


DEPARTMENT OF ADVICE

# The art of presenting

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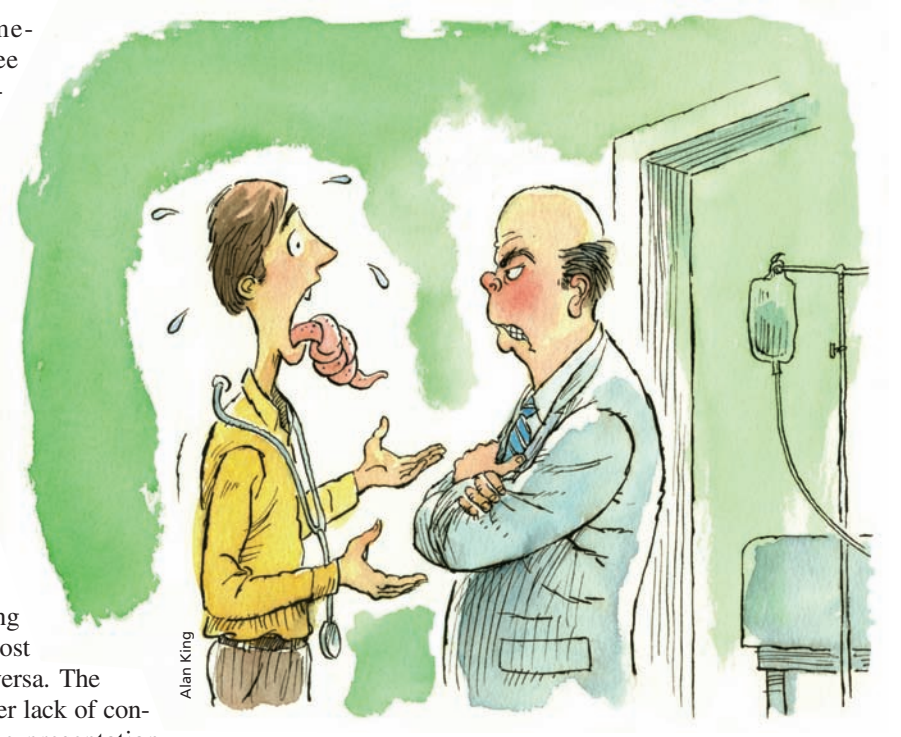
The oral case presentation is a time-honoured tradition whereby a trainee presents a new admission to the attending physician. We describe the presentation styles of students, residents and staff physicians and offer pointers on how to present like stereotypical members of each group.

Although the case presentation occurs in nearly all disciplines, internal medicine (especially "team medicine" or Clinical Teaching Units) has a long-standing love–hate relationship with the case presentation and thus will be used throughout the paper to illustrate the ups and downs (mostly downs) of presenting.


Alan King

## Presentation styles

### The clinical clerk

The case presentation can be the most exciting part of the day for the clinical clerk and the most dreaded for the attending physician, or vice-versa. The key feature of a clerk's presentation is his or her lack of confidence. Overinclusive and unconvincing, the presentation often showcases verbal diarrhea at its finest. The following pointers highlight the techniques best used by clinical clerks.

- Hedge your bets when reporting the physical exam (e.g., "I think I heard a murmur, or it could have been my stethoscope rubbing against his chest hair").
- Present impossible findings (e.g., "The spleen was almost palpable").
- Offer creative euphemisms for "I didn't do that" when asked for physical findings that were not obtained (e.g., "My physical exam did not alter the prior probability of a knee effusion").

### The elective clinical clerk

The elective clinical clerk, unlike other clerks, has declared an interest in pursuing a career in internal medicine. Thus, the case presentation is *definitely* the most exciting part of his or her day, because it guarantees face time with the staff.

Elective clinical clerks tailor their presentations heavily to impress specific staff physicians in the hope of receiving a positive reference letter. For example, they will list all of the negative findings, not just the pertinent ones, to show that they have left no stone unturned or detail overlooked. Elective clerks are also often hyperaware of their attending's preferred presentation format and will overindulge in this style. If a staff physician likes a narrative format, the clerk will record the interview to present the case in the patient's "own words." Finally, elective clerks who come from other institutions often take the opportunity to promote their own institution in their presentations, usually in backhanded ways.

The following pointers will help elective clerks hone their presentation skills:

- Present a ludicrous number of "pertinent" negatives (e.g., "The patient did not have any neurological symptoms. He denied headache, visual changes, weakness, paresthesias, vertigo, seizure activity, dysarthria, aphasia, alexia, agraphia, ataxia, abulia, akathisia, ageusia, allodynia, anosmia, apraxia, athetosis, astasia and astasia–abasia. Dangit, I forgot to ask about anosognosia").

- Show knowledge by posing questions you obviously do not need to ask (e.g., "Regarding the woman with recurrent urinary tract infections, would there be any problem with prescribing prophylactic nitrofurantoin … apart from the risk of pulmonary toxicity?").
- Promote your own institution, preferably in a backhanded way (e.g., "I guess this isn't the case in Toronto, but here at McMaster we learn to do only physical exam manoeuvres that have been validated in randomized controlled trials").

### The off-service PGY-1 resident

The off-service junior resident on a medicine rotation is the ultimate "fish out of water." Having begun to develop skills in their specialty of choice, off-service PGY-1 residents leave their comfort zone for cringe-inducing discussions of hyponatremia and eosinophilia. They go to great lengths to avoid the dissertations on diagnosis and management that internists love (e.g., by presenting the case of a patient who has rapid atrial fibrillation with a ventricular rate of 150 beats per minute by speaking at a rate of 150 words per second). Failing that, they seek solace by referencing their own specialty (and not so subtly suggesting its superiority). The following pointers highlight the presentation techniques of off-service residents:

- Avoid discussing "medical issues" by focusing on your own specialty (e.g., "This is an 85-year-old man presenting with shortness of breath. He also has been followed by urology for a remote history of prostate cancer. The cancer was discovered in 1990 and has been inactive since treatment in 1992. It was originally diagnosed by Dr. Thompson, a personal mentor, via transrectal biopsy, and pathology revealed a Gleason score of 5. The biopsy was then stained with [made-up-dye] #2 to determine its malignant potential, although that stain is no longer in use …").
- Use verbal and nonverbal cues to express the superiority of your own specialty (e.g., "Do you know what type of incision the general surgeon will use to repair the bowel we perforated during the paracentesis?").

### The internal medicine PGY-1 resident

With a background in internal medicine, this first-year resident generally has more medical knowledge and practical know-how than the other junior residents. The internal medicine trainee will stop at nothing to show his or her prowess in caring for patients, an earnestness that often manifests as a never-ending pursuit of esoteric (and often impossible) diagnoses.

Similarly, the internal medicine trainee goes to great lengths to display his or her burgeoning knowledge base. The goal is to get a "wow" from other junior residents (e.g., by reciting the differential diagnosis of Ortner syndrome) or from clerks (although getting a "wow" from a clerk is not difficult — this can usually be done by pronouncing "syncope" correctly). On occasion, this earnestness can resemble smugness, especially as the resident approaches the end of the internship and begins to think about how he or she will function as the senior resident/team leader.

As a junior resident in internal medicine, you may wish to incorporate the following techniques in your presentations.

- Pursue impossible diagnoses (e.g., "This 87-year-old man with a history of dementia now presents with worsening confusion, diarrhea and occasional arthralgias. Everything has improved with volume repletion and antibiotics, but his constellation of findings raises the possibility of undiagnosed Whipple disease. I've already received telephone consent from his third cousin in Florida, so I think we should call GI regarding small-bowel biopsy").
- Be overly smug regarding the senior resident's decisions (e.g., "When I run a team, I'll never …" [this smugness quickly disappears when the senior resident takes a week's vacation, leaving the PGY-1 resident to function as the "junior senior"]).

### The senior medical resident (R2)

The senior resident serves in a supervisory role and must help the junior residents and clinical clerks in their (often futile) attempts to impress the attending physician. As a result, the senior resident is indirectly evaluated every time the junior trainees present. The attending will love a senior resident who can help clerks present cases in a crisp, coherent manner. On the other hand, a poor presentation can raise more questions about the resident than about the clerk. To guard against the latter situation, the senior resident finds ways of showing their own clinical skills. Many do this by interjecting during the presentations of other team members. Unfortunately, these interjections rarely (i.e., never) advance the patient's care. They are, however, preferable to the "not my fault" approach taken by some senior residents who sit behind a clerk — in the line of sight of the staff — and shake their head in feigned disbelief as the clerk presents.

Below are techniques used by senior medical residents during presentations.

- Interject petty details to show that you are on top of everything (e.g., "I suppose the cardiac exam was 'normal,' but there was a physiologically split $S_2$ over the pulmonic valve").
- Interject information that serves only to let the team know your desired subspecialty (e.g., "I don't think we should discount the possibility of brucellosis in this patient. We probably should investigate for tularemia as well … and throw in a VDRL test too").

### The attending physician

As the presentee rather than presenter, the attending physician relies on the information he or she receives to make the final decisions regarding patient care. Knowing this, most trainees assume that attendings want to hear presentations that are comprehensive and error free. They are mistaken. Attending physicians love it when a trainee omits a key detail or misinterprets a key piece of information. Such instances provide attendings with two things they crave: the opportunity to show the clinical acumen achieved through years of experience, and the opportunity to create memorable teaching points. Everything an attending does while hearing a presentation is geared toward fulfilling these two goals (although a third — often unstated — goal is to stay awake). Some attendings simply listen intently and passively recognize subtle deficiencies (these attendings are typically described as

"nice," "approachable" and "boring"). Others have a different approach, actively trying to create gaps they can fill with one of many examples of their clinical expertise, as highlighted in the following pointers.

- Create gaps by preventing the trainee from presenting (e.g., Clerk: "The patient I saw is a 75-year-old male who was referred for chest ..." Attending: "Alright! Let's go see him! Nice presentation, but I'll give you some feedback: you've got to get to the point a little quicker next time").
- Create gaps by questioning everything the trainee presents (e.g., Intern: "This 70-year-old male was referred because of a CVA." Attending: "I think you mean 'stroke,' which is not an 'accident.'" Intern: "Sorry. Anyways, the patient had a positive Babinski reflex on his right." Attending: "Do you mean that his plantar response was up-going on the right?" Intern: "Of course, I don't know where I got that from." Attending: "Did you just end a sentence with a preposition?").

## Conclusion

Presentation styles vary tremendously among trainees. One aspect, however, remains constant: everyone involved is trying to highlight his or her own skills. Clerks want to showcase their ability to compile information, junior residents their diagnostic skills, senior residents their ability to manage complex patients, and attending physicians their clinical reasoning and mentoring skills. Implicit in this is the great strength of the case presentation: trainees at every level not only get to practise their own skills, they also see what they must do at the next level. Fortunately, all trainees provide the team with endless nuggets of entertainment — one just needs to stay awake to hear them.

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