Rediscovering the lost art of the oral case presentation

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Fashioning a succinct presentation requires synthesis and judgment to determine what to leave in and what to leave out

Presenting patients to supervisors in a cogent fashion appears to be a dying (or already dead) art among psychiatric residents. Trainees often approach the oral patient presentation as simply a routine necessity rather than a core professional skill that reflects their ability to synthesize and relay clinical information. In this article we offer suggestions on how to reclaim this lost art.

Tell a story. Think of your presentation as a story about the patient. A story has a beginning, middle, and end; in this case, the order is present illness, psychiatric history, medical history, social history, family history, examination, laboratory data, diagnostic impression, treatment plan, and prognosis. Do not intermingle these elements into a free-associative stream of consciousness or a tale of how and in what order you obtained the information. It is the doctor's—not the patient's—responsibility to be a good historian.[1]

Define the 'leading edge.' For an inpatient, the leading edge might be the symptoms that led to hospitalization. For an outpatient, it is not unusual for the present illness to go back many years, which is where the presentation should begin. Resist the temptation to start more recently because to do so often leaves the listener wondering—when did this begin, and how does it fit into the bigger picture?

Respect your listeners. You want to leave your audience with a clear picture of who your patient is. Presenting a patient should call to mind the saying, "If I'd had more time, I would have written a shorter letter." It takes more time and effort to fashion a succinct presentation than to produce a rambling narrative with extraneous material; it requires synthesis and judgment to determine what to leave in and what to leave out. George Murray, MD, a consultation psychiatrist and our mentor, is fond of saying, "Do you know how to bore your audience? Tell them *everything*." Respect your listeners' time and credit their intelligence. Your presentation should stimulate questions, not preempt them by being overly inclusive or exhausting all of your allotted time.

Do not rehash the history when presenting the assessment. The assessment is what you think about the history and examination data—how you put it all together to make sense of it diagnostically so you can approach treatment in an organized way. It is not the time to recapitulate what you should have summarized in the earlier part of your discourse. The diagnostic impression is where you can show off how you think as a physician. It is where you can shine.

Reference

1. Tiemstra J. The poor historian. Academic Medicine. 2009;84(6):723.

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