

Wednesday September 11, 2014

1:30-3:30 PM

Oral Presentations

Competencies	Threads	Integration
Physician as Clinical Problem Solver	Interviewing Problem Solving	Organ Systems Disease, Course (OSD, ICE)
Physician as Communicator	Presentation Skills	LPP (if case from LPP used)

Goals:

1. To observe, then practice giving, an oral presentation after a focused history is obtained.

Objectives:

By the end of the session, students will be able to demonstrate:

1. An understanding of the structure of oral presentations
2. The ability to properly place relevant aspects of the history into a concise focused presentation of the HPI.
3. An understanding of the reasons oral presentation skills are increasingly important in the current era of medicine.

Methods:

Before the Session:

Students should read the following articles

1. Goldfinger S. On needless words. *New Eng J Med.* 2005;352:1947.
2. Sobel RK. MSL-Medicine as a second language. *New Eng J Med.* 2005;352:1945-1946.
3. Review case and review the oral presentation framework (PASS ONE) in BLS Vista for a broad range of presentations. You should review the Introduction to the PASS ONE model, and the HPI presentation (7 cardinal features and beyond). We will teach the other types of presentations as the year goes on (the bedside presentation, the complete presentation, and the consult presentation). For this session, you don't need to continue watching the portion of the video where it goes beyond the HPI to the complete presentation
4. Review presentation checklist listed in BLS: This will be the checklist that you will be graded on during the Individual Interview sessions on either 9/26 or 10/3

During the Session:

1. The faculty mentors will model a patient presentation
2. Students will break into groups of 3 and will present either a case that they have seen from their LPP, or another case that you've seen in the past, either personally or in DCS2 (you may use cases from previous DCS2 small group sessions). If you absolutely cannot think of a case, there are 3 cases attached at the end of this handout that you will need to transform into "a focused presentation"
3. Their group will give feedback on oral presentations, using checklists (See BLS under "Resources")

1:30-2:00 Review of oral presentation goals and the focused presentation aspects of the PASS ONE model

- a. What are the goals of the different types of presentations
- b. What should be included?
- c. Is there information that should be left out
- d. Give Examples

As a result of teaching the oral presentation over the last few years, and in conjunction with the curriculum review process, a group came up with guidelines for various types of oral presentations that will allow you to organize your presentations in almost any context. We present that information here to help you in the rest of the session, to tailor your presentations to the specific circumstances. The Mnemonic is **PASS ONE**

As you prepare to do oral presentations, and in approaching any oral presentation, consider:

Purpose
Audience
Situation
Setting

Opening Line/Orienting Statement
Narrative
Evaluate

As the year progresses, we will practice giving different presentations to different listeners in different settings, and the PASS ONE model will help prepare the student for these varying tasks. For this session, we will practice the focused presentation, meaning the student's presentation will include a full HPI with 7 cardinal features, as well as any PMH, FH, SH and ROS that is relevant to the chief complaint.

ANATOMY OF A FOCUSED PRESENTATION

Opening Line/Orienting Statement

Your opening line will vary depending on the audience, the situation, and the purpose of the presentation. It should orient the listener to key elements of the chief complaint and how it relates to the broader case. Consider the following situations.

1. In a new patient who presents with symptoms of cough, you should make sure that the chief complaint is in the first sentence of your presentation. “This is a 32 year old man who presents to the hospital with shortness of breath and cough.”
2. You do not need to present all the details of the Past Medical History in the first line of the presentation, but you should consider whether some aspects of the medical history would influence the listener’s thinking and is so important that you should include it in the first sentence. For example, one would think differently if the opening line of the presentation above were: “This is a 32 year old man with a 12 year history of HIV infection and progression to AIDS who now presents with shortness of breath and cough.”
3. If you are calling a consultant, you should detail the reason for the consult at the end of the first line of the presentation. This may be a completely different presentation and problem for which the patient was admitted to the hospital or for which the patient is being seen by you today in the outpatient setting. In the above example, you might call a neurologist for symptoms of peripheral neuropathy (numbness and tingling in legs below the knees) for the last 3 weeks. So your opening line might sound like: “This is a 32 year old man with AIDS admitted 2 days ago with fungal pneumonia who we are asking you to see for symptoms of numbness and tingling below his knees over the last 3 weeks.” The rest of your presentation would focus, not on the disease/HPI, but would focus on the history that you took pertaining to the neuropathic symptoms, i.e. the pulmonary complaints really are a “Review of symptoms” to the consulting neurologist, even though it is the patient’s chief complaint.

Narrative

There are some basic aspects to telling a story (even non-medical stories) that apply here. You should pay attention to:

1. Timing and chronology-tell the story in a sequence beginning at the beginning and moving forward in time. “The patient has had symptoms of shortness of breath and cough over the last 3 weeks. It began with.... If there is more than one symptom complex that needs to be described, report on one completely, and then report on the other. In the above example, if the shortness of breath and the cough started at the very same time, this gets reported as one symptom complex. If the shortness of breath came on over the last 3 weeks, and the cough is a year round thing for years, then report them separately
2. Keep like items together (7 Cardinal features, Pertinent ROS/SH/FH/PMH/PSH (related to HPI), Medications/allergies, then the rest of the data base if it is being reported. Don’t skip around between the 7 cardinal features, PMH, PE etc. For example, describe the seven cardinal features of the chief complaint together so

that the listener will have a picture of what the complaint is about, then detail pertinent Review of Systems, risk factors etc

The rest of the presentation should follow what we gave you earlier in the DCS course under Guidelines for Oral Presentations

Content of the Narrative

CC-Identifying information and the chief complaint (see instructions for opening sentence above)

HPI-should reflect the chief complaint, its features (7 cardinal features), as well as pertinent positive features (pertinent positive is a symptom, risk factor or risk behavior associated with pathological conditions presenting with such a chief complaint which is present in the patient) and pertinent negative features (pertinent negative is a symptom, risk factor, or risk behavior associated with pathological conditions presenting with such a chief complaint which is absent in the patient). The pertinent positives and negatives depend on your knowledge of pathophysiology. You should at least detail:

- The seven cardinal features of the presenting symptom.
- The review of systems of the system in which the chief complaint falls.
- Questions related to disorders of anatomic structures that are related to the chief complaint
- Pathophysiologic features: symptoms of disorders that could present with the chief complaint
- Risk factors for disorders that could present with the chief complaint (something from the PMH, FH, SH, or medications that makes a particular diagnosis more likely, i.e. heavy drinking from SH or aspirin from medications are risk factors for a bleeding ulcer).

Past medical history/Past Surgical History-as related to the HPI.

Medications-list the medication and doses that the patient is taking.

Allergies-list agent and type of reaction.

Family History –list those diseases that are related to the HPI.

Social History description of work and marital history, and health habits including smoking, alcohol consumption, drug use, and sexual history as related to the HPI.

By the end of the HPI presentation, the listener should have some idea of the diagnostic possibilities that you are considering.

If oral presentation is a complete presentation of a full History and Physical (like you will perform in PD 2 and in the clinical years), you will present details of PMH, FH, SH, ROS in more complete fashion, but with less detail than information from these categories that are related to the HPI

Review of systems-for the presentation; you should only give those positive symptoms that will need to be addressed during the admission or at the end of the outpatient visit.

Physical Examination-patient's general appearance (uncomfortable appearing woman in

respiratory distress), a complete set of vitals, all parts of the exam that could have abnormalities produced by diseases that are on your differential.

Summary statement

1. **Must start with pt demographics (Sex, Age)**
2. **Most pertinent PMH, FH, SH, i.e. if is is immediately related to the chief complaint**
3. **End summary sentence with as much of a “commitment” your proposed diagnosis as you are able to give at your level of training. For instance, in the case above, you may say “32 year old male with a 12 year history of AIDS who now presents with fever and cough, suspicious for PCP pneumonia”.**
You may only be able to narrow down your most likely diagnosis after the history and physical (you will likely be doing more, i.e. labs, XRAYs, to further clarify).
For instance, “18 month old full term male with 2 days of cough and wheeze, and now 1 day of increased work of breathing, consistent with either asthma or bronchiolitis”
4. **Do not have your summary statement be a rehashing of the HPI!**

Notes on a Summary Statement*

Summary (def.) using few words to give the most important information about something

People call this a “Summary Statement” but as we mean it, it is not simply repeating the facts in a shorthand way. In our meaning, it is conveying the “most important information” or the essence of the case.

Other language that is used for this is a “Gist statement” or an abstract representation of the problem. This is language used most specifically by Scott Wellman MD, who works in the Center for Academic Achievement, so we want you to be familiar with the “gist statement,” but we are choosing to use the more common vocabulary of summary statements that you are likely to see written about when talking about oral presentations or write ups.

In generating a summary statement, it is important to clearly state that we are changing the patient’s words into “doctor” words. And we are using many descriptors. For example, it is not sufficient to say the patient has abdominal pain (which might have been the chief complaint) because it is not specific enough to allow you (or the listener, or the reader) to have an idea of what you think might be going on. I can’t problem solve abdominal pain. RUQ abdominal pain is better but still too broad. Use the information that the patient provided to you in the history to synthesize your thoughts and really describe the abdominal pain (NOT in the patient’s words). For example,

“40 yo overweight, Multip (G4), Caucasian woman with prior history of relapsing RUQ, colicky abdominal pain triggered by fatty meals, now

presents with acute, constant, moderate to severe RUQ abdominal pain with fever.

This paints a picture. It let's us know that this is someone who likely had cholelithiasis which has developed into acute cholecystitis. In generating your summary statement, you have used descriptive words (semantic qualifiers) to construct a more abstract mental image of the problem (Bordage, Medical Education. 2007)

The Summary Statement (Gist) is based on the key findings of the case so far. The Statement should:

1. Be a concise statement that accurately highlights the most pertinent features in a case without omitting significant points:

- Epidemiology (age, gender, risk factors)
- Key clinical features (symptoms, signs, data)

2. Transform specific details into medical terms (example: "jaundice" rather than "skin is yellow". Heart rate is more tricky. Some people like "tachycardia" rather than "heart rate of 150" however you should at least quantify the tachycardia, eg, "severe tachycardia" or Tachycardic to 150").

3. Use qualifying adjectives and adverbs to better describe key findings AND it should paint a picture of the patient including how ill the patient is:

- diagnostic considerations: diffuse vs focal; monoarticular vs polyarticular
- severity: mild vs severe
- progression: acute vs chronic; or constant vs intermittent
- Etc.

Ultimately, a good Summary Statement should provide the basis for developing an appropriate differential diagnosis.

*** Gist Statement or Abstract Problem Representation is how Scott Wellman refers to this, and may do so with students who he encounters in the Center for Academic Achievement**

Problem Lists*: The Joint Commission on accreditation of Health Care Organizations promotes the use of problem lists to allow clinicians to think more completely about their patient's health. The problem list is anything that has relevance to the patient's health, whether related to the chief complaint or not. It can be viewed as more of a "findings"

list since many of the elements may not constitute an active “problem”. An example is below for our 32 year old above

1. cough
2. fever
3. HIV+
4. low CD4 count
5. peripheral neuropathy
6. smoking (if he does)
7. hypercholesterolemia (if he is. Note, this is not likely related to his cough and fever AT ALL, but still important to his overall health, thus, goes on the problem list)

*Note – we will have more about problem lists in subsequent sessions

2:00-3:15

Split into groups of 3. Each student should take 15-20 minutes to present a case, either a case that is known well to you from previous experience, or one from the paper cases listed below. The second student will be the listener, and the third student will fill out the oral presentation checklist (see BLS).

SAMPLE CASES:

1. My name is June. I am 45 years old and I came in today because I am having some belly pain. I am not sure how long it has been going on - maybe an hour or two. I woke up this morning and was watching the morning shows while I was eating and suddenly I felt terrible. I called my sister and she said she was feeling bad today too. Her dog was sick and she was taking him to the Vet. I was supposed to go but I couldn't get off the couch.

Sometimes I take a TUMS for my stomach so I tried that today but it didn't help. I have been taking the TUMS for the past week more than usual for some indigestion. Now that I think about it, the indigestion has been more than normal. It is similar to the current pain but now it is more burning and the pain is much worse. The TUMS used to help but not today.

I have to admit that I was tempted to use some of my sister's oxycontin. She has a bad back and gets a lot of pain meds from her doctor. But with my history of heroin addiction for 15 years, I didn't do it. I have been clean now for 6 months and 2 days!

Do you think it could be something I ate? I ate a leftover ham and cheese sandwich when I got up this morning. My brother's girlfriend brought it over because she didn't finish it.

Gosh – the pain is so bad. It is like a gnawing pain right above my belly button. It is about a 7-8 out of 10. No matter what position I sit, it doesn't get any better. I feel like I am going to throw up but I haven't. Maybe I am constipated – I haven't had a bowel movement in a couple of days. I tend to be on the constipated side just like my mom. No blood in the stool the last time. No diarrhea. No trouble swallowing.

Do I feel warm? I feel like I am running a fever today but I don't have a thermometer at home. No chills. What did the nurses say my temperature was?

Now that I think about it, this is just like some pain I had 4 months ago. I went to the Emergency Room but they didn't do anything and sent me home.

The pain now hasn't moved at all since it started. I admit I have been drinking more lately from stress from work and home. I have the three kids and my husband of 19 years and I been fighting. I work as a radio dispatcher for a local cab company. I have been drinking about 3 drinks a day for 3 years now – maybe more lately but I don't keep track. I used to drink more but I had some belly pain and so I cut down.

I am still smoking cigarettes though. Can't give up that one! About ½ pack per day for 15 years.

I have never been hospitalized except the one time my blood pressure got too high because I had stopped taking my blood pressure medications

FH: I can't keep track!

2. Cough (from 8/31 session)

I am a 24 year old male, and I've had a cough for about a week, but it has gotten worse over the last few days. Initially, it was just like a cold: my nose was a little runny, and I had a cough that, you, know, you get with a cold. I was bringing up a little yellow stuff...sometimes, not always. Now over the last 3 days, the runny nose and stuff is better, but the cough is so much worse! I have a feeling like I have something stuck in the back of my throat, and sometimes I can get it up by vigorously clearing my throat, but sometimes I can't. I feel the overwhelming urge to cough it up, and over the last few days it's really taken some violent coughing to actually get it up. I do eventually get something up each time, but it's gotten to the point where the cough needs to be so forceful to get things up that I've been gagging, and one time I actually vomited. I've noticed it's worse at night, it's just that the stuff in the back of my throat seems to accumulate more easily when I am lying down. When that happens, I need to sit up, more because it is hard to get as vigorous a cough going if I am lying down. I find that I am exhausted after one of these coughing episodes (lasts a good 30 seconds or so before I get something up), but other than that I haven't been more tired. I don't have any problems breathing in between the episodes. After I cough, I often have this headache in the front on both sides, but it is brief, only lasts about 10 minutes after the coughing. I work nights at a nursing home, and last night they had to send me home it was so bad, I was keeping the patients up! My mother told me she thought this was pneumonia and that I should take my temperature, so I did last night for the first time and it was 101. It was 99.8 today. There is no one around who is sick, although there always seems to be one of the old ladies at the nursing home who has pneumonia. My mother thinks this is pneumonia and that I need to be on antibiotics. What do you think?

My social history? I live alone in an apartment, my parents live in town.

I have a girlfriend, she won't go near me in the last few days! Do I drink? Sure, I have a couple of beers when I go out with my friends on the weekends...ok maybe more than a few, but I never drive afterward. Do I smoke? I have a few cigarettes when I'm out with my friends if they are smoking, but I wouldn't say I'm a smoker.

As far as my PMH, my mother told me that I had asthma when I was little, took a nebulizer or something like that, but I don't remember doing that and I haven't used an inhaler at all recently. Other than that I've been healthy. Hay fever runs in my family (my brothers and sister) but I've never had problems with that.

Do you think I need an antibiotic?

3. Chest pain (from the 9/7 interpreter case, given by a patient with Limited English through an interpreter)

I am a 39 year old male (female) and I've had a couple of months of chest pain. At first it was infrequent, but now it is happening maybe 7-8 times a week so I wanted to get it checked out. It feels like a squeezing and is located right in the middle of my chest. Originally it happened only after meals, now it happens after maybe 1/3 of my meals, and has starting happening at other times, too. Last night it woke me up from

sleep for the first time: really scared me, that's why I'm here today. And in the last few days It's been happening when I lift something heavier at work, or if I've been bending over frequently, as I sometimes do at work (I work on the floor of an electronics assembly plant on GoldStar Boulevard). I feel sick to my stomach sometimes with it, but I haven't actually thrown up. I don't feel it anywhere other than in my chest, it's not in my arms or jaw or anything like that. I haven't been sweaty at all with it, and I haven't been lightheaded or dizzy or anything like that. I haven't had any cough. It usually subsides after about 10-15 minutes if I sit down and rest. I have taken my usual TUMS with this, and I guess it works, but the times I haven't taken my TUMS it's gone away anyway, so maybe it isn't the TUMS. I guess it does make the pain a little worse to take in a deep breath during the episodes. So I guess I wouldn't say that I'm short of breath, although as I said, it is a little hard to take a deep breath while it's happening.

I moved here from El Salvador 3 years ago, and I've been trying to save up enough money to bring my wife and two kids here too. It's been hard, I've been through several jobs here, I never know when this one will end. And with immigration reform, I wonder if I'll ever get my family here. There are some Salvadorans here, but not a huge community. I go to church, but, besides working, I don't do much else. I don't exercise per se (I get plenty of walking at work) I have been healthy in the past. The last time I saw my doctor in El Salvador, I think he told me that I had high cholesterol, but that was 3 years ago. He also told me I should be losing some weight, which has been hard for me. I've been about 240 pounds pretty much since I moved to the US. I've had indigestion for along time, and I take TUMS quite a bit, but that was more for mild stomach pain/queasy than chest pain. They aren't related are they?
Do I smoke? No, I never have. Do I drink? Sometimes I have wine with my dinner, especially if I get home late. I guess I have had wine with dinner most every night recently.

My mother died of heart failure back in El Salvador 10 years ago: her doctors told her she had coronary problems or something like that. I know that both she and my father had high cholesterol.

Do you think it's serious doctor?