Always know what your listener is expecting to hear 2 minutes or 7 minutes?

All of the labs or just the abnormal ones?