Learning Oral Presentation Skills
A Rhetorical Analysis with Pedagogical and Professional Implications
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OBJECTIVE: Oral presentation skills are central to physician-physician communication; however, little is known about how these skills are learned. Rhetoric is a social science which studies communication in terms of context and explores the action of language on knowledge, attitudes, and values. It has not previously been applied to medical discourse. We used rhetorical principles to qualitatively study how students learn oral presentation skills and what professional values are communicated in this process.

DESIGN: Descriptive study.

SETTING: Inpatient general medicine service in a university-affiliated public hospital.

PARTICIPANTS: Twelve third-year medical students during their internal medicine clerkship and 14 teachers.

MEASUREMENTS: One-hundred sixty hours of ethnographic observation, including 73 oral presentations on rounds. Discourse-based interviews of 8 students and 10 teachers. Data were qualitatively analyzed to uncover recurrent patterns of communication.

MAIN RESULTS: Students and teachers had different perceptions of the purpose of oral presentation, and this was reflected in performance. Students described and conducted the presentation as a rule-based, data-storage activity governed by “order” and “structure.” Teachers approached the presentation as a flexible means of “communication” and a method for “constructing” the details of a case into a diagnostic or therapeutic plan. Although most teachers viewed oral presentations rhetorically (sensitive to context), most feedback that students received was implicit and acontextual, with little guidance provided for determining relevant content. This led to dysfunctional generalizations by students, sometimes resulting in worse communication skills (e.g., comment “be brief” resulted in reading faster rather than editing) and unintended value acquisition (e.g., request for less social history interpreted as social history never relevant).

CONCLUSIONS: Students learn oral presentation by trial and error rather than through teaching of an explicit rhetorical model. This may delay development of effective communication skills and result in acquisition of unintended professional values. Teaching and learning of oral presentation skills may be improved by emphasizing that context determines content and by making explicit the tacit rules of presentation.

KEY WORDS: medical education; professional competence; communication; feedback; language; socialization; social sciences.


Oral presentation skills are central to physician-physician communication, but little is known about how these skills are learned. While the communication between physicians and patients has recently received increased scrutiny,1 less attention has been paid to the nature of communication among physicians. Studies from medical sociology and medical anthropology report that oral communication plays a central role in clinical care.2,4,6 In particular, the oral presentation of patient cases provides a vehicle for the collaborative conduct of medical work,2,3,6 the teaching and evaluation of clinical competence,2,4,6,7 the negotiation of professional relationships,2,6 and the reproduction of professional values.5,6,8,9 While previous studies have described some of the language characteristics and socializing effects of oral discourse among physicians, they have not analyzed how these skills are learned or taught.

Rhetoric is a social science which studies communication in terms of context and explores the action of language on knowledge, attitudes and values. Rhetoric has been applied to other professions such as engineering,10 business,11 physics,12 and social work,13 but has not been previously applied to analyzing medical discourse among physicians. To increase our understanding of physician-physician communication, we used the theoretical framework of rhetoric to study how medical students learn oral presentation skills and what professional values are acquired in this process.

METHODS

Twelve third-year students on their internal medicine clerkship at the University of California, San Francisco (UCSF)/San Francisco General Hospital and 14 teachers (8 residents and 6 attendings) were observed for 160 hours, including 73 oral presentations on rounds (42 by students and 31 by interns or postgraduate year 2 [PGY-2] residents). Observation was by a trained rhetorician (LAL) who
made rounds and took call with the patient care teams for part of two 8-week clerkships (October and November 1997, and January and February 1998). Nonparticipant observation was conducted following standard ethnographic technique, in which the observer dwells in the research community and, without engaging in the activities under study, records those activities and the relations between research subjects.

Observation was separated in time to allow detection of possible differences in presentation skills later in the clerkship year. The first group, a convenience sample consisting of 4 of the 8 students on the clerkship (2 students on each of 2 teams), was selected to allow indepth observation of a small number of students and their teams (2 interns, 1 PGY-2 resident, and 1 faculty attending for each team). Students were observed during all activities of the clerkship for a 3-week period (approximately 100 hours). During this time, the mean number of observed presentations was 7.5 per student and 5 per house officer. Based on the data gathered from the first group, hypotheses were generated, and all 8 students on the clerkship during the second time period were observed (mean number of observed presentations was 1.5 per student) for a 2-week period during team work rounds, attending rounds, and/or presentation rounds with the clerkship director (approximately 60 hours); most oral presentations occurred in these settings. Saturation sampling (when further observations yield minimal or no new information) was achieved through this process. Subjects were informed of our interest in “how students adjust to the clerkship”; however, in order to minimize observer effect, we did not disclose our specific interest in their communication skills until after the observation period.

Discourse-based interviews of 8 students and 10 teachers (5 residents and 5 attendings) were conducted and audiotaped. This sample included all the students on the clerkship during the second observation period and 5 of the 6 PGY-2 residents and 5 of the 6 team attendings during the same time period (those who agreed to be interviewed [all] and could be scheduled). Discourse-based interviews elicit tacit knowledge about language by having participants work with a discourse sample and explicitly justify content and organizational choices. Students were asked to arrange a written sample of patient material into oral presentation formats for different contexts and to justify and explain their choices. Teachers were given an already organized presentation sample and asked if they would present it differently in different contexts and to explain their choices. Teachers were also asked to interpret representative feedback statements selected from observational field notes. Different formats for the student and teacher interviews were chosen to reflect the preceptor relationship between students (creating the presentation) and teachers (critiquing the presentation). All students in the second group (n = 8) also completed a postclerkship survey. General survey questions inquired about the difficulties students had in composing and delivering case presentations, the “golden rules” of case presentation they had learned in their clerkships, and the advice they would offer to clerks beginning this rotation. Table 1 describes selected demographic characteristics of study subjects compared with the UCSF reference groups from which they were drawn. None of the teachers in the study had specific training in teaching oral presentation skills.

Data from field notes and transcribed interviews were qualitatively analyzed for emergent themes in order to uncover recurrent patterns of communication. Analysis followed the method of grounded theory technique in which textual data is organized into increasingly refined categories representing recurrent (“emergent”) themes. Final categories are checked with an expert insider (RJH) to ensure that they reflect the experienced reality of the discourse under study. Thematic findings from observations and interviews were triangulated using analyses of curricular documents, student surveys, and a review of the sociological, anthropological, and medical literature on medical discourse. Triangulation, a term from cartography, refers to the practice of collecting data from various sources in order to verify the accuracy of observational findings.

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* University of California, San Francisco Medical School Class 1997–1998.