Style Matters

Improving medical meetings

I—Educate speakers and chairmen of sessions in advance

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Programme organisers are well aware that their programme will ultimately be remembered—and judged—more on the performance of the speakers and chairmen of sessions than on the subject matter itself. One speaker in a symposium who abuses the time limits, presents material at an inappropriately high or low cognitive level, or gives a tedious delivery (to mention just a few of the annoying tendencies of speakers) is enough to rouse the ire of an audience and by so doing detract from the educational value of the session. Poor chairmanship may, for its part, lower the value of a symposium or panel discussion by frustrating audience participation in discussion, reducing the impact of well presented material by concentrating on highly specialised trivia, and so on.

I describe here an approach to this problem based on guidelines for speakers and chairmen that have been used by the Royal Australasian College of Physicians in New Zealand for the past four years.

The guidelines

The impetus for the development of the guidelines was the decision in 1978 to change the format of the college's annual clinical and scientific meeting. Changes included abolishing the longstanding format for sessions in which individual speakers presented 20-30 minute papers followed by a discussion, in favour of symposiums and panel discussions with many speakers and a variety of small group sessions. These types of session need much better coordination of speakers than do those with only a single speaker. Guidelines for all types of sessions have been published.¹ The most recent revision of those applying to speakers and chairmen of sessions are reproduced here as "Ten points for speakers" and "Ten points for chairmen."

Ten points for speakers at symposiums

A symposium provides the opportunity for a number of speakers to make relatively short presentations on various aspects of a major topic. It concludes with a general discussion between speakers and audience. This may take the form of a panel or a question and answer session. The balance between speaking and discussion will vary but usually discussion will occupy up to half the total time allocated for the symposium—that is, it occupies an important place in the symposium. Symposiums are often ruined because of speakers who ignore their allocated speaking times so that insufficient time remains for an effective discussion.

The following guidelines are drawn up for the guidance of speakers:

(1) (a) In preparing the address you should ensure that your material is set at a level appropriate to the knowledge and experience of the audience. For example, at a physicians' meeting, material presented at a uniform undergraduate, general practice, or "superspecialist" level is usually inappropriate. (b) Think about alternative forms of presentation—for example, brief illustrated case histories rather than a lecture. (c) Actively select material to be included and excluded. In the brief time span allocated it is clearly impossible to cover the whole topic and you should indicate to the audience what aspects of the topic you have left to be raised in discussion should the audience so desire. (d) Make sure the aim of your presentation is clear and that there is an identifiable "take home message."

(2) You must rehearse your paper with slides, preferably before a third party, before the meeting. During this practice the timing of the address should be noted and the material cut down or expanded as necessary to fill the allotted time. Also ask your listeners to criticise your paper in terms of points 1 (a)-(d).

(3) It is important that you understand how the projection, lighting systems, and pointers in the auditoriums work before you take the podium. This exercise should have been carried out well in advance.

(4) You must keep to time. Overrunning diminishes any discussion at the end, puts undue pressure on succeeding speakers, and annoys the audience. Chairmen will be instructed to interrupt any speaker who appears reluctant to step spontaneously out of the spotlight.

(5) Resist the temptation to turn and talk to the blackboard or projection screen, especially when it is blank.

(6) Some enthusiasm for the topic is welcomed. We see too many deadpan faces and flat deliveries on the podium.

(7) Avoid reading your paper word for word. Eye contact with the audience is an important way of maintaining their interest.

(8) A list of journal references relevant to the topic is always appreciated by the audience.

(9) When answering questions, stick to the point. If the audience is large repeat the question so that all may hear. This also gives you time to think.

(10) Think about the material to be put on your slides. You may find the notes "Preparing and using 35 mm slides in scientific meetings" useful.¹

Ten points for chairmen of symposiums

There is a subtle, psychological pressure on the chairman of a symposium to wonder how the period allocated for discussion will be filled. Observation shows, however, that there never is difficulty; indeed, the common complaint is that too little time is left for discussion. With this in mind, therefore, you must as a chairman:

(1) Make contact with the speakers in advance to discuss the format and direction of the session and matters such as timing.

(2) Familiarise yourself with the lighting arrangements in the room or theatre before the session starts and endeavour to ensure that your speakers are similarly prepared.

(3) Start each session on time. This is often difficult, especially after tea breaks; but loss of time at the beginning of a session can seldom be made up later.

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(4) Keep speakers (especially early speakers) to time. You should announce to the audience when introducing the session that you intend to do so, and if a speaker runs over time he or she will not then be surprised when you interrupt with the suggestion that remaining material be left for the discussion period. You may ask the speaker to tell the audience what aspects of the subject have not been covered in the presentation.

(5) Not encourage questions—except on matters of verification—from the audience between presentations unless the discussion period is to be divided among papers rather than aggregated at the end of the session. The audience may be requested to write down questions as they come to mind for use in a later discussion period.

(6) Not interpose a lengthy comment between speakers. You may make a brief summary while the panel is gathering after the last speaker and while the audience is gearing up to ask the first question.

(7) Be prepared with a first question to the panel. The first question is always the most difficult to elicit from an audience; and the transition from lecture to discussion may be smoothed if you ask it. It may, of course, not always be necessary to do so.

(8) Not monopolise the discussion period either by speaking extensively or by asking all the questions. Do not labour your own hobbyhorses.

(9) Be sensitive about when to direct the discussion along new lines. It is infuriating for an audience to have a discussion which is still attracting questions prematurely redirected.

(10) When closing the session, and before thanking the participants, remind the audience when the next session begins. This is especially important before meal breaks.

A copy of the appropriate guidelines is sent with an explanatory letter to speakers and chairmen when their participation in the meeting is confirmed. No one is exempt—including overseas visitors and previous participants.

Results and discussion

Modern audiences, experienced in the visual media, expect sophisticated performances from speakers. The study of Tsakraklides *et al* graphically illustrates many of the faults of speakers and chairmen at medical meetings.² Many excellent books and references on medical speaking are available,³⁻⁵ but the many complaints about speaking style suggest that few who take the podium at medical meetings read them.

On the other hand, there is a dearth of published advice to conference chairmen. Gibson's paper makes some useful points but these relate more to business or deliberative conferences than to medical meetings.⁶ Many chairmen to be have as their only

aspiration a desire to get the session finished and done with. A few are driven by an inner compulsion to show greater skill in the subject than the panel. Most have not the faintest idea how to manage the speaker who goes on too long—indeed, our attempt to introduce warning lights and buzzer systems was frustrated by the unwillingness of chairmen to use them.

Until 1980 the formal evaluations of college meetings were noteworthy for the number and heat of complaints about the performance of speakers and chairmen. The table compares the results of an evaluation of college meetings in 1979 and 1982. In the past two years criticism of these aspects of the meeting has been noticeably less (see table), and, indeed, in 1982 there appeared for the first time complimentary references to speakers and chairmen. We believe that the use of the guidelines has

Comparison of complaints about chairing and speaking at the annual college meeting in 1979 and in 1982

Complaints	1979	1982
Speakers going over time and lack of discussion time	12	1
Poor control by chairmen	6	0
Poor presentation by speakers	5	2
Poor slides or poor use of projection facilities	7	1
Total attendance (registrations)	153	137

contributed to this improvement and that the most important aspect of their use is their distribution to speakers and chairmen at a time when they are preparing for their sessions. No participant seems to have perceived the receipt of the guidelines as a discourtesy.

References

- 1 Richmond DE. Guidelines for meetings. *NZ Med J* 1980;92:316-9.
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- 3 Meadow R. Speaking at medical meetings. *Lancet* 1969;iii:631-3.
- 4 Leech R. Speak the speech I pray you. *Br Med J* 1976;ii:1124-5.
- 5 Dudley H. *The presentation of original work in medicine and biology*. Edinburgh: Churchill Livingstone, 1977.
- 6 Gibson R. How to chair a conference. *Br Med J* 1978;ii:1280-1.

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For 10 years a 14 year old boy has slept in a bedroom, one wall of which is formed from asbestos sheeting covered with lining paper and emulsion paint. Should this wall be replaced, and are there any health checks that the boy should have?

Asbestos is perfectly safe to look at, to touch, and probably even to eat. The one thing that is not safe is to inhale particles of it. This 14 year old boy has not therefore suffered any increased risk as a result of his sleeping arrangements during the past 10 years, particularly as the surface of the asbestos has been covered by lining paper and paint. In general, it is mainly during the installation and removal of asbestos materials that any danger arises in association with their domestic use. In the present case it would probably be much safer to leave the sheeting in place where it is doing no harm rather than risk creating a respirable asbestos aerosol by removing it. Naturally, dry drilling through the sheet should be avoided. There is no justification, however, for people to live in fear because they have been minimally or occasionally exposed to asbestos dust in the past. People who develop asbestosis or cancer as a consequence of exposure to asbestos nearly always have a history of intensive exposure that has been prolonged or repeated, or both. Once exposure has occurred there is no way of undoing any damage done, and it would, in the present case, be unwarranted and irresponsible to submit the boy to sequential health checks. The risks from the checking procedures, particularly if repeated radiological investigations were needed, would far out-

weigh any risks from asbestos exposure and any benefits that the health checks could achieve.—FRANCIS J C ROE, independent consultant in toxicology and cancer research, London.

Are herbal cigarettes a health hazard?

Smoking entails taking into the mouth, and usually also the lungs, the products of the incomplete combustion (pyrolysis) of plant material. Qualitatively the spectrum of chemicals in the smoke is similar, irrespective of the nature of the plant material, although the amounts of different types of constituents—for instance, aldehydes, phenols, and polycyclic hydrocarbons—vary over a range. It is primarily in relation to its nicotine content that tobacco smoke differs fundamentally from the smoke of other plant material. Since smoke constituents other than nicotine are considered by most authorities to be implicated in the aetiology of smoking associated diseases, it would be unsafe to assume that herbal cigarettes carry no health hazard, particularly as some herbal cigarettes yield more tar than most present day brands of manufactured cigarettes. Apart from this, the tobacco incorporated into cigarettes produced by major tobacco companies is grown, harvested, and processed under carefully controlled conditions. This may not always be the case for herbal concoctions.—FRANCIS J C ROE, independent consultant in toxicology and cancer research, London.