New Patient Presentations: How to Present the Overnight Course

Imagine it's 5PM and you admit an 80-year-old woman with CHF and atrial fibrillation. She is afebrile with a heart rate of 160, respiratory rate 28, blood pressure 164/86, and an oxygen saturation of 92% on a 100% face mask. She is dyspneic, her neck veins are distended, her heart is tachycardic and irregularly irregular, her lungs have diffuse crackles, and she has 3+ edema to the knees. The labs are notable for mild hypokalemia, the EKG shows afib with RVR, and the chest radiograph shows cardiomegaly, CHF, and small pleural effusions. Your impression is that she has CHF due to a fib/RVR and volume overload. You place her on BiPAP and work hard throughout the night. By morning she has diuresed 3L, her heart rate has dropped to 80 with diltiazem, and you've repleted her potassium. She is off BiPAP with an oxygen saturation of 98% on 2L, her blood pressure is down, and her lungs are clear. You are a master clinician!

So how should you present this patient to your attending the next morning? Should you tell her about the overnight events in the HPI (i.e., she was admitted to the floor and we started BiPAP and gave her furosemide and diltiazem)? Which oxygen saturation should you give (92% on 100% or 98% on 2L)? Which vital signs and lung exam should you describe?

Residents are fairly inconsistent about presenting patients with active first nights, which is problematic. Confusion inevitably arises when information is given out of order and out of context. For example, it confuses listeners to hear that the patient's oxygenation improved before saying that you diagnosed CHF and gave furosemide. Similarly, it's confusing to process the drop in heart rate without knowing about the diltiazem.

To ensure clarity, you should present patients like these in two parts. **Part 1** is a standard Yale Way presentation, culminating in your initial impression and plan at the time of admission without mentioning subsequent events. **Part 2** describes the overnight events, much like you would present any patient on follow up rounds. This approach makes your presentation cogent and helps listeners understand the sequence of events, as well as the rationale and consequences of your interventions (e.g., the Hct came down because the patient bled, or rose because you transfused her). This approach also allows the team to assess your initial hypotheses, which ultimately fosters accurate diagnoses-whether you end up changing your first impression ("when the patient's hypoxemia worsened despite Lasix, we realized it wasn't CHF") or confirming it ("we gave Lasix and her oxygenation improved"). Presenting any other way sows confusion. So take this approach:

Part 1: Present the admission according to the Yale Way, ending with the time you formed your initial impression and started treatment. Do NOT describe the overnight events, physical exam findings, or diagnostic test results here. At this point, your attending may challenge you to justify your initial diagnostic and clinical decisions.
Part 2: Tell the team what happened overnight and how the patient responded (or didn't respond) to treatment. Next, give follow up exam findings and test results, and share your evolved (or revised) assessment and plan.

As with all other features of the Yale Way, following a standard approach helps listeners understand what you're saying and fosters consistent habits in presenters. When patients are active after admission, breaking up the presentation into two parts helps the team follow a potentially complex narrative and understand your decision making. Ultimately, this approach helps everyone on the team understand how and why the patient's clinical course unfolded as it did, which is key to effective management.