

Tips & Tricks for Presenting Patients

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The presentation of a patient during rounds or in the ambulatory setting is never an easy thing, but with practice and a system, most students will find that they can become adept at presenting information to interns, residents, attending physicians and ancillary staff. Here are some simple tips and tricks to consider as you start to develop this skill.

Remember, the most basic purpose of the presentation is to report information. This report, when done in an ideal manner, is:

1. Concise - Information is provided in a smooth and quick manner
2. Relevant - Information includes most, if not all, essential elements related to the complaint
3. Clear - Information is devoid of ambiguity

Most students are familiar with the SOAP (Subjective/Objective/Assessment/Plan) format of both presenting and documenting a patient encounter. Here are 4 tricks and tips for each section:

Subjective

1. Include the demographic data and chief complaint (or reason for consult) in one summative sentence (often referred to as 'the bullet')- 'A 45-year-old male admitted on Monday for community-acquired pneumonia who we are seeing for a new complaint of abdominal pain'. Try to give the 'big picture' view with your sentence.
2. Before presenting, ask if your attending only wants info relevant to the Chief Complaint, or all information. Depending on the preference of the attending and the time to present, that answer might change. Always ensure you have all elements, but be prepared to pare it back.
3. For any symptom (not just pain), remember 'PQRST' - Palliation and Provocation/Quality/Radiation/Severity/Timing. More can be determined if we know the characteristics of the complaint.
4. Histories are important - Medical, Surgical, Family & Social. Consider OB/GYN or specific disease history too if relevant to the case.

Objective

1. Vitals, Vitals, Vitals!!! Don't simply say they are stable - report the specific numbers. Age is a vital too, FYI!

2. Again, ask your attending if they want the relevant physical or the complete physical and again, always do a complete physical but be prepared to cut it back for presentation.
3. If you have a specific condition that is evaluated by a specific physical exam element, always do the element. If you don't know how, look it up (try google and/or YouTube).
4. Remember the general and psych elements of a physical exam. How do they look and how do they act? These things are important both for assessing problems and knowing how to approach the patient.

Assessment/Plan

1. Pair your assessments to your plans - it's easier than listing each assessment and then trying to remember the relevant plan after.
2. If you don't know what's causing the symptom, the assessment is the symptom. Be sure to give a differential for the symptom (don't use 'rule out'...you can rule out ANYTHING from a symptom, no matter how ridiculous). For example - 'Abdominal pain of uncertain origin - possible diagnoses include pregnancy, GERD, gastric carcinoma and muscle strain.'
3. Your plan needs a plan - try to consider what you will do based on the results of your first plan - that becomes your follow-up plan. 'The good doctor makes a plan for today - the great one also makes a plan for tomorrow.'
4. Make sure your plans are specific - include types, strengths and doses of medication. Differentiate between imaging modalities and requested views.

If I could leave you with one thought, it's this:

'EVERYTHING flows from our presentation - if you take away all our technology and tools, we still have the power to listen, to question and to determine. These are the essential skills of the physician - everything else is just detail.'