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What's the Story? Expectations for Oral Case Presentations

This article focuses on teaching and evaluating oral presentation skills as part of the ongoing Council on Medical Student Education in Pediatrics (COMSEP) series on skills and strategies used by superb clinical teachers. While oral presentations by students can be used to enhance diagnostic reasoning,¹ we will focus this article on the characteristics of high-quality oral presentations by medical students, highlight several common pitfalls, and reinforce the connection between effective oral presentations and clinical reasoning. A model for evaluating student clinical performance, the RIME model, will be reviewed.

SETTING EXPECTATIONS

Students often struggle with what is expected of them when asked to give an oral presentation of a patient encounter. Many preceptors have asked a student to present a case, only to be answered with the question, "What would you like to hear?" Students frequently

perceive the oral presentation as "a rule-based, data-storage activity governed by order and structure."² Clinicians, however, view the oral presentation as a flexible form of communication, with content determined by the clinical context and audience. The first step in bridging this gap is to set explicit expectations. Students should be told early in the clinical experience the commonly accepted and expected style for oral presentations and the rationale for the organization. The ultimate goal of the presentation is to provide the justification for diagnostic and therapeutic decisions. Table 1 summarizes the elements of an effective oral presentation.³

ORGANIZATION OF THE EFFECTIVE ORAL PRESENTATION

Chief Complaint: Who Are We Talking About?

Presenting information in an expected order makes it easier for listeners to process information. This begins with

the chief complaint. Either a direct quote (eg, "My tummy hurts") or an identifying statement ("A 6-year-old girl with fever and abdominal pain") sets the context for this patient's story from the first line (a different context than that of a 16-year-old girl with abdominal pain!). Most preceptors prefer the latter style, which combines the chief complaint with important demographic and baseline data about the patient.

History of Present Illness: Tell a Good Story

Once the context is set, students should present the history in the order that makes the most sense, bringing in appropriate information from other parts of the history if that information significantly can affect the differential diagnosis. Our thinking about the girl with fever and abdominal pain changes considerably if she had her appendix removed 1 week earlier. However, some students may inappropriately relegate information regarding her surgery to

TABLE 1 Oral Presentation Expectations Checklist³

Expectations	Tips for Teaching	Not Done	Needs to Improve	Done Well
Chief complaint	Direct quote from patient or brief identifying statement that includes the patient's age and complaint			
History of present illness	Chronologically organized Tells a clear story Includes pertinent positives and negatives that help distinguish among possible diagnoses Includes elements of past history (such as medications, family history, social history) that specifically contribute to the present illness			
Physical examination	Includes vital signs and general appearance Includes abnormal findings and pertinent elements of physical examination			
Laboratory data	Includes pertinent and/or significant laboratory results/studies			
Summary statement	Synthesizes the critical elements of case into 1 sentence Includes epidemiology (age, gender, ethnicity, race, predisposing conditions) Includes key features (symptoms, physical examination findings, laboratory data) Uses semantic qualifiers			
Assessment	Includes prioritized problem list Includes pertinent differential diagnosis for each problem Identifies most likely diagnosis (and why) Includes less likely diagnoses (and why)			
Plan	Organized by problem list Includes diagnostic plans Includes therapeutic plans			

the past medical history (PMH) because they believe that the “rules” of presentation dictate this. Too often, students abbreviate the history of present illness (HPI) and fail to report the sequence of events, what has made the patient better or worse, the characteristics of the complaint, or associated symptoms.

The Rest of the History

The elements of the PMH, family and social histories, and review of systems that should be included in an oral case presentation depend on the patient's story and the details necessary to help the listener develop a good assessment. This may be difficult for inexperienced students, whose clinical reasoning skills might not yet be sufficiently developed to recognize which details are relevant. A preceptor may ask students to focus on just the “pertinent positives and negatives,” yet many students do not understand what this means. Pertinent information helps to answer a question about the patient's illness: What is the diagnosis? How sick is this

patient? Is the patient getting better or worse? For any piece of datum presented, students should be able to explain how that datum contributes to answering a question. A sibling with vomiting and diarrhea is pertinent to our girl with abdominal pain, but less so for another patient with wheezing.

The Physical Examination and Diagnostic Studies

All patient presentations should include the vital signs, the general appearance of the patient, and the key elements of the physical examination. Again, the student should not list all features of the physical examination, only those critical to the diagnosis. In our patient, an expanded report on the abdominal examination and her diffuse abdominal tenderness would be crucial, while a description of normal tympanic membranes should be skipped. A similar rule applies to results of diagnostic studies, which should be reported if relevant to answering 1 of the questions given earlier.

Following the Script

Inexperienced students tend to present information in the order in which it comes to their mind. They may report that “she said that her abdominal pain was severe, but there was no abdominal guarding on my exam,” blurring the distinction between history and physical examination findings. Similarly, students may mix objective findings with opinion, such as, “The stool was guaiac negative so bacterial infection seems less likely.” Using a written template may help students' organization. From the preceptor's perspective, adherence to the generally accepted organizational structure allows preceptors to more readily identify gaps in data collection.

Summary Statements: The “1-Liner”

Once the history, physical examination, and data are presented, students should summarize the case in 1 or 2 sentences. This summary statement is not a repetition of the identifying statement used at the opening of the presentation.

A good summary statement includes (1) key features, (2) epidemiology, and (3) important qualifying adjectives.

Key features may be symptoms, physical examination findings, or laboratory findings. For our girl with abdominal pain, this would include fever and abdominal pain (identified in the chief complaint), plus any other major symptoms, such as vomiting, diarrhea, and decreased urine output. Key examination findings might include tachycardia, dry mucous membranes, and diffuse abdominal tenderness. Key laboratory data might include a decreased serum bicarbonate level and elevated creatinine level. Key features should be combined into the simplest clinical terms; in this case, oliguria, tachycardia, dry mucous membranes, and elevated creatinine could be synthesized as dehydration.

Epidemiology includes demographics such as age (6 years old), gender (girl), and, when pertinent, ethnicity and race. Also included are predisposing conditions (recent appendectomy) and risk factors (sibling with vomiting and diarrhea).

Qualifying adjectives are those that further define key features.⁴ These qualifiers serve to identify critical decision

points in diagnostic reasoning, such as nonbilious (versus bilious) vomiting, and diffuse (versus localized) abdominal pain. Qualifiers may also describe the progression and severity of illness, such as acute (versus chronic) onset and profuse (versus mild) vomiting.

Pulling it all together, a student who reports that “our patient is a 6-year-old girl status post recent appendectomy, now with acute onset of profuse vomiting and diarrhea associated with diffuse abdominal pain and complicated by severe dehydration” has gone far beyond simply repeating the facts of the preceding presentation and is ready to move on to an assessment.

Assessment: Why Is This Patient Ill?

The assessment should include a rank-ordered discussion of the most likely diagnoses, with arguments in favor of the most likely diagnoses and against less likely possibilities. What is critical is to get students to make a commitment. Novice students tend to offer “laundry lists” of diagnoses in place of a true assessment. Based on the summary statement given earlier, you would expect a student to discuss gastroenteritis and *Clostridium difficile*

infection as possible diagnoses, but a discussion of toxic ingestion or head trauma as causes of vomiting would be unnecessary.

Plan: How Do We Care for This Patient?

Plans should be organized by problem list and subdivided into diagnostic and therapeutic plans. If the cause of our patient’s abdominal pain is still in doubt, the plan should propose next steps in evaluation of this problem. For other problems, like our patient’s dehydration, the plan will focus on therapeutics.

ASSESSMENT: THE RIME SCHEME

The RIME scheme describes 4 stages of clinical performance: reporter, interpreter, manager and educator.⁵ A “reporter” collects data reliably and presents them in an organized fashion. An “interpreter” exhibits clinical reasoning, reporting facts selectively while constructing an argument in the form of an assessment. “Managers” provide diagnostic and therapeutic plans as part of their presentation, while “educators” teach colleagues and patients in a way that uses current experience to enhance future performance and

TABLE 2 RIME Assessment Scheme: Oral Presentations⁵

	Hallmarks of Performance	Barriers to This Level of Achievement
Reporter	Reports reliably Organizes facts Collects/reports factual information thoroughly Answers the “what” questions	Erroneous details Disorganization Missing details
Interpreter	Analyzes data Selectively reports details Summarizes case by using descriptive adjectives to describe key features Presents a rank-ordered differential diagnoses for this patient Identifies problem list Answers the “why” questions	Exhaustive report of irrelevant details Case summary only repeats factual details Differential diagnoses presented as nonprioritized list for the chief complaint No problems identified
Manager/educator	Focuses on decision-making Discusses plans (diagnostic, therapeutic) for each problem Addresses the issue of “how” to care for patient	No plan discussed, or plans offered as random “to do” list
Educator	Educates colleagues through presentations Discusses patient/family education Identifies topics, resources for self-education	Cannot explain plan to others Lack of insight/initiation (ie, self-education)

extrapolates care of the individual patient to broader practice patterns.

The primary goals at the clerkship level are to help students solidify reporting skills and function more consistently at the level of an interpreter. No performance level is beyond the reach of a student, however, and the best students will exhibit manager or educator skills, especially for routine cases. Table 2 summarizes the hallmarks of each level of performance.

CONCLUSIONS

High-quality oral presentations have the potential to promote coordinated patient care, enhance efficiency, and encourage teaching and learning.⁶ While the presentation is intended primarily

to inform the preceptor about a patient, it also informs the preceptor about the student. High-quality presentations incorporate reliability, organization, clinical reasoning, and decision-making. The RIME scheme provides a useful way to organize observations, which in turn facilitates feedback.

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REFERENCES

1. Bannister SL, Hanson JL, Maloney CG, Raszka WV Jr. Using the student case presentation

to enhance diagnostic reasoning. *Pediatrics*. 2011;128(2):211–213

2. Haber RJ, Lingard LA. Learning oral presentation skills: a rhetorical analysis with pedagogical and professional implications. *J Gen Intern Med*. 2001;16(5):308–314
3. Lewin LO, Beraho L, Dolan S, Millstein L, Bowman D. Inter-rater reliability of an oral case presentation rating tool in a pediatric clerkship. *Teach Learn Med*. 2012, In press
4. Chang RW, Bordage G, Connell KJ. The importance of early problem representation during case presentations. *Acad Med*. 1998;73(suppl 10):S109–S111
5. Pangaro L. A new vocabulary and other innovations for improving descriptive in-training evaluations. *Acad Med*. 1999;74(11):1203–1207
6. Green EH, Hershman W, DeCherrie L, Greenwald J, Torres-Finnerty N, Wahi-Gururaj S. Developing and implementing universal guidelines for oral patient presentation skills. *Teach Learn Med*. 2005;17(3):263–267

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