**Guide to Presenting Patients**

Introduction

This guide outlines useful pointers for case presentations as you will increasingly be called on to use these skills in clinical education. The principles of an effective presentation can be generalised across all types of presentation. Hopefully you will have already had some experience of presenting patients if the opportunity arose on your clinical attachment. You may have gathered important learning points from others in your firm regarding what a case presentation should include or even advice as to how to present. Presenting patients is an essential skill for medical students to acquire as a life-long professional skill and it will be an essential component of many examinations during your clinical years. Junior doctors will routinely participate in case based discussions as part of their assessment in the Foundation Programme.

Case presentations: what, why, when and where?

A case presentation is a verbal description of a patient and his/her medical problem. As a medical student your clinical competence will be partly judged both in formative and summative assessments on your ability to give a good case presentation.

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| What topics are usually included in a case presentation?  The information in a case presentation is analogous to the convention of the way that the case notes are written up , and is usually given in the following order:  The presenting complaint (PC)  The history of the presenting complaint (HPC)  Examination findings  Case summary  Differential diagnoses  Planned investigations  Initial management plans  However, content is context and audience specific.  Consider:   * omission of irrelevant material (for that audience) * commence with a summary statement * presentation has bearing on the present illness, relevant past medical history, social and family history and systems review * separate/distinguish subjective from objective data * concise/compressed amount of facts * present the most important information first * similarities with written presentations   + an orderly, familiar organisational format   + a full characterisation of symptoms   + reconstruction of the patient’s narrative into a coherent description of  an illness     There are different types of case presentations: bullet presentations (<1 minute) are typically given either in stand-up ward rounds, in the corridor, or over the telephone. It is a very brief description often used to introduce the patient briefly to a new audience.  Here is an example of the bullet presentation. This could be over the telephone:   * “Mr Lucas is a 42-year-old journalist who presents with knee problems for three months and was found for the first time to be hypertensive. As an enthusiastic jogger, Mr Lucas is anxious to have the knee problem resolved.” * “Mrs O’Connor is a 56-year-old widowed telephone operator with long-standing insulin-dependent diabetes who now complains of weekly dizzy spells over the past two months.”   A formal case presentation (sometimes called the short case) (5-7 minutes) is usually given to supervisors and colleagues at the bedside or in a sit-down conference.  A complete case presentation (sometimes called the long case) might last 10 minutes and will typically outline the written medical record. Junior doctors are expected to make case presentations as part of the Foundation Programme.  Why are case presentations used in medical education?  One of the most frequent presentations that doctors are involved in is the case presentation. It is the primary means by which clinicians convey information about patients to each other.  Medical education has a long history of apprenticeship-type education. That is, knowledge, attitude and skills acquired by working alongside qualified practitioners. So, by observing case presentations, students are expected to learn what it contains and the skills of making a presentation (“See one, do one”).  What are the contexts in which case presentations take place?   * Vivas * Examinations * Seminars * Tutorials * PBL * Ward rounds * Grand rounds * Conferences * Communication skills sessions * Telephone calls * Opening for an extended discussion/teaching session * Obtaining consultation on a difficult/troublesome feature of a patient’s problem   Who attends case presentations?  Case presentations are an important forum for inter-professional communications:  Students, house officers, consultants, doctors, social workers, nurses, physiotherapists and other healthcare professionals. Patients and their relatives may sometimes attend as well.  Where do they take place?  Wards, clinics and other healthcare settings, medical school |

Dealing with uncertainty

In a recent study, Lingard et al (2003) analysed case presentations made by medical students. They found as students developed their case presentation skills, the way they dealt with uncertainty became more sophisticated, tending to use their mentors as models. They became more confident about admitting when they didn’t know something and more able to identify whether the gap was in their own knowledge or another source of uncertainty. Sources of uncertainty include;

* Limits of individual’s knowledge - *“I’m not sure”*
* Limits of evidence - *“I can’t convince myself it’s not bacterial - better use antibiotics”*
* Limitless possibility - *“It’s not probable, but it’s conceivably possible”*
* Limit of patient’s account - *“She may not remember correctly”*
* Limits of professional agreement - *“…used to treat this way, now we treat like this”*
* Limits of scientific knowledge *- “Some people think it’s a factor in the milk, but no-one has isolated it”*

The Foundation Programme

Junior doctors are expected to make case presentations as part of the Foundation Programme (FP) using basic communications skills to contribute to “Case based discussions” (CbD). This is an important element of your work. Sometimes you will be assessed on your ability to identify a patient for whom you have cared and use the medical record to describe and provide a rationale for your actions. You will be assessed on your medical record keeping, your clinical assessment, investigation, referrals, treatment, follow-up future planning, professionalism as aspects of your overall clinical judgement. Your assessor will work with you to identify anything that you did which was especially good and make suggestions for development.

See <http://www.foundationprogramme.nhs.uk/pages/home/training-and-assessment>

In clinical communication, we aim to help you develop the basic skills that are the cornerstone of effective presentations which will support your clinical effectiveness and help you perform well in these types of assessments. Developing effective skills early in your education tends to be easier than trying to change less effective skills later.

* Effective presentation skills

Content

* Introduce self and patient (using patient’s name only where appropriate)
* State purpose of the presentation (context E.g. assess treatment, planning for
* discharge, unusual medical problem etc.)
* Present the information in a structured and logical manner (with flexibility

to respond to questions)

* Emphasise notable points
* Give specific information
* Summarise key points
* State if there are any outstanding issues or points about which you would like input
* Clear statement of closure
* Exclude jargon

Presentation materials

* Overheads, slides, flip charts, multi-media and sound system etc
* Legible to everyone in the audience – (if audience is 10m away, use font size 5mm; if 10-15m use 10mm; if 15-20m use 15mm)
* Consistent in appearance – colour, font, size, titles, style
* Amount of info per visual – 6 words per line/ 6 lines per visual
* Consider dyslexia guidelines – avoid serif fonts; use dark

Presentation

* Voice – clear and audible; neither too loud or too soft
* Speech – speed – neither too fast or too slow; tone – varied to maintain interest
* Eye contact – look at audience also helps engage them
* Timing – start and finish on time

Rehearsing presentations is important. Consider doing this:

* In your head
* Out loud
* In a mirror or on audio/videotape
* In front of colleagues
* On site / at the venue
* Presenting patient cases

There is no set format for making a case presentation but the following structure might be helpful:

* Identify date and reason for visit
* History
* Physical examination
* Lab Data
* Assessment
* Plan

### Format for written case presentation

The following is a model of how to format a written case presentation. This is not necessarily how you would present verbally. What differences might you need to make?

Name

Date of birth

Sex

Marital status

Address

Religion/spiritual beliefs

Ethnicity

Medical and surgical history

1. Presenting complaint (confirm the presenting condition – site and side)
   * History
   * Symptoms
   * Duration
   * Onset
2. Systematic enquiry of systems
   * Cardiovascular
   * Respiratory
   * Alimentary
   * Genito-urinary
   * Central nervous
   * Endocrine
   * Locomotor
   * Psychiatric/mental health
3. Past medical history
   * Previous illness episodes
   * Previous treatment
   * Previous anaesthetics and operations - Difficulties with general anaesthetics (Mask ventilation or endotracheal intubation)

Drugs

* Current medication – name, prescription, OTC or alternative remedies (always use generic drug names), dose, frequency, allergies (including nature)
* Recent medication

Allergy history

* Substance – medications (antibiotics), foods
* Reaction
* Triggers for asthma and eczema

Personal and social history

* Occupation
* Hobbies
* Housing
* Level of independence
* Support from relatives, neighbours, social services
* Marriage / partner
* Children

Lifestyle factors

* Alcohol, Tobacco
* Drug use

Family history

* Family illnesses, causes of death of first degree relatives
* Inherited disorders (including reactions to general anaesthetic)

Nutritional status

* Risk / Need for intervention

And finally, remember the patient…Below is an excerpt from The Oxford Clinical Handbook (Longmore et al, 2007)

**Presenting your findings—and the role of jargon**

We are forever presenting patients to our colleagues, almost never questioning the mechanisms and motivations which permeate these oral exchanges—and sometimes send them awry. By some ancient right we assume authority to retell the patient's story at the bedside—not in our own words but in highly stylized medical code: ‘Mr Hunt is a 19-year-old Caucasian male, a known case of Down's syndrome with little intelligible speech and an IQ of 60, who complains of paraesthesiae and weakness in his right upper limb … He admits to drinking 21 units per week and other problems are …’

Do not comfort yourself by supposing this ritualistic reinterpretation arises out of the need for brevity. If this were the reason, and we are speaking in front of the patient, all that is in bold above could be omitted, or drastically curtailed. The next easy conclusion to confront is that we purposely use this jargon to confuse or deceive the patient. This is only sometimes the case, and we must look for deeper reasons for why we are wedded to these medicalisms.

We get nearer to the truth when we realize that these medicalisms are used to sanitize and tame the raw data of our face-to-face encounters with patients—to make them bearable to us—so that we can think about the patient rather than having to feel for him or her. This is quite right and proper—but only sometimes. Usually what our patients need is sympathy, and this does not spring from cerebration. These medicalisms insulate us from the unpredictability of experiential phenomena. We need the illusion that we are treading on wellmarked- out territory when we are describing someone's pain—a problematic enterprise, not least because if the description is objective it is invalid (pain is, par excellence, subjective), and if it is subjective, it is partly incommunicable.

These medicalisms enroll us into a half-proud, half-guilty brotherhood, cemented by what some call patronage and others call fear. This fear can manifest itself as intense loyalty so that, err as we may, we cling to our medical loyalties unto death (that of the patient, not our own). Language is the tool unwittingly used to defend this autocracy of fear. The modulations of our voice, the stylized vocabulary, and the casual neglect of logic and narrative order ensure, in the above example, that we take on board so little of our patient that we remain upright and afloat, above the whirlpools of our patients' lives. In this case, not a case at all, but a child, a family, a mother worried sick about what will happen to her son when she dies: a son who has never complained of anything, has never admitted to anything, expresses no problems—it is our problem that his hand is weak, and his mother's that he can no longer attend riding for the disabled, because she can no longer be away from home and do her part-time job. So when you next hear yourself declaim in one breath that ‘Mr Smith is a 50-year-old Caucasian male with crushing central chest pain radiating down his left arm’, take heed—what you may be communicating is that you have stopped thinking about this person—and pause for a moment. Look into your patient's eyes: confront the whirlpool.

Recommended reading

BILLINGS, J. A. & STOECKLE, J. D. (1999) Oral Case Presentations (Ch 18 - pp 294-305). *The Clinical Encounter: A Guide to the Medical Interview and Case Presentation.* 2nd ed. Missouri, Mosby.

LINGARD, L., GARWOOD, K., SCHRYER, C. F. & SPAFFORD, M. M. (2003) A certain art of uncertainty: case presentation and the development of professional identity. *Social Science & Medicine,* 56**,** 603-616.

LONGMORE, M. WILKINSON, I. TURMEZEI, T. CHEUNG, C.K. (ed). (2007) *Oxford Handbook of Clinical Medicine (7th ed),* Oxford, UK, OUP. pp25

WOOLF, K., KAVANAGH, J. & GARDNEW, M. (2009) Giving Presentations (Ch 5 – pp 38-43). In. WASHER, P. (ed) *Clinical Communication.* Oxford University Press, Oxford.