**Oral Presentations**

Approach to the Delivery of the Content of the Presentation

STAGE=style, timing, audience, goals, elicit feedback

**STYLE**

Style, which includes appearance, demeanor and nonverbal signals, strongly impacts the quality of your oral case presentation.

Modulate your voice and cadence of your presentation. Every patient is unique; capture the special elements so as to engage the listeners. ***Listener should be able to visualize your patient.***

Stand up straight and make eye contact so as to connect with listeners.

Do not bury your nose in the chart; and do not read verbatim your presentation. ***Get rid of your notes (at least for the HPI).***

Become enthusiastic about this patient, and show your engagement with the situation.

Rehearse and know the situation well enough to feel confident and show it. In the case of inadequate time for preparation, say so, only once, and be confident about what you do know. “Sweating bullets” severely limits your learning and that of others.

Avoid distracting “Um’s/Ah’s” during your presentation- silent pauses are always preferable to “um’s”

No one likes to listen to repeated nonsense syllables or fillers, such as, “ok”, “maybe”, or “the patient said that….” Eliminate verbal “tics” from your repertoire.

Learn from colleagues, attend to presenters who engage you and make the exercises fun, then imitate them.

**TIMING**

Timing is influenced by expectations specific to the setting of your oral case presentation.

Specific courses, clinical settings, and supervising residents or attendings impose differing expectations for the duration of a presentation. ***Ask supervisors and instructors about their expectations and preferences for length, conciseness, and when they prefer summary versus details. Observe your colleagues.***

Mostly people want to help learners. Complex medical issues, busy clinical services and other demands on your instructors may require your attentiveness and may influence the timing of your presentation.

**AUDIENCE/SETTING**

Presentations typically occur in the conference room, hallway or bedside. Each audience and location requires adjustments to your presentation.

Bedside presentations require attention to the patient and family and usually include an ***invitation to them to add to or edit the information in your presentation***. While bedside presentations may seem difficult or awkward, studies confirm strong patient preference for them and, with practice, growing learner preference, too. Following a bedside presentation, it is important for you to check with the patient in order to clarify or resolve any questions related to your presentation. Make additional adjustments related to special audiences (grand rounds versus daily work rounds), to the degree of privacy available, and to how well listeners already know the patient.

**GOALS**

The specific goals of a presentation determine the details of content, length, and organization.

**Elicit Feedback**

Feedback on presentations enables you to obtain information from different observers, utilize ideas derived from multiple perspectives, make targeted adjustments, and check on whether you are advancing your skills.

Feedback provides important information about how to adapt your approach in the future. More feedback is better than less, and immediate feedback is preferable to feedback that is delayed. The following strategies can assist in structuring and organizing feedback.

Self-assess each component of your presentation in light of the STAGE framework.

In advance of a presentation, establish your colleagues’ (and faculty) expectations about the Story, Timing, Audience adjustments, and Goals.

Share your self-assessment (strengths and opportunities for improvement) and request feedback on the accuracy of your self-assessment.

From both junior and senior colleagues, solicit feedback and suggestions about a specific component of the STAGE framework.

Develop a plan for improvement and specify a time to follow-up with faculty regarding your progress.

**COMMON MISTAKES IN ORAL PRESENTATION**

Common problems fall into two broad categories: first, information—failing to summarize, organize and transmit coherently huge amounts of information (this requires learning a new jargon); and second, “delivery”-- failing to maintain connection and relationship with listeners.

*Labored rhythm, with little audience contact* - novice students typically have difficulty tracking all the information and tend to present in a wandering, disorganized and/or desultory fashion. Maintaining eye contact with your listeners means that you should not read your write-up verbatim, and instead use notes. The skill to convert a written history and physical examination into a compressed presentation requires practice, like any other skill. At first, take the time to practice it two or three times in advance. For most learners, it is helpful to find a classmate or resident who can spend a few minutes listening, give you feedback and watch you try again. Most learners also benefit from audio-taping (or video-taping) in order to gain personal insights. Like any skill, this one is easier for some students than others; so some advanced students may need to continue practicing.

*History of present illness too brief* - 90% of correct diagnoses come from the history alone; so do not sabotage your listener’s understanding of the case by omitting important information. The HPI portion of the oral presentation, as a general rule, should take 1/3 to 1/2 of the presentation time. Common pitfalls include incomplete characterization of major symptoms, reporting lists of symptoms instead of a chronological story, omitting pertinent negatives or positive ROS questions, and omitting specific information about past history that relates to the present problem.

*Failure to use parallel reference points* - in both write-ups and oral presentations, relate time in “hours/days/weeks prior to admission”. Avoid “at 2:00 in the morning of last Wednesday” or “on May 25th”; instead, say “three hours prior to admission”, or “at 2:00 am, three days prior to admission”.

*Editorializing* - avoid comments like “do you even want to hear this?…” or “cardiac examination revealed a systolic murmur….well, I thought heard it, but the resident didn’t…so maybe it isn’t there….I don’t really know….”

*Use of negative statements instead of positive statements*. Positive statements add color and accuracy to your presentation. “Chest X-ray shows normal heart size” is better than “chest X-ray shows no cardiomegaly”. “In summary, this patient’s problem is acute dyspnea” is better than “the patient’s problem is rule-out pneumonia”.

*Unnecessary and repetitious descriptive sentences.* Overly repetitious sentences become monotonous and lose the listeners. “On pulmonary exam, the lungs were normal…on cardiac exam, the heart sounds were…, on lymph node exam, there were no cervical nodes…” is unnecessary – your listener knows that S1 and S2 are part of the cardiac exam! Use brief descriptive sentences: “an S3 gallop was heard at the left lower sternal border.”

*Disorganization –* Every novice learner has this problem. Because students are frequently encountering new illnesses, new twists on extreme human conditions and new situations for presentation, be aware that disorganization can happen even with careful preparation. Rehearsal, feedback, experience with multiple types of problems and situations, and attending to the structure of presentations you hear and admire will each help improve organization. If you sense that you are not on track, pause. Do not make editorial and self-referential comments like “Oh, I can’t believe I forgot to tell you this!” Saying “…in summary, this patient…wait, I forgot to tell you the most important thing…” will kill a presentation.

Everyone forgets, and everyone has feelings of embarrassment too, so listeners will help you get all the data on the table, and help you reorganize it, but they will be less charitable if you spend presentation time making a big deal about shortcomings and talking about yourself. Be certain that you have the opportunity to talk with your supervisors about the shortcomings and the associated feelings in feedback sessions.

*Lack of proper terminology for physical findings*- for example, “lymph node exam shows some small cervical nodes” is not as descriptive as “…there were three soft tender mobile nodes in the left anterior cervical chain which measure 1 x 1 x 2 cm each… “ Commitment to accuracy will improve your physical examination skills.

*Naming a diagnosis instead of describing physical findings*- diagnoses belong in the assessment, descriptions in the physical examination. For example, avoid “exam showed the murmur of mitral regurgitation” …instead say “a 2/6 holosystolic murmur was heard at the apex and radiated to the axilla”. Avoid “skin exam showed psoriatic lesions on the elbows…”; and instead say “there were several 2 cm. diameter round plaques with silver scale distributed on the extensor surface of the elbows…”

*Avoid reading through every lab test ordered* – In general it is preferable to organize lab data presenting the important points and providing trends of the key information. For example, if you were following a patient for anemia the hemoglobin/HCT trend over the last several days would be important.

*Save your assessment and plan for the end* – Often students will begin to discuss their assessment or plan after they read an abnormal lab value. For example, “potassium was high at 6.5 so we gave kayexalate, IV calcium and checked an EKG”

Adapted on 9/17/15 from a document prepared by Melanie Hagen MD