

Oral Presentation Guidelines – Outpatient

Adapted from guidelines by Drs. Steve McGee and Anne Eacker

This oral case presentation guideline is intended to serve as a resource for both medical students and their educators. Style may vary slightly in different clinical settings but we hope that this offers a framework that is applicable to the majority of situations.

Principles

1. The purpose of the case presentation is to concisely summarize the patient's history, physical exam, and your assessment of the patient's medical issues and how to best manage them
2. Presentations should be given in the patient room whenever possible. If you have questions about the plan or what to include in the presentation, check with your preceptor outside the room.
3. Presentations should be brief, less than 5 minutes
4. Prioritization is essential; oral presentations should reflect the agenda you set with the patient.

Basic structure:

1. Identifying information
2. Subjective: In the outpatient setting patients may be presenting with new symptoms, in which case you report a classic "history of present illness", or they may present for follow-up regarding chronic medical issues.
3. Objective: Pertinent physical exam; in some situations labs/studies performed at the time of the visit (e.g. point of care urine testing)
4. Assessment/Plan

Details:

1. Identifying information: This should be a statement which identifying the patients age, gender, important medical problems and reason for presentation. It may be very brief when the preceptor already knows the patient.
2. Subjective:
 - a. New symptoms: Provide a classic HPI. A chronologic history, reporting the details of their symptoms (duration, frequency, evolution of symptoms, aggravating/alleviating factors, etc), followed by pertinent negative symptoms/risk factors.
 - b. Chronic medical issue: Offer a brief summary of their medical issue, this may include objective information (e.g. most recent A1c), recent medications started to treat the issue. Focus on events since their last clinic visit for this problem. Review pertinent positives and negatives appropriate for the medical issue (e.g. symptoms of hyper or hypoglycemia).
 - c. When patients present with several things to address, these should be clearly separated. E.g. Diabetes Management, HTN management, Low back pain.

3. Objective:
 - a. Begin with a general description and vital signs
 - b. Limit physical exam to that pertinent to issues addressed at today's visit
 - c. Labs/studies: While hospitalized patients often have labs and studies to report, this is less common in the outpatient setting. Information that pertains to issues addressed today should be included.
4. Assessment and Plan:
 - a. Begin with a statement summarizing the patient visit.
 - b. Go through your assessment and plan by problem in order of priority.
 - c. Focus your assessment on the decisions that need to be made today. For new problems, this is often about diagnosis—e.g. the differential and your plan for further workup. For chronic problems it's often about management—e.g. how to adjust antihypertensives.
 - d. There is no need to discuss irrelevant options for diagnosis or management. If the diagnosis and plan are obvious, present them and move on.

Delivery Tips

1. Be aware of your body language – including posture, eye contact
2. Keep your language precise and do not editorialize
3. If presenting with the patient present, try to use lay language as much as possible.
4. Follow the outline of the OCP in a linear fashion