What is the purpose of the oral case presentation?

Strong oral case presentations are concise summaries of a patient’s presentation with the bulk of the discussion time focused on clinical reasoning and synthesis of the patient’s illness script. The information provided is only the minimum essential facts required to understand the patient’s current clinical circumstance.

The ability to perform a concise oral case presentation is a critical skill for physician communication and, given the changing landscape of ACGME resident work hour restrictions, the importance of this skill in facilitating efficient work rounds cannot be overstated.

How does the oral case presentation differ from the admission note?

The admission note contains more information than presented in the oral case presentation. It serves as a reference document for current and future providers to understand everything currently known about this patient. In the era of electronic medical records, this document is available for review by all team members at any moment.

The oral case presentation is not meant to serve as a recital of an admission note. Instead, it pulls the essential facts from an admission note which are required for listening providers to understand the patient’s presumed admission diagnosis or diagnoses.

What is the expectation for supervising team members (senior residents, fellows, attendings) prior to work rounds?

Patients staffed the previous evening by attending: present patient in typical subsequent-day SOAP format, rather than complete oral case presentation.

Patients admitted overnight and not yet seen/staffed by daytime attending: Residents should expect supervising team members to have read the admission note in detail prior to attending rounds and therefore should feel comfortable providing only essential details in their oral case presentations.

Recommendations for Efficient Oral Case Presentations
Presentation Structure and Length (5-8 minutes)

- Patient History (< 3 minutes)
- Identification and Working Diagnosis (cues listener)
- History of Present Illness / ED Course (3 – 5 sentences maximum)
- Active Past Medical History Relevant to Presentation
- Medications Relevant to Presentation
* Do not routinely mention allergies, family history, social history, or review of systems in the presentation – if there is a crucial detail from these sections then mention in the history of present illness

Physical Examination (0 - 1 minute)
  Vital Sign Trends
  Abnormal Findings Pertinent to Clinical Presentation
  Pertinent Negative Findings Related to Illness Script

Diagnostic Testing (0 - 1 minute)
  Pertinent Normal and Abnormal Laboratory Studies with Updated Data
  Pertinent Normal and Abnormal Imaging Studies / ECGs / Microbiology

Overnight Events (0 - 2 minutes)
  Major Overnight Events
  Bedside Nurse Report (Structured Interprofessional Bedside Rounding)

Assessment and Plan (< 5 minutes): updated for the current day’s plan only
  Brief Summary Statement with Working Current Diagnosis
  Review Only the Major (2-3) Active Problems with Associated Plan(s)
  Review Checklist

Suggested Reading