Improving international medical graduates’ performance of case presentations

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Abstract

Health care professionals use case presentations to communicate patient information among themselves during treatment and management. It is a critical genre of performance for medical residents to master for professional success. This genre is characterized by uncertainty and unique rhetorical moves, grammar, vocabulary and discourse strategies. As the format is established but not universal, international medical graduates (IMGs) in the United States anecdotally report case presentations to be the most difficult of communication tasks due to their lack of familiarity with the genre, problems with grammar and vocabulary, and the inability to organize, summarize or articulate their findings into the prescribed, interactive format. Many report crippling anxiety. For communication skills trainers, reviewing the literature in health communication and applied linguistics greatly informs the training of case presentation delivery. This paper describes the communicative tasks required of residents, followed by the components and genre particular to case presentations and how the task is perceived by residents compared to their attending faculty. Next, it explains the linguistic features unique to the task. Finally, it describes an individualized program established to train IMGs to approach the case presentation with the attitude of confidence and the deliberate manner of speaking required for professional discourse.

Keywords: case presentation; international medical graduates; communication skills training; non-native speakers of English; frontstage and backstage communication; professional discourse

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1 Introduction

In the United States, twenty-five percent of physicians have been trained outside North America, as reported by McAvinue, Boulet, Kelly, Seeling and Opalek (2005). These international medical graduates (IMGs) are often non-native speakers of English (NNS) who find working in clinical settings challenging due to language and cultural differences as well as a lack of experience with the American healthcare system. While most overcome these difficulties within their first year of residency, some need assistance in meeting those goals. English for Specific Purposes (ESP) professionals can provide the assessment and training necessary to give IMGs the confidence required to overcome hurdles and be comfortable working in English.

Tailoring training to the needs of each IMG has given me an understanding of the work that residents do and the communication skills they need for success. It has also made me aware that I cannot solely apply language training techniques to help them improve pronunciation and grammar; I also need to review the literature in discourse analysis, health communication, and medical education for a deeper understanding of the complexities that each IMG faces. In particular, many express that delivering case presentations to attending physicians and senior residents is the task that they have the greatest trouble mastering, with some reporting a crippling anxiety. I set out to understand why this task is so troublesome and how I can intervene to aid them in mastering it.

2 Communicative tasks of IMGs

When working with residents to improve their communication skills, the focus is on improving their performance on the communicative tasks required as they move through a typical day. Among them are the following: examining and interviewing patients, discussing patients with colleagues; giving instructions to patients and other healthcare professionals; leading discussions with patients and their families; telephoning social services and other physicians; consulting with physicians in other specialties; teaching medical students; writing patient care notes; dictating discharge summaries; delivering formal morning report and research presentations; and presenting cases to their supervising or faculty physician, the attending physician. All of the above activities involve talk. Indeed, as with many professions, ‘Talk is work’ for IMGs, as Roberts and Sarangi (2005) state, and this range of tasks highlights that IMG learning ‘divides into two domains: learning to talk with patients and learning to talk about patients’ as claimed by Lingard, Schryer, Garwood and Spafford (2003). Further, Iedema and Scheeres (2003) discuss the way medical professionals
work today, with a greater emphasis on a team approach to patient care that requires physicians to interact with many service providers in ways that have never been necessary before. It requires taking on a much more interactive, participatory style and playing new roles as well as ‘speaking to new people in new ways’ (Iedema & Scheeres, 2003: 332). While this is most likely challenging for all residents, it is even more so for IMGs.

From my experience with NNS medical professionals, I would predict the most challenging communicative tasks would be those which are unplanned or unpredictable, such as telephoning or interviewing patients and discussing treatment plans with their families, as colloquial language or non-standard American English can be challenging for most NNS. Surprisingly, what I have been told repeatedly by IMGs is that presenting the case to the attending physician is the most difficult. Thus, over the years IMGs have presented cases to me, often audio- or video-taped for analysis and feedback, and I have given feedback on language skills. But these role-played exercises rarely uncovered the problems residents claimed to have; in our sessions, they seemed to perform the task acceptably. Therefore, I set out to understand what case presentations are and why they seemed so difficult for residents to master despite the fact that it is a standard format that is practiced numerous times daily: is it the issues inherent in making the presentation, or is it the linguistic task itself?

3 The case presentation

The case presentation is crafted from, first, the gathering of data from the physical examination, the medical interview, discussions with families and other caregivers, and hospital records and test results. Next, the resident identifies and ranks the patient’s problems, filtering out the irrelevant, arriving at a differential diagnosis. Following that, the resident discusses a plan of management and treatment with senior residents and then compiles a narrative to present to the attending. Through presentations, cases ‘come to life in the “here and now”’, as suggested by Sarangi and Roberts (1999).

Case presentations can be performed in different formats under different conditions, with varying demands regarding length (from three to fifteen minutes) and content (from the patient’s entire history to only the positive laboratory and examination findings), depending on the clinical setting, the preferences of the attending physician and the nature of the patient’s chief complaint. Residents also have varying amounts of time to prepare for the case presentation, from approximately twenty minutes or less in ambulatory clinics to hours or overnight in a hospital inpatient setting.

According to Anspach (1988), the case presentation follows a ritualized genre and order of delivery, beginning with the patient’s age, race, gender and chief
complaint, moving through the history of the present illness, past medical and social histories and review of body systems, to vital signs and the results of the physical examination. It is often delivered most logically following this order, with topical phrases inserted as each section is presented.

This order is demonstrated in Transcripts 1 and 2. In Transcript 1, at turn 3, the resident begins, ‘…I have a 60-year-old gentleman with past medical history of hypertension, diabetes, coronary heart disease who presents today with complaints of…’. Later, at turn 21, the resident introduces the new topic with ‘His review of system is…’ and at turn 27, she concludes, ‘So my assessment is that…’.

Likewise, Transcript 2 begins similarly at turn 1: ‘So we have patient here. She is thirty-five year-old and she came with complaint of runny nose which started two weeks back…’. Near the end of turn 1, she adds, ‘Past medical history…’ At turn 5, she says, ‘So if I go to examination right now…’ and near the end of turn 5, she concludes, ‘so for the treatment-plan wise…’.

This format is taught overtly in American medical schools and is thus assumed to have been mastered by physicians entering residency. But it is not universal; thus, as IMGs may or may not have received similar instruction in medical schools abroad, they anecdotally report that they begin their first rotation not being familiar with the format.

3.1 Frontstage versus backstage communication and performance

Of interest is Sarangi and Roberts’ (1999) discussion of frontstage versus backstage professional communication, where ‘frontstage’ represents the interaction between the professional and those outside the profession such as the patient, and ‘backstage’ represents the everyday talk of work between and among professionals. They observe that frontstage interactions depend on what takes place in the backstage.

In applying this to IMGs, Lingard et al. (2003) write that residents report the case presentation as being a school genre, one of the few times in their workday when they are in a student role more than a professional one. Interestingly, IMG residents tell me that they feel most at ease in the professional role of a physician with patients and their families (defined above as ‘frontstage’) and have fewer communication problems then as compared to when presenting cases to superiors (defined above as ‘backstage’).

The following comments made by my IMG cohorts anecdotally about presenting cases to attending physicians corroborate this: ‘I can’t find the words to say in English’; ‘My mind goes blank’; ‘It only goes wrong with some attendings’; ‘I mix up the order’; ‘He asks so many questions that I panic’, and ‘I’m afraid of looking weak’. And residents report that they often communicate directly with
the attending physician only when they present a case. If they do poorly on this task, they can be perceived as being weak overall in terms of medical knowledge and given a weak evaluation in the rotation despite their performance in other tasks. Indeed, Lingard, Garwood, Schryer and Spafford (2003) point out that the case presentation must be mastered before entering the professional community and that this level of mastery must be maintained. Attending faculty report that the case presentation is more a workplace than a school genre, an opportunity for health professionals to construct and exchange shared knowledge; uncertainty is taken for granted, and the style should be flexible according to the case and time constraints. In fact, they argue that success in the student role allows the case presenter to move into the role of a clinician (Lingard, Garwood, Schryer & Spafford, 2003).

Therefore, this tension and evaluative element likely play a key role in affecting how IMGs deliver the case presentation. The reality is that presenting a case is an inherently face-threatening display of professional knowledge and a form of socialization and self-presentation (Atkinson, 1999). It is intensely questioned and suspect if delivered with hesitation; thus, it should be delivered persuasively despite inherent uncertainty (Anspach, 1988; Erickson, 1999). Atkinson (1999) adds that interruptions with questions affect the confidence and perception of the presenter. Indeed, many residents report anecdotally either memorizing or reading the case presentation to complete the task as soon as possible.

The role of questioning can be examined in Transcript 1, where the case is delivered interactively, with the attending physician controlling the flow and direction in the style of a school genre. The resident’s tone is more deferential and formal, following a student-teacher format of question/answer with frequent interruptions and correction. The student role is most apparent when the resident makes errors in judgment regarding medications, at turns 33 through 39 as well as 43–47, where the attending physician teaches through the answer and gives praise in the end, at turn 50. In contrast, Transcript 2 demonstrates more of a relaxed, informal narrative style, more of a workplace genre, with questions or interruptions from the attending only when clarification is needed, for instance, at turn 2 for content and at turns 6–11 to clarify misunderstandings due to mispronunciation.

3.2 The language of the case presentation

According to Cicourel (1999) the language of the case presentation is casual yet technical, with stylized vocabulary and syntax (Anspach, 1988). For example, it can be peppered with slang and ‘gallows humor’ as well as use of abbreviations, inside jokes, and informality (Erickson, 1999). The patient may be depersonal-
ized, referred to as just ‘patient’ (see Transcript 1, turns 34, 44 and 47). IMGs may in fact deliver cases in a much more formal, less conversational tone than their cohorts who are native speakers of English. For Anspach (1988), the case presentation is characterized by precise verb choice, particularly present perfect and past tense as well as passive voice and reported speech. (In Transcript 1, this can be found in switching between what the patient reported in the history using past and present perfect tenses with the findings of the physical exam in present tense: turns 3, 7, 9, 11, 15, etc. In Transcript 2, turn 1 demonstrates difficulty with the use of present, past and present perfect tenses.)

Further, it requires mastery of the nuances of the modal system and phrases for hedging. Iedema and Scheeres (2003) discuss how the use of modals admits the speaker’s uncertainty, allowing for others in the team to offer their views. IMGs demonstrate a lack of mastery of these features at times. For example, in Transcript 1, H uses the verb ‘want’ when she seems confident of what her patient’s diagnosis and her resulting treatment plans are (turns 27, 29, 31 and 33). After the attending physician’s correction (turns 34–38), she switches to the verb ‘think’ and uses expressions such as ‘something like’ and ‘give him something’, thus reducing her level of certainty (see turns 39, 41 and 49). Similarly, in Transcript 2, near the end of turn 5, the IMG states ‘so for the treatment-plan-wise, I am thinking right now, you know, this is like a viral bronchitis…’. She continues in turn 11, ‘and we see after that’.

IMGs also demonstrate problems with the pronunciation of discrete sounds and syllable stress (see Transcript 2, turns 6–11, regarding ‘bacterial infarction’) and syntax (see Transcript 2, turn 5: ‘…and the throat there is some enlargement of tonsil plus also some erythema… but no any pus pockets over there…’, among many other instances of syntax error). They report problems with recall of medical terminology, especially the names of drugs and over-the-counter or generic medications used widely in the United States. It is well known that fluency and recall of vocabulary and medical knowledge can also be affected when blocked by performance anxiety. Fluency problems are demonstrated particularly throughout Transcript 2, with numerous insertions of ‘uh’ and volume dropped to the point of being inaudible with some utterances.

4 Training IMGs to enhance delivery of case presentations

These initial findings form a clear picture of why case presentations may be challenging for all residents, and especially for IMGs. While some IMGs indeed need to work on English grammar and pronunciation, all need a meta-cognitive awareness of why the case presentation as a professional task is complex and of the expectations of their attending physicians and senior residents.
Reviewing the literature in the fields of discourse analysis, health communication, and medical education has enhanced the way I advise IMGs and individualize a plan of work for their improvement. While I continue to role-play the case presentation, it is done in a more interactive fashion to encourage more flexibility in delivery. Further, the resident is asked to present the case in different versions, from just the positive findings in three minutes to a more detailed ten fifteen minute presentation. I also continue to record presentations but now provide transcripts and highlight problems regarding the linguistic features discussed above, such as pronunciation, syntax, verb choice and tense, modal use, and vocabulary. In addition, I comment on humor, non-verbal skills, assertiveness and confidence as they relate to presentation of self. We target more direct eye contact and assertive delivery rather than trying to memorize or read notes. The goal is fluency, conciseness and confidence in performance.

Further, we discuss the genre and complexities of the case presentation, frontstage versus backstage perceptions, their dual role-relations as student and physician, and the expectations of attending physicians. We work on time management techniques and note-taking strategies that can help them organize the case more systematically. It is through these discussions that IMGs can gain the insight and confidence they need to deliver case presentations more effectively.

5 Future training and research

ESP professionals must tailor training to their clients’ needs. In doing so, they need to rely on their clients to be informants into their professional world, yet these clients often do not fully grasp what forces affect their performance, at times even causing crippling anxiety. In addition to linguistic analysis, reviewing the literature in the professional field can give additional insights that can be incorporated into more effective training. A similar approach could be applied to how IMGs deliver and participate in morning report formal presentations, another highly interactive, evaluative and anxiety-inducing communicative task about which IMGs also express having difficulty. As the number of IMGs employed in the United States continues to rise, and as the field of medicine continues to develop innovative ways of using talk at work, residency training programs also need to evolve to meet communication needs of all residents.
Appendix

Transcript 1: ‘Acute Sinusitis’

Role play of a case presentation set in a family practice clinic. Participants are H, resident, and S, attending physician.

1 H: Hi Dr. S; how are you today?
2 S: I’m fine; how about you?
3 H: Good, thank you, Dr. S. I have a 60-year-old gentleman with past medical history of hypertension, diabetes, coronary artery disease who presents today with complaints of cough, nasal congestion and headache for the past 10 days.
4 S: um-hum.
5 H: According to him, 10 days ago he started with some cold symptoms of sore throat and runny nose.
6 S: um-hum.
7 H: His sore throat resolved but he started with a cough which is still persisting
8 S: Let me interrupt you one second. Uh..Does he having any yellow mucus?
9 H: He does have…uh…a mucus in his cough and it’s yellow in color. He also complains of some thick nasal drainage which is also yellow in color and some post nasal dripping.
10 S: How about any fever?
11 H: He denies any fever or chills.
12 S: Is he a smoker?
13 H: He’s not a smoker.
14 S: nods.
15 H: He has used over-the-counter medication with no relief. He used over-the-counter Sudafed for congestive symptoms...
16 S: um-hum
17 H: and his wife’s Motrin for his headache...
18 S: um-hum.
19 H: His other medical, uh, his other medications include hydrochlorothiazide, Lantus insulin, Lopressor, aspirin and Plavix.
20 S: um-hum.
21 H: His review of system is negative except for the things we discussed er….before. His examination…his blood pressure is 140 over 90, his pulse is 88...
22 S: How about temperature?
23 H: His temperature is 99.6. He does have a low-grade temperature.
24 S: um-hum.
25 H: His throat is mildly erythematous. His right side maxillary sinus is tender and his right sided anterior cervical lymph node is also tender and palpable.
26 S: um-hum… OK
27 H: His chest is clear to auscultation and his heart has regular rate and rhythm...So my assessment is that he has acute sinusitis and with the history of 10 days I want to start him on antibiotics.
28 S: nodding: um-hum
29 H: I want to give him Augmentin 875 milligrams twice a day for 10 days
30 S: OK
31 H: I also want to give him something for congestive problems.
32 S: What do you want to give?
33 H: I want to give him Sudafed? (rising intonation)
34 S: Let me ask you this. You said patient had a hypertension, his blood pressure is 140 over 90..
35 H: right
36 S: Do you think, uh, Sudafed is a good choice?
37 H: Oh, you’re right Dr. S. He does have hypertension and Sudafed would increase his blood pressure further so it would not be a good choice.
38 S: OK
39 H: So I think I’m going to give him antihistamines, something like over the counter Coricidin
40 S: OK
41 H: I also want to give him something for a headache..
42 S: OK, wh...
43 H: I want to give him Motrin 400 milligrams three times a day with meals.
44 S: Let me ask you this. You said patient has a diabetes?
45 H: Right
46 S: His blood pressure is 140 over 90? Do you think Motrin is a good choice for this patient?
47 H: Oh... you’re right, Dr. S. It’s good point again. Motrin is not a good choice in this patient because it can increase the blood pressure as well as it can compromise the kidney function..
48 S: Very good.
49 H: So, I think I’m going to just have him take Tylenol Extra Strength for his headache on an as needed basis. And um...I’ll have him follow up if his symptoms do not improve in three to five days.
50 S: Very good. It’s a very good case.
51 H: Thank you, Dr. S.

Transcript 2: ‘Viral Bronchitis’

Role play of a case presentation set in a family practice clinic. N, resident and S, researcher in the role as attending physician.
1 N: So we have patient here. She is thirty-five-year-old and she came with complaint of runny nose which was started two weeks back and which, uh, was clear initially, and now getting the yellowing color—little bit thick, and started coughing since last two days which was dry initially, now is productive. She is producing like yellowish in color sputum. No any blood in the sputum or no any blood in the nasal discharge. And also complaining of the feeling warm. But actually there’s no any fever she recorded at home. And also complain for the ear pains and which is mild like five by ten in (inaudible). And also feeling the sore throat since last for five days. And..uh..she has the difficulty of the swallowing liquid as well as the food. And she .uh..she has been eating good otherwise and no any problem with the urine output or or no any problem with the stool. No any shortness of breath. No any chest pain. Past medical history, she has a history of the asthma and for that she is taking Albuterol, but since last two days because of this cough and congestion, she use the nebulizer twice at home yesterday.

2 S: You say normally she doesn’t use it at all?

3 N: No, normally she doesn’t use that. When she doesn’t get any flare up. Since last two days, she has a problem with the cough, so she is using nebulizer.

4 S: uh-huh

5 N: After nebulizer, says she is feeling better. So if I go to examination right now, on examination, ear looks good other than tympanic membrane are bulging and nose is swollen at nasal terminal and the throat there is some enlargement of tonsil plus also some erythema. But no any (inaudible) or no any pus pockets over there. And uh there is no any cervical lymphopathy and lungs clear to oscultation. No any wheezing and heart is (inaudible). No any edema feet. No any I mean significant finding on physical examination. And..uh..so for the treatment plan-wise, I am thinking right now, you know, this is like a viral bronchitis, started with that. And top of that she’s getting bacterial infarction...

6 S: She’s getting what?

7 N: Bacterial...

8 S: Bacterial what?

9 N: Bacterial (ha ha) infaction...

10 S: Infection?

11 N: Infection. ... So I’m planning to treat with the Entex, which is antihistamine and decongestant two times a day. And also I want to give the antibiotics Doxycycline 100 mg twice a day...and uh.. also want to (inaudible) the refill for her Albuterol (inaudible) so she can take it for the (inaudible) nebulizer. And also I advise regarding to continue the steam inhalation, saline nasal drop and like that. And see me next week to know how she’s feeling. And we see after that.

12 S: Fine.
About the author

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Notes

1 Transcript 1 is a role play between two IMGs; H is a resident and S is now an attending physician. In Transcript 2, H is an IMG resident and S is the researcher. Both are set in a family practice clinic.

2 As Sarangi (personal communication, 2007) points out, in the context of the IMG in the student role, the case presentation is, rather, a frontstage activity while the consultation with the patient constitutes the backstage activity on which the case presentation is based. Therefore, the nuances of what constitutes frontstage/backstage may change based on the perspectives of the participants.

References


