Advice to the Young Clinician:
The Art of Presentation

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The skill of presentation is fundamental to practicing the art of medicine. It is important to effectively convey the logic behind your actions, whether in writing or oral presentation. I repeatedly see students, residents, and even physicians present in a haphazard way. These people often have intelligent contributions to make to the discussion, but their message is often lost in the confusion and disarray of ideas. With this editorial, I aim to underscore some of the crucial elements of a good presentation so that others will appreciate how truly gifted you are.

EXPECTATIONS

The first step is to understand what is expected of you and to know the basics about what factual information must be conveyed in this exchange. It is equally as important to know who will be the recipient of your message and the specific format they prefer. Be sure you know the parlance of each specialty and the differences among the specialists—eg, a presentation to a cardiologist will not be the same as a presentation to an obstetrician simply by the nature of their professional differences.

When presenting patient information to a cardiologist, you must be sure to know all the coronary artery disease (CAD) risk factors of your patient as well as previous cardiac catheterization details. If your patient has chest pain, be sure to include the descriptors of angina too. Be mindful how often patients with CAD present without classical angina. I frequently hear patients underscore pain while waving their hand from left to right in an attempt to dismiss my concern. On the other hand, an obstetrician is going to want to know your patient's last menstrual period, menstrual cycle characteristics, and gestational history.

However, regardless of the specialty, there are always some common critical facts that need to be addressed. For example, understand upfront if you are being asked to give a full comprehensive presentation or a 1-minute brief update.

EFFECTIVE PRESENTATION

Young healers typically get a brief rundown on how to properly present a patient and are encouraged to describe this information in a certain order. Often this education is inadequate and they learn shortly after how they screwed something up—eg, how they should have presented the history of present illness or what they should have left out of the analysis.

It is important to learn how to present a patient efficiently and thoroughly for 3 reasons.

- ***Develop a method.*** Per Sir William Osler's recommendation, if you consciously do things the same way each time, you are less likely to forget something of significance. If you always order your presentation as chief complaint, history of present illness, past medical history, current medications, and then allergies, you are less likely to ever forget to ask your patient if they are allergic to something and even less likely to prescribe a medicine that may result in a fatal allergic reaction.

Implicit for a good presentation is that you have performed your evaluation in a thorough manner and that you have followed a proper method. For example, present the history with proper method by recounting the patient's story in a chronological and descriptive manner. Start by referencing when the problem began (ie, when the patient was last well) and present the physical exam results by logically reporting information from head to toe.

- ***Present clearly and concisely.*** It is important to present effectively so that your listener—typically a fellow clinician—can clearly understand what you did or plan to do. A good presentation will enable a subsequent care provider to easily pick up where you left off and provide a smooth transition to enable the best possible patient care. Note: A good presentation is not a comprehensive data dump, where you look to impress the listener with the fact that you asked everything. A good presentation is giving the listener the significant information they need to know so they are able to understand what you learned, have input into the case, and perhaps eventually take over that person's care.

For example, an improper patient presentation is calling your attending at 2 AM to give an overly thorough description of your stable patient's entire health history, including his banana allergy. (This actually happened to me!) Instead, you should succinctly give your listeners the information they need to make their own independent assessment as to what is going on with the patient.

This part is slightly tricky, because it implies that you know all of the pertinent positive and negative questions and answers to include in your presentation—which as a young healer you may not. You are learning these as you pursue your training and will continue to learn more and more each day of your career. Like any other skill, the discovery and recognition of significant information comes with practice.

- ***Present well.*** The listener is often going to judge your competence based in part on how well you use the language of medicine—in short, how well you presented. You can be brilliant yet present badly—and your mentor will think you to be disorganized or incompetent. The sooner you master the skill of presentation, the sooner you will impress all of those who listen to you and earn recognition as someone who is organized and coherent. You will more likely be viewed as competent.

RULES FOR AN EFFECTIVE PRESENTATION

- ***Use your patient's words.*** There is always a chief complaint and this is best given in the patient's own words and not your assessment of what he or she meant. For example, the patient said, "I couldn't breathe" is better than your assessment, "The patient presented with shortness of breath or dyspnea."
- ***Carefully outline the history of present illness (HPI).*** This is the most important part of the entire history, so you want to be very careful that you attend to it well. Begin by describing the patient: "This is the first university hospital admission for this 24-year-old African American female who was well until yesterday's admission when she noted she couldn't breathe."

The HPI should read like a newspaper article, wherein the most important sentence—or the lead—is first and then subsequently followed by more detailed information of lesser importance. Like a good journalist, do not bury your lead. Do not hide a critical piece of historical information further down in the body of the report, when in fact it is crucial to understanding the patient's illness.

For example, if your patient was also suffering from an underlying malignancy, was on oral contraceptive therapy, and her shortness of breath occurred simultaneously with the abrupt onset of a dry cough on the day after her long airplane flight, which was 1 week after she had her left leg placed in a cast for a chip fracture of the ankle that occurred while skiing, say so. She may have pulmonary emboli, and as you present your patient in a logical and prioritized fashion, you will help your colleague better understand how you reached that conclusion. Although each piece of information could theoretically be categorized under many different parts of the patient's history, they are details that are extremely important in deciphering the case. It is up to you to recognize them as such and give them to your listener as coherently and concisely as possible.

Remember to present your data methodically and chronologically in a continuum from when the patient felt well to the present sick condition.

- ***Personally ask the patient about medications and allergies.*** Follow your HPI with past medical history, medications, and allergies. Even if a nurse or medical assistant has filled this information in for you, you should personally ask each patient about medications and allergies. Do this every time you see a patient, for the rest of your life. To not do so is bad practice, and mistakes made by missing this opportunity to collect and/or confirm valuable patient information can harm your patient and your career.

This is a good template for the most essential components of the subjective portion of your presentation. Remember to collect as much information as possible. If asked, you should be prepared to provide supplemental facts from the family history, social history, and review of systems, while realizing that pertinent information should already have been mentioned in the HPI.

- ***Vital signs are vital.*** Begin the objective exam with your patient's general appearance followed by his or her vital signs. The general appearance should be such that you could easily pick the patient from a crowd of people or a waiting room. In fact, vital signs are arguably the most important signs under the objective portion of your presentation along with the general appearance. Yet, these 2 descriptors are often given little to no mention.

You can be brief, for example: The patient "looks to be in no acute distress and vital signs are stable." Just be sure to include some recognition of this valuable information. Note: As with the history of present illness, make sure to mention significant vital signs when they apply directly. If our theoretical patient was suffering from pulmonary emboli, we would want to specifically mention her respiratory rate, followed by her pulse oximetry reading.

- ***Every great healer knows the value of (appropriately) touching your patient.*** Almost every patient you care for in the clinical practice of medicine, certainly in primary care medicine, should have his or her heart and lungs auscultated. There may be some particular exceptions to this rule, but most physicians should listen to their patient's heart and lungs at each visit. This is not necessarily for the purpose of discovering some pathology—not to search for a mid-systolic click or pick up subtle bronchophony—but so you may lay your hands on the patient.

You should go out of your way to practice a "laying on of the hands." It is part of a therapeutic, professional intimacy between physician and patient, a conveyance of compassion for the person you are providing care. It is a sign, at a minimum, of kindness.

- ***Comment on "the other" or anything else in the physical exam that may be noteworthy.*** In our patient above, you may also comment if you hear a fixed splitting of the second heart sound as might be heard in massive pulmonary emboli.

- ***Assess and make a plan.*** After your objective exam, comes the hardest part for physicians in training: the assessment and plan. It is the most challenging, for the less clinical training you have experienced the less ability you possess to develop a broad differential diagnosis. The assessment should not be a repetition of your history and physical. It should be your synthesis of a working diagnosis, even if you do not know what is going on.

For example, if you are not sure what is causing your patient's shortness of breath, you should list what you know as fact: "Problem number 1 is dyspnea, etiology unclear. Problem number 2 is recent left leg fracture. Problem number 3 is previous codeine anaphylaxis, and problem number 4 is health maintenance—it is noted that it has been several years since her last pap smear." Call your patient's problem what you understand it to be at the time. Other examples might be "chest pain, etiology unclear" or "vesicular unilateral T5 dermatomal eruption, etiology unclear."

By stating your working diagnosis, you know where you are and are given a lead as to how to proceed. Also, it communicates to your listener that the gears are turning, and you are thinking along a logical train of thought, even if you have not yet arrived at the answer.

- ***Implement your plan.*** This plan should be congruent with your assessment. If you have mentioned 3 active problems in your assessment, you should have 3 active plan items. The plan also includes patient education goals, prescription of medications, and diagnostics, including any additional studies you would like to order.

In addition, every time you see patients it is wise to include in your plan what they can do to help themselves, as well as when they should contact you again and return for care. Some variations to this apply. If you are seeing a patient for an acute or sick visit, there should be some mention of health maintenance under his or her assessment or plan. This is your opportunity to inquire if he or she is up to date on age-appropriate health screenings (eg, an annual well-woman exam). If not, part of your plan should be a recommendation that your patient also consider making an appointment for whatever health screening exams they require.

In continuing with the example of our clinical case of a young woman with shortness of breath, our plan might have the following components:

- o Explained my concern for life-threatening pulmonary emboli to patient; she agrees to emergency department transfer by ambulance for consideration of imaging studies to rule out pulmonary emboli
- o Continued nonweight bearing and use of crutches in light of her recent leg fracture
- o Avoid codeine given allergy to same; consider nonsteroidal anti-inflammatory for pain relief
- o Patient urged to make a follow-up visit at a later date for a well-woman exam.

Physicians should also include recommendations about diet, exercise, and stress under their plan.

THINGS TO AVOID

Common mistakes occur as presentations become disorganized and messy. Your presentation should start with the subjective (What did your patient say?), followed by the objective (What did you observe, auscultate, palpate, percuss—find?), followed by your assessment (What do you think is going on?), and finally, your plan (What are you going to do?).

A common mistake that all physicians in training and young physicians make is going from topic to topic, or from S to P to A to O to S to O to S again, back to P, etc. My advice to you is to tell them the S, the pertinent S, and nothing but the S. Then pause. Indent your presentation so the listener knows you are now leaving "the land of S," for the "land of O." When you get to O, always begin with general appearance, followed by those most vital signs. (They are vital!)

When young healers get to the assessment, they often want to repeat the S and O again. You must fight hard not to do this and continue on to A and P by laying out the patient's problems and attempted solutions. My advice to the young healer is to practice your presentation skills as often as you can and be thankful when a senior clinician "pokes you in the ribs" and tells you to do it differently.

You must always strive to be the best communicator of medicine possible. In the end, the patient will be better served, you will be a better physician, and you will be viewed in a more mature light. ■

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FURTHER READING AND RESOURCES

- McGee S. Oral case presentation guidelines. University of Washington. http://maziquemedcases.files.wordpress.com/2011/02/oral-case-presentation-guidelines.pdf.
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