



Guidelines for the Oral Presentation

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The Oral Presentation: An Introduction

The oral presentation is a critically important skill for medical providers in communicating patient care with other providers. It differs from a patient write-up in that it is shorter and more focused, providing what the listeners need to know rather than providing a comprehensive history that the write-up provides.

This guide will provide general advice on how to organize and provide an oral presentation, with examples (both good and bad) and some pointers in the form of "do" and "don't" suggestions.

Recognize that different preceptors, attendings, residents, consultants, nurses, interdisciplinary teams, *etc.*, will have different expectations or requirements for your presentation. The suggestions below are suggestions for a standardized presentation, but you would benefit from asking your team how they would like your presentations to be structured, the level of detail, and target length. Regardless, your overall guiding principle for presentations is as follows:

Include only what is relevant to the patient's presentation (and consequently your differential diagnosis and plan). Leave out everything else.

You'll know you've gotten it when your audience can guess at, and agree with, your differential diagnosis before you've reached the end of your presentation, based on the information you have provided along the way.

Why Worry About the Oral Presentation?

- The oral presentation is the most common way in which we provide information to other team members and hand off care of patients to other providers. Because of this, it is important to know how to convey the right information appropriately and succinctly.
- To organize an oral presentation effectively, you must think critically about what is important with your patient, your differential diagnoses, and your plans. The oral presentation provides you a framework and an excuse to do so and can provide you with a chance to reflect on the information you have for the patient, even suggesting that you may need to go back and get more information.
- For a trainee, the oral presentation remains one of the most common ways your clinical performance is evaluated. Because many skills go into the oral presentation (such as good data gathering, advanced physical exam skills, prioritize too many of multiple patient problems, and knowledge base), an effective oral presentation can provide a nice, efficient summary of your clinical skills. As a consequence, if your oral presentation is not polished, you may be incorrectly assessed as being deficient in one of these skills.

Presenting the New Patient

The device below represents how to present a brand new patient, such as would be seen for an inpatient hospital admission. Guidelines on how you may modify the presentation for other purposes are in the sections that follow.

The Opening Statement

The opening statement of an oral presentation differs from a written H&P in that the oral presentation usually begins with some basic demographics and reads more like the first line of the HPI than a written H&P, which begins with a chief complaint.

Do: Give basic demographics and a few items of past medical history that are relevant to the chief complaint only. Keep this brief and focused.

Good example: "Mr. ___ is a 64 year old man with a history significant for immune thrombocytopenia who was admitted for bleeding post colonoscopy."

Don't: Don't add a lot of extraneous information to the opening sentence. Get to the chief complaint quickly. Your audience will try to tie every bit of information you give in that opening sentence to every other bit and the chief complaint, so anything that is not relevant will be confusing or distracting. Therefore, do not include past medical history that does not directly relate to the chief complaint or HPI, but feel free to add it later.

Bad example: "Mr. ___ is a 64 year old man with a history of immune thrombocytopenia, COPD, sleep apnea, obesity, type 2 diabetes, lumbar fusion 6 years ago, steatohepatitis, and chronic kidney disease with a baseline creatinine of 1.7 who was admitted for bleeding post colonoscopy."

History of Present Illness

The HPI flows directly from the opening statement (which includes the chief complaint) and thus should relate directly.

Do: Have some form of organization in mind. The overall form of organization may vary, but for most presentations, a *chronological* organization usually works well and is easy to follow.

Good example: "Her symptoms began three days ago, when approximately 20 minutes after having a breakfast of a cheese omelette, she started to have 'gnawing' epigastric and right upper quadrant pain, which she rated 8/10. The pain lasted about two hours and resolved spontaneously but recurred approximately three times a day since then, each time 6 to 8/10, only associated with meals about half the time. Each episode lasted half an hour to three hours, resolving spontaneously. Overnight, however, the pain lasted for more than four hours, so she tried Pepto-Bismol, which did not help, so she came into the emergency room. She has not noticed the color of

her stools but noticed that her urine seems darker." (This follows a logical, chronological flow with relevant ROS at the end.)

Don't: Don't organize your HPI based on mnemonics you use to remember the elements of the HPI ("OPQRST" is handy because it's alphabetical, but it is not actually presented in a logical format).

Bad example: "Her symptoms began three days ago 20 minutes after having breakfast of a cheese omelette. She tried Pepto-Bismol last night, which did not help. The episodes resolve spontaneously. The pain is a 'gnawing' pain, in her epigastrium and right upper quadrant. The pain is 6 to 8/10. Each episodes lasts half an hour to three hours and occur three times a day since onset. She has not noticed the color of her stools but noticed that her urine seems darker. Overnight, the pain lasted more than four hours, so she came into the emergency room." (This follows the OPQRST/AA format but has less logical flow.)

Do: Begin the HPI with when the illness began, not with when they sought care. For some recurrent or chronic conditions, this may go back some time, so you should summarize the entirety of the course of the illness in a succinct way.

Do: Include only the *relevant* review of systems, but include it in the HPI (and not the ROS section).

Don't: For the most parts, you should not veer into other pieces of data (past medical history, exam, labs) before you've completely presented the HPI unless you're certain that doing so is vital to understanding the patient's presentation (e.g., "He was found in clinic today to have a creatinine of 4.7, above his baseline last month of 2.0").

Special Cases: If the patient has sought care at other facilities, you can usually include that course at the end of the HPI. This may require you present some labs and data out of order, but if it makes more sense to do it this way, it would be a reasonable approach.

If you have multiple problems to discuss, unless they are very closely tied together, consider presenting each one separately, following the above HPI format for each individual problem.

Past Medical History

Do: List the diagnoses of PMH in decreasing order of importance and relevance, as they relate to the HPI and/or the care you provide them in the encounter. (For example, "type 1 diabetes" may not be immediately relevant to the HPI but will likely affect how your inpatient plan for the patient.)

Do: Expand on relevant elements of the PMH. For example, if your patient is admitted with a CHF exacerbation, include a summary of their last echo.

Don't: Don't list irrelevant PMH (something that does not significantly impact HPI or your current care for the patient). Recognize your audience may look it up or ask you about it.

Don't: Don't just list the history from an undifferentiated EMR record. These are frequently incomplete and have extraneous other information.

Medications/Allergies

Do: Include the medications that are relevant to the patient's presentation, current illness, and your treatment plan, if you have not mentioned them already. Use your judgment on whether knowing a dose and frequency of medications is relevant. If it is highly relevant to the HPI, or if there is something non-standard about it, you should probably include it. Otherwise, recognize that your audience probably has a limited attention span for hearing a long list of names and numbers.

Don't: You do not always need to include every medication, particularly if the patient's medication list is very long. Instead, be prepared to refer to or show a list if requested.

Social and Family History

Do: Include the elements primarily that are relevant to the patient presentation or your care of the patient (e.g., factors that may affect hospital discharge).

Do: Add in some social context, especially if you think it would be helpful to contextualize the patient, family, living situation, etc. This portion of the presentation may be useful to communicate information that you would not want to write into the patient's chart.

Don't: Do not use vague terminology ("occasionally," "rarely") for the sake of being brief, as these terms are interpreted in highly variable ways by different persons. Give actual frequencies.

Don't: You do not need to present an entire genogram, but don't use "non-contributory" as a surrogate. If the absence of particular relevant family history is important, state it as such (e.g., "there is no family history of autoimmune diseases").

Review of Systems

Don't: Do not need include a review of systems in most cases. If the pieces of ROS were relevant, they should have been in your HPI. If they aren't relevant, don't include them in your presentation at all.

Do: If your setting does merit that you go over the review of systems (e.g., you wish to present it at a comprehensive preventive care visit), discuss which systems/ROS you reviewed rather than stating, "All systems negative."

Vitals

Do: Include vitals, as they have are considered "vital" for a reason. Consider giving ranges or baseline if relevant (e.g., "weight is 115 lbs., down from 140 lbs. six months ago") or if variable (e.g., "pulse has ranged from 72 to 138 since admission").

Don't: Do not use vague phrasing as "afebrile, vital signs stable" in an effort to be brief. For a new presentation especially, saying something is "stable" is meaningless because stability implies a course of time (and "stable" does not mean "normal").

Physical Exam

Do: Explain the relevant parts of the physical exam in detail. Doing so includes not only pertinent positives but also pertinent negatives.

Good example: "On cardiac exam, her PMI was displaced laterally. She had a normal S1 and soft S2 without any murmurs. There was no S3. Carotid up strokes were brisk without delay."

Don't: Avoid saying simply "normal" or "intact" for the important, relevant parts of your exam.

Bad example: "Her heart was normal except for a laterally displaced PMI."

Don't: Do not include the comprehensive, exhaustive exam. If it is not relevant exam, leave it out, knowing you can add it in if asked about it. Especially avoid providing stock phrases because you are accustomed to including them (e.g., "no clubbing, cyanosis, or edema") without a good reason for doing so.

Labs and Studies

Do: Include the relevant labs explicitly (in general, give the actual numbers rather than "normal").

Don't: Do not include all the labs. As with medications, your audience will not have the focus and attention span for a long string of numbers. Have additional labs available to report if asked.

Do: Include comparison labs if there has been a change, even if the comparison is not from the current presentation, if you feel it important to interpret the information.

Do: Attribute studies if you did not do the interpretation yourself (e.g., "Per the radiology report, the ultrasound showed...").

Summary Statement

The summary statement is essentially the "opening argument" of what diagnosis (or diagnoses) you think are most likely and primes your audience for why this is the case by providing evidence. While the beginning (including demographics and relevant PMH) mirrors the opening statement of your HPI, it should include more information.

Do: Keep the summary statement short, one or (rarely) two sentences that include only the most relevant pieces of information (history, exam, labs and studies).

Good example: "Ms. ____ is a 64 year old woman with a history of type 2 diabetes who presents with recurrent, post-prandial, severe mid-abdominal pain with exam findings of a low-grade fever, minimal abdominal tenderness, and a leukocytosis of 18,000."

Don't: Do not simply repeat the opening sentence from your HPI without modification.

Bad example: "Ms. ____ is a 64 year old woman with a history of type 2 diabetes who presents with abdominal pain."

Assessment and Plan

Formulating an assessment and plan often is done in a problem list format. Each "problem" is a specific issue (disease, symptom, aspect of health care, etc.) you would like to specifically address. The chief complaint should always be included and usually is the first problem you present.

For each problem, present an assessment and a plan. The assessment is your sense of what diagnosis/-es are most likely and why, or your understanding of the patient's state (such as "worsening renal function" or "with wound dehiscence"). The plan is what you intend to do about it (diagnostically, for treatment, or both).

Classically, the assessment and plan are presented together by problem, one problem at a time: present problem A, given your assessment for it, then provide a plan, then move on to problem B and repeat. In giving your assessment, explain your thought process; in giving the plan, explain how the plan relates to your assessment.

It is important to commit to a diagnosis as being most likely and to be specific about your plan. This may seem intimidating early on, as you may be unsure given your lack of experience and knowledge. Recognize that the cognitive processes of committing to a diagnosis and a specific plan are part of the learning process, however, more so than just being right.

Good example: "The first problem is her sudden hypoxia and chest pain. Most concerning given her recent surgery and immobility as well as history of autoimmune disorders is a pulmonary embolism, especially given the acute nature and pleuritic chest pain. Acute coronary syndrome is also possible given her age and risks of

hypertension and hyperlipidemia, though the pleuritic chest pain is less likely. Additional considerations include pulmonary edema with mobilizing her intra-operative fluids or nosocomial pneumonia. For my plan, I am obtaining an EKG and troponins immediately as well as a creatinine, as I plan to get a CT angiogram to evaluate for PE if these are negative. The CT should also give me some information regarding pulmonary edema and pneumonia. Given that she so recently had major abdominal surgery, I am holding off anticoagulation until I determine if she has a PE or ACS."

Do: Prioritize your assessment/plan. Typically, the most serious problems and the ones relating to the chief complaint/HPI go first.

Don't: Avoid vague plans, such as "give some antibiotics."

Don't: Don't make your assessment/plan all plan with no assessment. Don't assume that someone will know your assessment simply by the plan you put forth.

Bad example: "First problem is hypoxia and chest pain, so I'm getting an EKG, troponins, and a CT."

Special case: Interacting problems: In a patient who has multiple interacting problems, it can be confusing to determine when to present the assessments and plans. If your problem list is prioritized, you will generally explain the most significant problems first, but it is often permissible to separate this out and let your audience know (e.g., "The steroids will affect his poorly controlled blood sugar, which I will explain when we get to 'diabetes.'")

Special Case: ICU and complicated patients: Usually, the assessment and plan is presented by problem. However, in a severely ill and complicated patient, typically in the ICU, the problem list is often presented by body system. For example, you would present "cardiac" as a system and then discuss all the problems related to the cardiac system, including their assessments and plans, before moving on to "pulmonary," and so forth. Even if you use the body systems approach, the body systems should be prioritized, with the most critical ones to your patient presented first.

The Follow Up (or Daily) Presentation: What's Different?

When you are presenting a patient whom you have presented very recently (such as on daily rounds on an inpatient service), your presentation will be much shorter, more focused, and generally only include what is new, changed, or updated as follows:

HPI: The HPI will normally be replaced with an "interval history," which summarizes all events that occurred with the patient since your last presentation, as well as a "subjective" portion which explains how the patient is feeling and includes the patient's own description of how he or she is feeling.

Example: "Overnight, he had an episode of shortness of breath with sats down to the low 80s. A rapid response was called, and respiratory therapy suctioned a large amount of mucus. After that, his sats came up to upper 90s on 2 liters of oxygen. This morning, he has no shortness of breath and no mucus production, and the nurse has weaned him off oxygen."

The remainder of this history portion is generally left out with the exception of some medications if you are tracking them. For example, if you are providing the patient with antibiotics, it is common to state something such as, "She is on day four of five of ceftriaxone."

Vitals: If the patient is hospitalized, it is often useful to give a range of vital signs rather than just the most recent, as you wish to summarize the patient's vitals over the course of the day since your last presentation, not just the moment you are giving your presentation. The

Physical Exam: The physical exam should be very brief and typically *not* comprehensive. Focus on the portions of the physical exam that you are actively following for the patient's active problems (even if normal) and anything that has changed from previous exams.

Labs/Studies: These should be limited to what is pertinent, what actively needs to be followed, and what is relevant to your assessment/plan. This is especially the case if your patient has fallen prey to the overuse of daily labs; not all daily labs are relevant. In these cases, it is often acceptable to summarize the labs as "normal."

Summary Statement: Since the patient should be known to the audience, your summary statement can include a reminder of who the patient is rather than an argument (for example, "Mr. ____ is our 64 year old patient with gallstone pancreatitis"). If something significant has occurred in the hospital stay (birth, surgery, intubation, etc.), you may wish to include how many days it has been since that event.

Assessment/Plan: For problems you are working up, the assessment/plan is as above. If a problem has resolved, mention it briefly if still relevant, but if no longer relevant, do not include it.

The Outpatient (Known Patient) Presentation: What's Different?

Because most outpatient encounters are on a much shorter timeline than inpatient encounters, it is vital that your outpatient presentations be succinct and *brief*. In this way, you should only limit your presentation to the most pertinent information.

The presentation of a brand new patient in an outpatient setting often follows the pattern above. If a patient is known, however, such as in a follow-up outpatient visit, much of the information can be omitted. Here are some changes:

Past Medical History: In general, this can be left out if the patient is known to your audience, with the relevant portions listed in HPI.

Medications: Stick to what's pertinent to the reason the patient is being seen.

Family and Social History: Only include if important to the presenting complaint. Most often, you will leave most or all of this out.

Physical Exam: Be very focused on your exam, again only included what is pertinent to the patient's visit.

Labs/Studies: Include only what is relevant. Often, there are monitoring labs in outpatient visit that may or may not be relevant, so you can typically describe only what stands out or is relevant to your assessment/plan.

Assessment/Plan: Typically, you only want to include an assessment and plan for each problem for which the patient is presenting and any chronic issues (even if stable) for which the patient is following up. If your clinic encounter is focused (*e.g.*, a problem-focused visit or a specialist visit), you will typically not have an assessment/plan for the problems that do not pertain to that visit.