Oral Case Presentation Template

Purpose

The purpose of the oral case presentation exercise is for the student to learn time management on rounds and how to think and communicate like a "doctor." The desired skill for which the student is to learn during the oral case presentation exercise is different than the communication skills learned in writing a comprehensive H&P.

Objectives

At the end of this exercise the student will:

1. understand the process used in clinical reasoning
2. organize an oral case presentation in a logical and concise manner
3. describe that information which should be included and that information which should be excluded when communicating a patient case orally.

Learning activities:

1. At the **Week 1** preparation meeting the student will be given explicit instructions to the student on the expectations for oral case presentation to be given at the **second week's** meeting.
2. The student will receive an oral case presentation primer which gives excellent examples of both good and bad oral case presentations. It is necessary for you to read this primer prior to presenting your first case.
3. At the second week meeting the student will give an oral case presentation following the template below.

    Keep the following in mind:

    a. The oral case presentation should be given within a two minute time frame.
    b. It is permissible to use the same patient case that you are using for a comprehensive written H&P.
    c. It is very important for you to write down your oral case presentation so that it can be read aloud.
    d. Practice the oral presentation so that all the necessary elements are included.
    e. Do not attempt to memorize or to present "off the top of your head."

There are **six elements** in an oral case presentation:

1. HPI (there should be no or little past medical history or review of systems)
2. Focused physical exam
3. Summary statement
4. Focused differential diagnosis

5. Clinical impression (working diagnosis)
6. Management plan (generalized not specific details)

The **history of present illness** should be:

1. Logical and chronological
2. Contain detailed symptoms of the illness discriminators
3. The HPI should give a picture of the severity of patient illness (this is usually best described as the effect of the illness on routine daily activity)
4. Include information from all sources in addition to family and patient. Information from medical sources is particularly important. If the patient has been seen by another physician prior to admission it is important to describe not just what the physician did but what the physician thought.
5. Always include what is on the parents' mind, especially if they have a fear or worry. It is very difficult to successfully manage the patient without understanding the parents' concern.
6. Justify why the patient needs to be admitted to the hospital and cannot be management as outpatient.
7. Omit past medical history and review of systems information unless it explicitly pertains to the reason that the patient is admitted to the hospital. Or that that information is so important to the patient's overall health that it cannot be omitted.

The **physical exam** always needs to contain the vital signs and grown information including percentiles. Otherwise, the remainder of the physical examination should pertain only to organ systems for which clinical information is relevant. Physical exam details should be very complete and comprehensive for those organ systems and even though the physical exam should be thorough and complete reporting the information should be very focused to "where is the money."

The **summary statement** translates all of the information of the HPI and physical exam into two sentences. This is a very difficult skill to learn but is extremely important to be able to summarize everything to this point into a "two sentence nugget." In the summary statement in which physical exam information is being translated use terms such as "tachypnea and tachycardia" instead of specific numbers like "respiratory rate of 50 and heart rate of 160."

Following the summary statement you should write a **short and focused list of diagnoses** that are realistic and possible. (Keep in mind that during the time in which you are performing history interviews that your **differential diagnosis** should be very long. It is during the history interview that you compare and contrast illness scripts and then from that you ask additional questions. The purpose of the summary statement is to help you then shorten and narrow your differential diagnosis to only a few possible realistic conditions. These conditions should be supported by your HPI and physical exam. It should also be kept in mind that experienced

clinicians have short differential diagnoses and then latter expand their differential diagnosis list if the clinical course requires.

Following your differential diagnosis commit to a **single diagnosis**. Simply state that diagnosis and do not write a justification for your choice as you might do in the written H&P.

Following this clinical impression or working diagnosis, write a **general management plan**. This is in contrast to your written H&P management plan. In the written H&P management plan you should have a very detailed and comprehensive list as one would when writing admission orders. In the oral case presentation, the management plan is presented in a general manner. The student should, however, know the details of the admission orders so that if asked by the attending could answer any management plan question detail.

In **Week 3** the students will learn the skill of **patient handoffs** at the time of evening checkout and the skill of **requesting subspecialty consultations**.