Ochsner Journal 16:65–69, 2016
© Academic Division of Ochsner Clinic Foundation

Developing Oral Case Presentation Skills: Peer and Self-Evaluations as Instructional Tools

Dustyn E. Williams, MD,[1,2] Shravani Surakanti, MD[1]

[1]Department of Internal Medicine, Baton Rouge General Medical Center, Baton Rouge, LA [2]Department of Internal Medicine, Tulane University School of Medicine, New Orleans, LA

Background: Oral case presentation is an essential skill in clinical practice that is decidedly varied and understudied in teaching curricula.

Methods: We developed a curriculum to improve oral case presentation skills in medical students.

Results: As part of an internal medicine clerkship, students receive instruction in the elements of a good oral case presentation and then present a real-world case in front of a video camera. Each student self-evaluates his/her presentation and receives evaluations from his/her peers. We expect peer and self-evaluation to be meaningful tools for developing skills in oral presentation.

Conclusion: We hope to not only improve the quality of oral case presentations by students but also to reduce the time burden on faculty.

Keywords: *Clinical clerkship, education–medical–undergraduate, faculty–medical, schools–medical, students–medical*

Address correspondence to Dustyn E. Williams, MD, Department of Internal Medicine, Baton Rouge General Medical Center, 3700 Florida Blvd., Baton Rouge, LA 70810. Tel: (225) 255-0368. Email: dustyn.williams@brgeneral.org

INTRODUCTION

When done correctly, oral case presentation is a powerful clinical skill. A fluent case presentation allows for efficient and effective transitions between providers. Such communication is essential within and between provider teams and between physicians and supporting staff. The oral case presentation also serves as a useful proxy for assessing student competency in clinical reasoning and patient care.[1-3]

Despite its clear importance, oral case presentation has not been consistently and effectively taught in medical school. Student and faculty perceptions of the oral case presentation vary widely.[3] Evaluations of the oral case have also varied, and the variation has been attributed to interrater variability[4-6] despite attempts to standardize the process.[7] The variance in expectations is exacerbated by nonspecific faculty feedback that forces students into formative changes contrary to the intent of the feedback.[8]

Course directors and clinical educators have defined what makes an excellent oral case presentation.[9,10] Some have attempted to develop curricula that standardize training based on these expectations[11] or curricula that go beyond standardization alone.[2] In 2012, Heiman et al assessed a curriculum that takes advantage of both online learning modules and deliberate practice in the preclinical years.[12] These methods are effective but are time and resource intensive and require significant faculty involvement.

Other studies of interventions to improve case presentation skills have shown mixed results for the outcome of summative end-of-clerkship evaluations; however, summative ratings may have poor accuracy and reliability for assessing specific skills.[11,13] No study has assessed the direct instruction and evaluation of oral case presentations, nor has any compared peer and self-evaluation to the evaluation of faculty members.

The purpose of this education innovation was to create a sustainable, scalable method of coaching and evaluating oral case presentations. Our objective was to develop a curriculum that (1) aligns faculty and student perceptions of the purpose of oral case presentation, (2) clarifies what makes an excellent oral case presentation, and (3) trains students to communicate effectively and efficiently with the healthcare team. To accomplish these objectives, we developed evaluation criteria that meaningfully assess the elements of the oral case presentation with a clear aim to foster growth. We hope the methodology also helps with coaching and aids peer and self-evaluations free of faculty commitment. It should allow for real-world implementation rather than sterile simulation.

Success will be defined by affirmative answers to 2 questions: Can a brief curriculum within the internal medicine core clerkship improve the ability of medical students to present oral cases? Can this process alleviate faculty time burden by using peers as evaluators and self-reflections as means to improve the measured skill?

THE COURSE

Three oral presentation sessions are scheduled as part of the internal medicine clerkship at Baton Rouge General. The first session occurs during the second week of an 8-week block. Students, independent of their peers, bring a history and physical of a patient they have admitted and present an oral history and physical in front of a camera. The session is repeated at weeks 5 and 7. The students record 3 separate oral presentations at weeks 2, 5, and 7 that are both peer and self-evaluated.

After the first session, students are given a perception survey (Figure 1) followed by a 30-minute lecture by the clerkship director that demonstrates the differences between the written history and physical and the oral case presentation, as well as their significance. Students then watch 2 prerecorded case presentations; one is excellent, and the other is abysmal. The clerkship director reviews what makes a strong case presentation vs a poor case presentation. The session concludes with an explanation of the scoring system (Figure 2) and the scorecard itself (Figure 3).

At the end of each session, students have 72 hours to evaluate themselves and each other. The videos are uploaded to an unlisted YouTube channel and are hosted for free, viewable only by those with a link. At the end of 72 hours, the videos are changed to private, viewable only with a Google account and a specific invitation. Students view the videos individually on their own time, rather than in a group environment.

Assessment is performed through an evaluation tool (Figure 3) that has been converted to a web format for ease of data storage and acquisition. Scores are reported to the students.

For the initial study, faculty members also viewed the videos at the end of the block. If data demonstrate that the students can reasonably evaluate their peers as well as faculty can evaluate their peers, faculty evaluation will be eliminated from the model.

To ensure that students accurately evaluate each other, they are instructed that the portion of their grade represented by this evaluation is based on how closely their evaluations match faculty evaluations, not necessarily how

Student Name: _____

Clerkship Block: _____

This form is filled out during the BEGINNING / END of the block (circle one)

Entrance and Exit Forms:	**Disagree**		**Neutral**		**Agree**
Oral presentation skills are essential to practice in the field of medicine	1	2	3	4	5
I am confident in my ability to present an oral presentation effectively	1	2	3	4	5
I know the key components that are required in an oral presentation of a history and physical	1	2	3	4	5
I know the difference between a written history and physical and the oral presentation	1	2	3	4	5
I can describe to another learner what makes an effective oral presentation	1	2	3	4	5
Exit form only:					
I enjoyed this curriculum and would recommend it to be provided to future medical students	1	2	3	4	5
Rate this course in overall quality, 5 being excellent 1 being just awful	1	2	3	4	5

Figure 1. Perception survey distributed to students at the beginning and end of the course.

History

0 None
1 Missing age, gender, or chief complaint
2 Age, gender, chief complaint, medley of history including common illnesses
3 Age, gender, chief complaint, RELEVANT history (or none if not relevant)

Important Information

0 Fails to mention
1 Reads through them, saying everything written down
2 Is succinct, gets through them quickly, leaves out extraneous
3 Only the relevant information

Physical Examination

0 Just didn't do it
1 Reads the entire physical examination, head-to-toe, fails to identify relevant data
2 Relevant data included or highlighted, extraneous information or commentary remains
3 Only the relevant data are presented

Labs

0 Didn't do it
1 Presents every value, every value as important as the last
2 Presents every value, but emphasizes importance of one over another, identifies trends
3 Presents the values you need to know, leaves out the ones you don't

Assessment and Plan

0 Didn't do it
1 Reads written H&P, long winded without focus
2 Satisfactory, includes argument, but argument is uncertain or has too much summarization
3 Succinct, clear, ties each differential diagnosis to key elements of the case

Figure 2. Explanation of the scoring system. H&P, history and physical.

well they perform on the video. Higher scores do not necessarily mean a higher grade; demonstration of accurate measurement drives scoring.

THE TOOL

Members of the Clerkship Directors in Internal Medicine (CDIM) have provided recommendations for what makes a good oral case presentation,[9] and Green et al reported what hospitalists and clinical educators in practice thought was important.[10] Attempts at developing tools to assist in education and evaluation have also been made.[11,13] One, published by faculty at Northwestern, took the approach that the teaching tool should be the evaluation tool.[12] We adapted this approach as the underlying foundation for our evaluation of oral case presentations but expanded it to cover a greater spectrum beyond yes or no. A single distracting phrase "uh" is different than every sentence punctuated by an "uhm," and a 5-minute case presentation does not have the same consequence as a 14-minute case presentation. Therefore, the scale was modified to 0-3, rather than 0-1. Likewise, to assign greater emphasis to the act of speaking and the presentation rather than simply to the content, we added items to reflect the CDIM members' and other clinical educator recommendations.

Oral Presentation Evaluation Form

	Fails to Include	Novice	Competent	Master
History				
First Paragraph - timing and characterization	0	1	2	3
Second Paragraph - includes pertinent facts but excludes extraneous information needed to establish and modify a differential	0	1	2	3
Important Information				
Relevance and focused reporting of medical history, family history, surgical history, allergies, medications, and social history	0	1	2	3
Avoids a separate review of system	No			Yes
Physical Examination				
Vital signs first	No			Yes
Focused physical examination relevant to the diagnosis, includes data necessary for the differential diagnosis but excludes extraneous information	0	1	2	3
Labs				
Includes laboratory data essential to the diagnosis and excludes irrelevant data	0	1	2	3
Demonstrates understanding of which labs are relevant and which are not				
Assessment and Plan				
Synthesis statement	0	1	2	3
Assessment includes a list of at least three differential diagnoses with arguments for and against each. Arguments are succinct.	0	1	2	3

General and Style	*Beginner, Painful*	*Competent, Not Painful*	*Masterful, Inspirational*
Duration (5-8 minutes)	1	2	3
Organization in the proper order	1	2	3
Use of distractors (uhs, uhms, ahs)	1	2	3
Eye contact and use of notes	1	2	3
Cadence and use of voice	1	2	3
Makes a case	1	2	3

Student doing the evaluating (you) _____

Student evaluated (person on camera): _____

Figure 3. Oral presentation scorecard.

CONCLUSION

Spoken communication is critical in the practice of medicine. In the traditional model of instruction, teaching this skill requires a large amount of time or is variably experiential. This innovation in medical education has multiple benefits compared to traditional education. First, it will attempt to assess whether faculty are needed to evaluate and grade students or whether students are capable of adequate peer evaluation. Second, this course will teach and evaluate a skill with a true-to-life evaluation; the evaluation does not focus on whether a task is performed but on how well it is performed. Third, it will assess whether traditional experience (presenting on the wards) can be augmented simply by reviewing peers, thereby alleviating a significant faculty time burden.

ACKNOWLEDGMENTS

Dr Dustyn Williams is the clerkship director in internal medicine for the Tulane University School of Medicine campus in Baton Rouge, LA, and founder of the online video-based education company OnlineMedEd. Dr Shravani Surakanti is an internal medicine resident at Baton Rouge General Medical Center.

REFERENCES

1. Wiese, J. *Teaching in the Hospital*. Philadephia, PA: American College of Physicians; 2010.
2. Wiese J, Varosy P, Tierney L. Improving oral presentation skills with a clinical reasoning curriculum: a prospective controlled study. *Am J Med*. 2002 Feb 15;112(3):212-218.
3. Lingard L, Schryer C, Garwood K, Spafford M. 'Talking the talk': school and workplace genre tension in clerkship case presentations. *Med Educ*. 2003 Jul;37(7):612-620.
4. McLeod PJ. Faculty assessments of case reports of medical students. *J Med Educ*. 1987 Aug;62(8):673-677.
5. Kalet A, Earp JA, Kowlowitz V. How well do faculty evaluate the interviewing skills of medical students? *J Gen Intern Med*. 1992 Sep-Oct;7(5):499-505.
6. Herbers JE Jr, Noel GL, Cooper GS, Harvey J, Pangaro LN, Weaver MJ. How accurate are faculty evaluations of clinical competence? *J Gen Intern Med*. 1989 May-Jun;4(3):202-208.
7. Kroboth FJ, Hanusa BH, Parker S, et al. The inter-rater reliability and internal consistency of a clinical evaluation exercise. *J Gen Intern Med*. 1992 Mar-Apr;7(2):174-179.
8. Haber RJ, Lingard LA. Learning oral presentation skills: a rhetorical analysis with pedagogical and professional implications. *J Gen Intern Med*. 2001 May;16(5):308-314.
9. Green EH, Durning SJ, DeCherrie L, Fagan MJ, Sharpe B, Hershman W. Expectations for oral case presentations for clinical clerks: opinions of internal medicine clerkship directors. *J Gen Intern Med*. 2009 Mar;24(3):370-373. doi: 10.1007/s11606-008-0900-x.
10. Green EH, DeCherrie L, Fagan MJ, Sharpe BA, Hershman W. The oral case presentation: what internal medicine clinician-teachers expect from clinical clerks. *Teach Learn Med*. 2011 Jan;23(1):58-61. doi: 10.1080/10401334.2011.536894.
11. Green EH, Hershman W, DeCherrie L, Greenwald J, Torres-Finnerty N, Wahi-Gururaj S. Developing and implementing universal guidelines for oral patient presentation skills. *Teach Learn Med*. 2005 Summer;17(3):263-267.
12. Heiman HL, Uchida T, Adams C, et al. E-learning and deliberate practice for oral case presentation skills: a randomized trial. *Med Teach*. 2012;34(12):e820-e826. doi: 10.3109/0142159X.2012.714879.
13. Kim S, Kogan JR, Bellini LM, Shea JA. A randomized-controlled study of encounter cards to improve oral case presentation skills of medical students. *J Gen Intern Med*. 2005 Aug;20(8):743-747.

This article meets the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties Maintenance of Certification competencies for Patient Care and Medical Knowledge.