Oral Case Presentation Benchmarks

On completion of Foundations of Clinical Medicine, students should be able to perform an accurate, complete and well organized *comprehensive* oral case presentation for a new clinic or hospital patient, and *adapt* the case presentation to the clinical setting. A comprehensive OCP includes these sections:

Identifying information & chief concern	Name & age
	Known medical problems highly relevant to the chief concern (< 4)
	Chief concern and duration of symptoms
History of present illness	Background: Health at the time of symptom onset and details of any chronic illness directly related to the chief concern.
	Details of the presenting problem: Beginning at symptom onset and proceeding sequentially.
	Predisposing conditions & risk factors
	Pertinent negatives
	Optional: Hospital course or evaluation to date
Past medical history	All active medical problems and any other problems relevant to evaluation or ongoing management. Summarize for each major, active problem: diagnosis, current treatment, control, and complications
Medications & allergies	Prescribed medications and doses Non-prescription medications and complementary therapies Drug allergies and the type of reaction
Habits and risk factors	Substance use not already covered in HPI
Social history	Summary of social influences on your patient's health and health care: living situation, social support, occupation and avocation, any financial or other concerns
Physical exam	General appearance and vital signs
	Name each organ system in order and report all pertinent exam findings, both normal and abnormal: • Comprehensive exam of system(s) relevant to chief concern • Other findings (normal or abnormal) that will help your listener answer a clinical question Report all abnormal findings
Summary statement	Restate the ID, and summarize the key features from the history and exam
Assessment	Format determined by clinical context
Plan	Format determined by clinical context

PURPOSE AND FORMAT OF EACH SECTION

The purpose of the oral case presentation is:

- To concisely communicate the findings of your history and exam to other members of your team
- To formulate and address the clinical questions important to your patient's care

Identifying Information and Chief Concern (ID/CC)

Purpose: Sets the stage and gives a brief synopsis of the patient's major problem.

Format: -Identify the patient by name and age

-Include no more than four medical problems (sometimes there are zero) that are highly relevant to the chief concern. List only the diagnoses here, and elaborate on them in the HPI or PMH.

-Report the chief concern and duration of symptoms

Template: "Mr. _____ is a ____ year-old man with a history of _____ who presents with _____ of _____ duration."

Example: "Mr. T is a 32 year old man with Crohn's disease who presents with bloody diarrhea of 3 days duration."

History of Present Illness (HPI)

Purpose: Provides a complete account of the presenting problem, including information from the past medical history, family history and social history related to that problem.

Format: The HPI should occupy 1/3 to 1/2 of your total presentation time. The content of the HPI in the oral case presentation is the same as the HPI in the write up.

Template: A 5-paragraph format is one common structure for the HPI. Use this structure for your case presentations for patients seen in college tutorials. Your preceptors may ask you to adapt this structure in different clinical contexts.

Paragraph 1: Background

Characterize the patient's health at the time current symptoms began. If the presenting concern is related to a chronic illness, give a brief summary of the illness, including when it was diagnosed, treatment, complications, and how well it is controlled.

Example: "Mr. T was in his usual state of good health, with well controlled Crohn's disease, until three days prior to admission. He was first diagnosed with Crohn's in 2011, when he presented with diarrhea, abdominal pain, and weight loss. He was treated with steroids and then infliximab, and his symptoms have been well controlled, with one to two bowel movements per day. He had had no recent flares or hospitalizations before this week."

Paragraph 2: Details of the presenting problem

This is an organized and edited version of the patient's narrative, beginning at the onset of symptoms, and proceeding sequentially to the time of presentation. This section should describe the presenting concern completely:

- Quality
- Time, duration, & frequency
- Aggravating or alleviating factors
- Associated symptoms
- Attribution
- Any prior episodes

If the presenting concern is pain, also describe:

- Position (or location)
- Radiation
- Severity

Paragraph 3: Predisposing conditions and risk factors (aka. 'pertinent positives')

Information from the rest of the history (PMH, medications, habits and risk factors, family history, ROS) that is directly related to the presenting problem. For example, a family history of cirrhosis is pertinent and should be included in the HPI of a patient who presents with jaundice. The same family history of cirrhosis would NOT be pertinent to a patient with dysuria, so would NOT be included in the HPI.

Paragraph 4: Pertinent negatives

Pertinent negatives are symptoms, conditions and risk factors that your patient does NOT have that directly affect your assessment of the patient's problem. For example, "No family history of liver disease" is a pertinent negative in a patient presenting with jaundice.

To start with, report the absence symptoms from the major organ system involved and the absence of constitutional symptoms in the pertinent negative section.

Paragraph 5: Evaluation of this problem to date

(Optional)

3. Past Medical History (PMH)

Purpose: To provide a succinct overview of other important medical and surgical history that will aid in the care of the patient.

Format: Report active medical problems and other medical history that is pertinent to evaluation or ongoing management. Medical or surgical history that is relevant to the chief concern should be included in the HPI. If a past diagnosis or surgery is not active or relevant, it is included in the write-up but NOT in the OCP.

Include a brief synopsis of each active major problem:

- Diagnosis
- Current treatment
- Control
- Complications

4. Medications and Allergies

- List all prescribed medications (by generic name if possible) and doses
- List all non-prescription medications and complementary/alternative therapies
- Report any drug allergies and the type of reaction

5. Habits and Risk Factors

- Summarize substance use not already mentioned in HPI, including tobacco, alcohol, drug use
- Risk factors relevant to the presenting concern should be included in the HPI

6. Social History

Purpose: To provide your listener with the social context of the illness and its impact on ongoing care

Format: In 2-3 sentences summarize the patient's living situation and support systems, occupation, and any social issues that could impact care.

7. Physical Examination

Purpose: Succinctly and accurately describe the patient's physical examination, emphasizing pertinent findings

Format: Begin with general appearance and vital signs.
Name each organ system in order, and report the relevant exam:

- HEENT and neck,
- Chest
- Cardiac
- Abdomen
- Neurologic
- Musculoskeletal
- Skin

Report all pertinent physical examination findings, both normal and abnormal:

- Complete exam of the organ system(s) relevant to the chief concern
- Other findings (normal or abnormal) that help your listener answer a clinical question. Use concise but complete descriptions of positive findings.

Report all abnormal findings regardless of organ system.

If the examination of a system NOT relevant to the chief concern was normal, you may say "Normal".

8. Summary Statement: The first sentences of your assessment

Purpose: To synthesize the important history and exam findings, to frame the clinical problem and to lead your listener into your assessment. This is NOT simply a restatement of the ID chief concern.

Format: Restate the identifying data ***and*** summarize the key features from the patient's history and physical exam.

Template: "In, summary, *NAME* is a *AGE* year old man who presents with a history of *PRESENTING CONCERN (REFINED WITH SEMANTIC QUALIFIERS) AND MAJOR ASSOCIATED SYMPTOMS.* His history is notable for *ELEMENTS OF THE HPI, PREDISPOSING CONDITIONS AND RISK FACTORS THAT IMPACT YOUR ASSESSMENT.* Physical exam is notable for *KEY FINDINGS, NORMAL AND ABNORMAL, THAT IMPACT YOUR ASSESSMENT.*

9. Assessment

Purpose: Address the clinical problem(s) important in this encounter, and demonstrate your clinical reasoning. The clinical problem may range from a new and undiagnosed problem to routine follow-up of a chronic problem.

Format: Format may vary based on type of problem. For example:

1. An undiagnosed problem. Your assessment would address the top 3-4 items on the differential diagnosis suggested by your patient's history and exam findings.

   Example*: The most likely reason for Lily's rash is eczema. Her skin dryness and pruritis, and her family history of atopy are all consistent with eczema, as is the history of worsening in the winter and after frequent swimming. She also has a classic distribution on the hands and elbow creases. A less likely possibility is scabies, which frequently affects the hands. However, Lily's skin between the wrists and elbows is spared, which would be atypical for scabies.*

2. An exacerbation of a chronic problem. Your assessment would address the most likely reasons for the exacerbation, as suggested by your patient's history and exam findings.

   Example*: The most likely reason for Mr. C's CHF exacerbation is medication non-adherence due to both costs and confusion. He reports filling his medications less often than monthly because even the co-pay is expensive, which is confirmed by his*

pharmacy. Although he manages his own medications, he is unable to accurately describe what each is for, or his dosing schedule. A second possibility is new ischemia; however, he's had no chest pain or tightness, and initial ECG and enzymes were negative. Finally, a URI could have precipitated this exacerbation, as he had low grade fever, cough, and rhinorrhea last week. However, those symptoms have resolved as his edema and shortness of breath have progressed, making this possibility less likely.

3. Routine follow-up of a chronic problem. Your assessment would address current control of the problem, evidence of complications, and adequacy of current education and treatment.

   Example: *Ms. B's type 2 diabetes is well controlled, with most recent HgbA1c of 6.8. She reports excellent adherence to diet and exercise, as well as metformin. She has no evidence of retinopathy or neuropathy on exam and urine for microalbumin was negative.*

10. Plan

Purpose: To outline your next steps in addressing your patient's clinical problem(s).

Format: The plan is usually presented as a bulleted list, and may include interventions in these categories:

Diagnostic evaluation	Lab tests
	Imaging
	Consultation with specialists
Therapy	Behavior change
	Medications
	Counseling
	Referral to another provider (e.g. physical therapy)
Monitoring and follow-up	Repeat laboratory tests to monitor response to treatment
	Routine screening tests
	Primary care clinic follow-up
Education	Education about diagnoses done by you
	Referral to other providers for additional teaching, e.g. diabetes educator, pharmacist

Adapting The Comprehensive OCP To Other Contexts

Example #1: An outpatient presenting for routine follow-up of a known problem

S: Subjective

ID/CC: Include 'scheduled follow up for' and list problem(s) as well as any additional issues identified during agenda setting.

HPI: Start with a brief synopsis of the problem that the patient is being seen for:

- Diagnosis
- Current treatment
- Control
- Complications
- When the patient was last seen in clinic

Status of the known problem since the last visit:

- Symptoms/control
- Intervening problems
- Pertinent positive/negative symptoms

PMH: Brief synopsis of other ongoing medical problems

Medications and allergies

Any *changes* in PMH/FH/SH since the last visit

O: Objective

Physical Exam

- Vital signs
- General appearance
- Exam of the pertinent systems ONLY

A: Assessment:

Start with your summary statement

Address current control of the problem(s), evidence of complications, and adequacy of current education and treatment.

P: Plan

Example #2: An outpatient presenting with an exacerbation of a chronic problem

S: Subjective

ID/CC: Same as comprehensive OCP

HPI: Same as comprehensive OCP

PMH: Brief synopsis of other ongoing medical problems

Medications and allergies

Any changes in PMH/FH/SH since the last visit

O: Objective

Physical Exam

- Vital signs
- General appearance
- Exam of the pertinent systems ONLY

A: Assessment

Start with your summary statement

Address possible causes of the exacerbation

P: Plan

Example #3: A patient presenting to her primary care clinic with a new problem

S: Subjective

ID/CC

History of present illness as in comprehensive OCP. Include predisposing conditions and risk factors, pertinent negatives, and evaluation and treatment to date.

PMH: Brief synopsis of other ongoing medical problems

Medications and allergies

Any changes in PMH/FH/SH since the last visit

O: Objective

Physical Exam

- General Description
- Vital signs
- Exam of organ systems relevant to the presenting problem

A: Assessment

Start with your summary statement

Address differential diagnosis of the new problem

P: Plan

Delivery Tips for Oral Case Presentations:

- At the bedside, introduce your patient and any family members to your team.
- Maintain good posture.
- Establish eye contact with your team and your patient, glancing at your notes only as necessary.
- Present with a clear, energetic, and interested voice.
- When presenting at the bedside, recognize the impact of your choice of words on your patient:
    - Avoid medical language that might frighten your patient, unless he has used it. Examples: "*End-stage liver disease*" and "*Another possibility is lung cancer…*"
    - Avoid language your patient might find insulting. Examples: "*Morbidly obese" and "Pleasantly confused elderly woman.*"
- Follow the standard format of the OCP precisely.
- Orient your listeners to the next section of the OCP with a brief pause followed by the title of that section.
- Use precise language.
- Do not rationalize, editorialize, or justify as you present. Just present the "facts".
- Be aware of your patient's confidentiality, especially if the patient is in a shared room.