Presenting Your Patient
A Guide for Medical Students Rotating in the Emergency Department

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For the SAEM Undergraduate Education Committee

Introduction

Welcome to the emergency department (ED)! The purpose of this guide is to assist medical students who are rotating through the emergency department with the development of presentation skills. The attending will want you to be able to present information on each patient that you see in a coherent, systematic, and time-efficient manner. Many patients are in the ED for a single, discrete issue or problem. However, a number of patients will be complex. They will probably have several chronic conditions, which may be the reason for the ED visit, or will impact the treatment plan and ED management.

As you see each patient, keep in mind that your goal is to identify and address the acute problem(s). The emergency department visit differs from a routine office visit, in which the physician may be addressing a number of issues. It is often unrealistic to attempt to address each health issue of the patient in the ED. ED treatment is confined to addressing only those issues that led to this ED presentation or which directly affect the type(s) of treatment the patient will require in the ED. What you do for the ED patient is also different from what you are expected to do when working up an admitted patient on the floor. When you are seeing floor patients, it is not unusual to spend 30 min or more with the pt each time you visit them. On the floor, you are assessing the efficacy of interventions made since admission. However, you can't spend this much time with each patient in the ED, and you are making the first set of interventions that will affect the remainder of the patient's course in the hospital.

Now, let's say you have seen your patient! Before you head off to find the attending or senior resident to present your patient, make sure you have checked the patient's chart and noted certain key pieces of information. Don't forget to read the nurse's notes and the triage sheet. Ideally you will do this before you see the patient, but sometimes in the ED

you have to see the patient before the chart is available. Both of these documents will offer some sort of comment with regards to why the patient is here. If the chief complaint given by the patient to you differs from what is written on the triage sheet or the nurse's note, be sure to resolve the differences with the patient and remember to comment on them during your presentation. If you are at an institution with computerized patient records, you may want to check recent discharge summaries as well as determine date of last ED visit. Don't spend too much time on this task prior to seeing the patient; if this information isn't quickly available, see the patient, get a treatment plan going, and then check with the desk clerk to see what info can be obtained.

Anatomy of the Presentation

When you see the patient, you will gather a lot of data. Only some of it will be important enough to include in your presentation. Key questions to consider (and which will be in the mind of the listener):

Why is the patient here?

Can they be treated here and referred elsewhere for follow-up, or do they require admission? If they require admission, what level of care is appropriate (floor, step-down, ICU, isolation, etc.)?

ID patient, location in the department, and why the patient is here.

Begin your presentation by identifying the patient. Use a name and a limited amount of demographic information (e.g. Ms. Rodriguez is a 38 year old female in bed 3). Don't call patients "the woman in room 2" or "the man with right arm pain". There are a lot of reasons to avoid doing this. The first reason is that each patient is a human with one or more immediate health care needs. They should be identified by their name, and not by their disease process(es). The second reason is that patients get moved around quite a bit by various individuals, for a lot of different reasons. The person who is moving the patients around may or may not notify you that your patient is being moved to another room. The man who was in room 2 when you examined them can easily get moved to room 6 by the time you present the patient. Imagine the confusion that can result if the attending / senior resident goes without you to room 2 to see the patient there, but now room 2 (without your knowledge) now has a different man who will of course report something different to the attending /senior resident compared to what you have reported.

State the chief complaint, and give a limited amount of history of present illness. Provide relevant details. How long has the symptom or problem been present? Has the patient had

previous episodes? Is this an exacerbation of a previously diagnosed chronic condition such as asthma, GERD, or hypertension? What makes the symptom get worse? Better? Has the patient sought care regarding the problem in the past? If so, what was done? If the symptom is a pain, describe things such the character of the pain (e.g. sharp, dull, pulsating, constant, etc.); whether it radiates versus staying in one place; and any accompanying or associated symptoms (e.g. the person says they become nauseated or diaphoretic when the pain comes on). Briefly state how long symptoms have been present, exacerbating/relieving factors, whether the patient has had similar problems in the past, and if the patient has tried treatments prior to coming to ED. If this appears to be complication or exacerbation of a previously diagnosed problem, say so.

PMH

In preferably two sentences or less, indicate PMH. You can report it as a single sentence, such as “Ms. Foster has a 10 year history of hypertension, has end stage renal disease and has been on dialysis for 3 years. In limited cases, it is also appropriate to indicate that the patient does not have a history of such-and-such disease. For example, if the patient is a 60 year old male with a chief complaint of crushing chest pain associated with exertion and he says that he has no known medical problems, it is appropriate to state that the patient denies any history of angina or myocardial infarction.

Keep in mind that the purpose of reporting the PMH is so that you and your listener can consider what aspects of the patient’s PMH (e.g. previous fractures, migraine headaches, etc.) may directly or indirectly affect how you will manage the patient. For example, the patient’s chief complaint may be cold like-symptoms, which they define as a runny nose, nasal congestion, moderately decreased energy level, and sneezing. Such a patient probably has a URI. If they tell you that they have a PMH of hypertension, then remember not to give this patient Sudafed or any other sympathomimetic to treat the nasal congestion because such drugs will only aggravate hypertension.

Special Note: if you are presenting a neonate, infant, or toddler, consider presenting information about presence/absence of prenatal care, birth history (spontaneous, induced, vaginal delivery C section, complications during or after delivery, days in hospital prior to discharge after birth).

PSH

Past Surgical History This issue doesn’t necessarily need to be reported for all patients. It becomes important if the patient’s chief complaint may be suggestive of a surgical problem. For example, if the patient is a 40 year old female with abdominal pain, nausea, and vomiting, and she tells you that she had an appendectomy at age 25, it is appropriate to state in your presentation what the patient has told you. If she denies any history of

surgery but has abdominal pain as her chief complaint, it is useful to indicate that she has no history of surgical procedures. Either way, the listener needs to hear about the presence or absence of previous surgeries in a patient with abdominal pain because the physical exam findings will give information in regards to whether the patient might be developing a surgical issue, or may be experiencing delayed complications (e.g. small bowel obstruction) of prior surgical procedures.

Don't forget to ask about previous eye surgeries if the chief complaint involves the eye.

Sometimes patients forget to tell you about aspects of their PMH or PSH. After you have asked the patient "do you have any medical problems?" and "have you ever had surgery?", a backup way to elicit problems they might have forgotten to mention is to ask "have you ever stayed in the hospital overnight?" If they say yes, then ask when and why.

Medications

Ask what medications the patient is taking, and report them. Sometimes the patient will tell you they are taking a medication after they deny having any medical problems. They don't do this to mislead you. What happens is that in their mind, they don't have a medical problem because the medication is keeping whatever it is treating under control. By inquiring about current medications when you see the patient, you may also learn about chronic conditions that the patient has. In this way, when you are doing your presentation you can simply report in one or two sentences what medications the patient takes, and if there are questions about additional details from the attending /senior resident, you can fill in the details later on.

Along the same lines, the patient may say they are taking no medications at all. Ask if they are supposed to be on any. You may find that they are supposed to be taking several different medications but, for whatever reason, they are not. This information is useful to include in the presentation because it may help explain the reason for the chief complaint.

Allergies

Always, always, always report whether the patient has any known allergies to medicines. If they state that they do, ask what happens when they take the medication. It would be quite dangerous to give to a patient something to which they are allergic. On the other hand, it may be that the person has identified an intolerance as an allergy. Report what

the patient states, and then discuss with your listeners how you have interpreted the information.

Social History

Report whether the patient smokes, drinks, and uses any recreational or street drugs. In certain specific situations, other aspects of the social history should also be reported. For example, it is important to inform the listener of the patient's living (e.g. patient lives alone, is a group home resident, lives in a dormitory, is a prisoner, etc.) if, in light of the chief complaint, the living situation affects disposition or may suggest that other people are at significant risk for similar illnesses. For example, a patient who presents secondary to a head injury may need to be admitted for observation if they live alone and don't have anyone who can monitor them for possible deterioration. It is important to report whether a patient who appears to have contracted a potentially serious infectious illness such as meningitis lives with others versus lives with others or has come from an institutionalized setting, because it may become important to contact and treat others who live with the patient. Asking about the source of heating, or the presence of smokers in the place where the patient lives, is important if the complaint is a respiratory one (e.g. asthma exacerbation). Mentioning during your presentation that a patient has been a victim of domestic or other interpersonal violence is very important. In general, allow the chief complaint to guide you in regards to how much social history to elicit from your patient, and then decide whether or not it is something that needs to be included in the information that you present to the attending or other listeners.

- Other aspects of the social history to consider including in your presentation:
- if the patient has emigrated here from another country, and if so, when
- if the patient has been outside of the country within the past year
- information about the patient's occupation if it is relevant to the chief complaint or would affect disposition or treatment

Immunization Status

This question is important in most pediatric patients, but is sometimes also relevant for adult patients. If the patient is a child, ask the parents if the child's immunizations are up to date. Most parents will say yes. The next question is to ask the parents how they have determined that the child's immunizations are up to date. If they say that the child has received all the immunizations each time that they were recommended by the PMD, then they are probably correct. If they look at you blankly and say, "Well, I guess they're up to date – they've gotten a lot of shots" then find out who the PMD is and at some point during the visit, attempt to contact this person to verify that the immunizations are indeed

current. If the person is a child or adult who has emigrated from another country, don't assume that the immunization status is current. You can ask the patient or caretakers what immunizations have been given. They may or may not know. Just keep in the back of your mind whether their chief complaint should lead you to consider certain diseases that most people in the US don't contract if they have not had the opportunity to receive immunizations that are standard for US citizens.

Most people assume that if the child is enrolled in public school, that their immunizations are up to date. This is usually true but not always. There was a recent major problem in our nation's capitol in which thousands of schoolchildren were attending public school for months (or years) without proof of immunization. At some point, their parents were sent letters from school officials, but it took several months to either vaccinate or disenroll the children.

You don't need to comment on immunization status for most adult patients, unless the chief complaint involves burns, eye injury, or skin abrasions/lacerations. In these cases, remember to ask about tetanus status. If an injury like this has occurred and the patient has not had a booster in the past five years, they will need a booster during this visit.

When you report immunization status, a simple statement will suffice. Sample statements that you may find helpful are as follows:

"Immunization status for this recent emigrant from El Salvador is unknown."

"Child's father says he thinks the child's immunization status is up to date but he isn't sure."

"Child's mother has the child's immunization card with her which shows that the immunizations are current."

"Mr. Brown says he doesn't know when he received his most recent tetanus booster."

"Mr. Suarez says he last received a tetanus booster two years ago secondary to a forearm laceration."

GYN History

While information such as last menstrual period (LMP), previous pregnancies, and gynecologic diagnoses will be written somewhere on the chart of each female, it is usually not necessary to include all of this information in the oral presentation of each female patient. Include the information in the oral presentation when the chief complaint or likely treatment plan will be affected by this information. For example if the patient is a 25 year old female with a chief complaint of a finger laceration secondary to injuring it on broken glass, the only aspect of her GYN history that may need to be presented orally is the LMP. In such a patient, an x-ray will probably be obtained prior to laceration repair in an effort to search for retained glass fragments. Knowledge of the LMP is not absolutely essential because most attending will check a pregnancy test anyway

(regardless of the LMP) prior to ordering the x-ray. If the patient is a 25 year old female complaining of abdominal pain, vaginal bleeding, or has symptoms that suggest any type of endocrine or gynecologic problem, then more detailed information about the GYN history is important and should be presented.

Vitals

If all the vital signs are normal, you can say this. But make sure to read the triage sheet carefully, and inform your listeners of any vitals that are not normal. For example suppose that the patient has a fever but all other vitals are normal. You can say that "vitals remarkable for a temperature of 101.3 degrees, with remaining vitals within normal limits." It is helpful to report a pulse ox and fingerstick in the vitals if these numbers are important to the patient's disease process.

Physical Findings

Look at the physical examination (PE) as a screening tool to show the cause of the chief complaint. It's not meant to be a comprehensive physical that one would do as part of routine well-baby or well-adult care. You don't have to state every single detail that you found during the exam. Start with the patient's general appearance, then give the findings from the physical exam that are relevant to the chief complaint and any findings that help to either rule in or rule out disease. Findings are pertinent if they:

- help rule in or rule out disease
- are related to the chief complaint
- are a grossly abnormal finding, requiring either immediate attention in the ED, or at least a suggestion to the patient that they see a PMD about the issue

Problem List, Assessment, and Plan

Before you make your assessment, make a problem list. Do not skip making a problem list. At the very least, make it in your head because it tells you what should be in your assessment. The problem list is typically going to consist of abnormalities identified either through the chief complaint or on physical exam such as "elevated blood glucose" or "fever" or "right lower quadrant pain". Once you make the problem list, prioritize the items. If the person has numerous items on this list, choose the ones that have to be addressed immediately and decide which ones can be handled on an outpatient basis by PMD or clinic referral. Prioritizing the patient's issues is also important with regards to deciding which tests or labs should be done.

Next, make your assessment. This is what you will report to the attending / senior resident. When you make your assessment, give consideration to a differential diagnosis (or diagnoses) that will tie together the elements of the problem list. Some patient's have an obvious problem (e.g. a lacerated forearm). For the rest of the patients, carefully consider 2-4 things that could be causing the chief complaint, and include them in you differential.

After reporting your assessment, your listeners will want to hear your plan – that is, how you want to address the abnormalities you have identified. Your plan will lead you to which item in the differential is most likely. Therefore, the plan should be supported by the chief complaint and the data in your physical exam. When you give the plan, have in the back of your mind an idea of what you are looking for with each test that you order – because some attendings /senior residents will ask you why you want to order a given test.

Disposition

Disposition refers to what you want to do with the patient. There are, in general, two things you can do here: discharge or admit. Here is a simple strategy that may help you report your proposed disposition. Decide whether you think the patient can be safely discharged, whether you think more information is required before making a decision, or whether it is obvious the patient needs to be admitted and the only question is the level of care required. Don't worry about whether or not your initial thoughts end up being "correct"; all that matters at this point in the presentation is that you have given some sort of thought as to what needs to be done to allow the patient to either get admitted or go home. Report the disposition that you feel is appropriate; examples of this are listed below.

Situation #1: You think the patient can be safely discharged.

State that:

After completing the actions mentioned in your plan to address the patient's issue, you plan to discharge the patient and refer them to their PMD or a clinic for follow-up

or

After obtaining and evaluating the labs/x-rays discussed in the plan, you will make an intervention if necessary, then discharge the patient and refer them to their PMD or a clinic for follow-up

Situation #2: You think you need more information before deciding that it is safe to discharge the patient.

State that: After obtaining the results of the diagnostic studies discussed in the plan, you will make an intervention, then re-evaluate for possible discharge

Situation #3: You think the patient needs to be admitted.

You can report that you want to do one of the following options:

- admit to the floor
- explore options for a stepdown or monitored bed
- send the patient to an intensive care setting

Your disposition will need to be periodically re-evaluated by you. You will do this by checking up on the results of x-rays/labs/test, and re-examining the patient to see if interventions you have done have helped the patient. If you notice any abnormal labs or x-rays, consider what they mean and how they should be addressed. When you report back to your attending/senior resident with this data, remind them of who the patient is, then give a revised plan and disposition.

Hopefully this guide will help you to synthesize information that you gather as you interact with your patient in the emergency department. Enjoy your stay and learn as much as you can!

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