Appendix 1: AUC Pearls for USMLE® Step 2 CS
ICE

Introduction

- Greet patient, shake hands and introduce yourself - to put patient at ease and establish rapport
- Ask patient how s/he would like to be called
- Ask the patient why s/he came in today (ie "So what brings you in today?")

History Taking

- Focus on the process
- Keep diagnostic possibilities wide open
- Don't focus on an obvious dx early
- Open-ended questions first, second and third. You can be specific later.
- One question at a time
- Get all the concerns on the table early--"Anything else?"
- Ask ALL appropriate attributes of a symptom (for pain think OLD CARTS)
- Location
- Other symptoms
- Chronology/Timing
- Alleviating factors
- Things that make it worse
- Experience of the symptom/Quality
- Severity
- Always ask about Past Medical History: (think PAM HUGS FOSS mnemonic)
    - Previous Episode/Symptom
    - Allergies
    - Medications
    - Hospitalizations (HITS – Hospitalizations, Injuries, Trauma, Surgeries)
    - Urinary Changes
    - Gastrointerstinal Complaints
    - Sleep Patterns
    - Family History
    - OB/GYN History
    - Sexual History
    - Social History (Occupation, Home Life, Smoking, Alcohol, Drugs)
- Review of Systems

After you have gathered all the necessary history, explain to the patient that you will be transitioning into the physical exam. Ask the patient if s/he is comfortable with proceeding.

Physical Exam

- This is a focused exam
- Think about your differential before you do your exam
- Wash hands every time, before and after examining a patient
- Vitals will be given, but you may want to repeat. All vitals should be included in your note.

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- Keep your patients modestly draped. If you need to remove their gown to perform a portion of the physical exam, be sure to let the patient know what you are doing and why.
- Technique matters
- ALWAYS listen with stethoscope on the skin, NEVER though a gown
- Do heart and lungs on every patient wearing a gown
- No GU/breast/corneal exams—can be listed in the tests you order for the initial work up—do talk to your patient about these
- Remember to write a statement of general appearance
- There may be abnormalities!
    - May be real or simulated
    - If you observe something abnormal, it is supposed to be that way and report it as such

Post-encounter discussion with the patient

- Don't just leave the room!
- Discuss differential dx with patient
- Discuss your diagnostic plans with patient (MRI for example – explain what it is and why you are doing it.)
- Be prepared for questions from patients
    - For example, "Am I going to die?" "Did I do something to cause this?"
      Don't let these sidetrack you from your task

Step 2 CS Note

- You only get 10 minutes per note
- Typing is required
    - You will only be handwriting anything if there is a computer glitch
- You must be succinct: Character limit in each area: 950 characters or 15 lines
- Accurate spelling, especially of medical terms, is important – patient safety
- Abbreviations must be acceptable to USMLE (http://www.usmle.org/pdfs/step-2-cs/cs-info-manual.pdf) – study this list carefully – again, patient safety
- Post-encounter note
    - History and Physical
        - History: Describe the history you just obtained from this patient. Include only information (pertinent positives and negatives relevant to this patient's problem(s).
        - Physical examination: Always document vital signs and general appearance. Describe any positive and negative findings relevant to this patient's problem(s). Be careful to include only those parts of examination you performed in this encounter.
    - Data Interpretation
        - Based on what you have learned from the history and physical examination, list up to 3 diagnoses that might explain this patient's complaint(s). List your diagnoses from most to least likely. For some cases, fewer than 3 diagnoses will be appropriate, however the majority should have 3 diagnoses. Then, enter the positive or negative findings from the history and physical examination (if present) that support each diagnosis.
        - If you're not sure how to order your differential, a quick rule of thumb is to count up how many pieces of supporting evidence you have for each. The

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diagnosis with the most supporting evidence should be listed first, and the one with the least should be last.

Lastly, list initial diagnostic studies (if any) you would order for each listed diagnosis (eg. restricted physical exam maneuvers, laboratory tests, imaging, ECG, etc.)

Appendix 2: AUC Pearls for USMLE® Step 2 CS

CIS

Communication and Interpersonal Skills (CIS):

- Introduce yourself every time
- Call your patient Ms. or Mr. or ask!
- Ask open-ended questions
- Make transition statements
- Don't interrupt your patient!
- Explain medical terminology (ie hypertension = high blood pressure)
- Empathize
- Be culturally sensitive
- Partner with the patient
  - Ask the patient what they think/want to do

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- Ask the patient if they have questions (and answer them)
- Teach back
- Explain what you think and want to do
- Make sure your patient is ok with the plan!
- Counsel patient if appropriate
- Don't forget about closure
- Provide hope and a follow-up plan

- Questioning skills – examples include:
  - Use of open-ended questions, transitional statements, facilitating remarks
  - Avoidance of - leading or multiple questions, repeat questions unless for clarification, medical terms/jargon unless immediately defined, interruptions when the patient is talking
  - Accurately summarizing information from the patient
- Information-sharing skills – examples include:
  - Acknowledging patient issues/concerns and clearly responding with information
  - Avoidance of medical terms/jargon unless immediately defined
  - Engaging in the teach back process
  - Clearly providing
    - counseling when appropriate
    - closure, including statements about what happens next
- Professional manner and rapport – examples include:
  - Asking about expectations, feelings, and concerns of the patient; support systems and impact of illness, with attempts to explore these areas
  - Showing consideration for patient comfort during the physical examination; attention to cleanliness through hand washing or use of gloves
  - Providing opportunity for the patient to express feelings/concerns
  - Encouraging additional questions or discussion
  - Making empathetic remarks concerning patient issues/concerns; patient feels comfortable and respected during the encounter

Appendix 3: Mnemonics for USMLE® Step 2 CS Patient Encounters

Use these mnemonics to help ensure you ask about all of the important questions about a chief complaint or history. These mnemonics can be written on your scratch paper once the buzzer goes off for each encounter.

OLD CARTS

O – Onset
L – Location
D – Duration
C – Characteristics
A – Aggravating Factors
R – Relieving Factors
T – Treatment
S – Severity

PAM HUGS FOSS

P – Previous Symptom/Episode
A – Allergies
M – Medications

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H – HITS – Hospitalizations, Injuries, Trauma, Surgeries
U – Urinary Problems
G – Gastro-Intestinal Problems
S – Sleep Pattern

F – Family History
O – OB/GYN History
S – Sexual History
S – Social History

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