STEP 2 CS EXAM

WHAT IS THE EXAM ABOUT?
It’s all about becoming able to take a focused history from a patient, examine him, give a DD and what the work up should be, i.e. becoming able to interact with patients.

WHAT ARE THE EXAM COMPARTMENTS?
You’ll see 12 standerized Patient (SP). SP is an actor who acts as a patient. You’ll have 25 mins for each case, 15mins for patient encounter and 10mins for writing the patient’s notes (PN) out of the patient room. You’ll see 5 cases, then have a launch break of 30mins. After that you’ll see 4 cases, break for 15mins and finally 3cases.

In the examination day, after you register, they will show you a video about the exam and if you have any question they will answer you. After that they will show you the medical instruments that you’ll be able to use (Autoscope, tongue depresser, ..etc) Then you’ll enter to the exam place which you can’t leave till the end of the exam. This process will take about 1 hour and a half. At this time you will be relaxed. The whole exam will last about 8 hours.

In the exam Place:
It’s a big hall consist of 12 numbered rooms in the same raw, they will ask you to stand in front one of them, then they will tell you to start your first encounter. You’ll see a closet on the door, open it and read the patient Chief Complain (CC) and write it down with his/her name, age, and the positive VS. You have to write a template before you enter the room (see template in Page 2) They will give you a clipboard with a pen and blank papers headed with the encounter number. You will use the paper just to write your notes inside the room and they are not used in your evaluation.

Inside the Room:
You will meet the patient, Say Hi, I’m Dr...................., I’m here to evaluate your health problem. May I have a seat please.. Start with: what seems to be the problem today?

You’ll use the following template (which you already prepared before entering the room)
CC: (Chief Complain)
HPI: (History of Present Illness)
PMH: (Past Medical History) HSAMM
H (Hospitalization) “Say: have you ever been hospitalized?”
S (Surgeries) “Say: did you have any surgery in the past?”
A (Allergies) “Say: Do you have any allergies?”
M (Medications) “Say: Do you take any medications including over the counters?”
M (Major illnesses) “Say: Did or do you have any major illnesses?”
FH: (Family History) “Say: Do you have any similar problem in the family?”
SH: (Social History) WADSS
W(Work) “Say: What do you do for living?”
A (Alcohol) “Say: Do you drink Alcohol, how much, how often?”
D (illicit Drugs) “Say: Do you take any illicit drugs, what kind, which way, how often?”
S (Smoking) “Say: Do you smoke, how much, how often, for how long?
S (Sexual history) “Say: Are you sexually active, how many partner, any preference M/F.

• In the next page you’ll find an example of how a typical template should be..
Encounter Number (1-12)

Patient Name, abnormal VS

CC:

HPI:

ROS:

PMH: H
  S
  A
  M
  M

FH:

SH:  W
  A
  D
  S
  S

COUNCILLING:
Suggested Encounter Time Course:
- 1min for writing the template.
- 6-7mins for history taking.
- 5mins for Examining the SP.
- 2-3mins for Counselling, discussing the DD, and the work up.

The upper mentioned template has modifiers depending on the case:

**Pediatric:** PDVNS
- P: Pregnancy history “Say: Did his mother have any problem during the pregnancy?”
- D: Delivery history “Say: Any problem during his delivery?”
- V: vaccination history “Say: are his vaccinations up to date?”
- N: Nutrition “Say: Are breast feeding him, do you give him any food or formulas?”
- S: School and development “When did he first smile, sit down, stand up, walk, speak… Is he doing well in the school?”

**Obs/Gyn:** LMC, PDAM, contraceptives.
- LMC: Last Menstrual Cycle “Say, When was your LMC?”
- P: Pregnancy “Say: Have you ever been pregnant?”
- D: Delivery “Say: Any problem during the delivery?”
- AM: Abortion, Miscarriage “Did you have any abortion or miscarriage”
- Contraceptives: “do you take any contraceptives?”

**Psychiatric:** DASHH
Start with: How was your mood recently?
-D: Depression: “Do you feel sad?”
-A: Anxiety: “Do you feel anxious?”
- S: Suicide “Have you ever thought about hearting or killing yourself”
- H: Homocide “Have you ever thought of hearting others”
- H: Hallucination “ Do see, hear, or smell things that others don’t?”

**Neurological:** LMC, VHS, WN, G, H/S
- L: Language “How is your language?”
- M: Memory “How is your memory?”
- C: Concentration “How is your concentration?”
- V: Vision “Any problem with your vision?”
- H: Hearing “How is your hearing?”
- S: Swallowing “Any problem in swallowing?”
- W/N: “Do you have any weakness or numbness any where?”
- G: Gate: “Do you have any difficulty walking?”
- H/S: Headaches/seizures “Do you have any headaches, Did you have any seizures?”

**Notes:**
- LMC= Mini Mental Status.
- VHS for evaluating the brain stem (Cranial nerves in the upper (II), middle (VIII), and lower (X&XII) parts of the brain stem)
- WN for evaluating the motor and sensory functions.
**Important note:**
ROS: don’t forget to Review the other systems after taking the HPI, by asking quick question:
- Do you have any fever, wt loss, appetite changes?
- Any headaches or seizures?
- Do ever have SOB (Shortness Of Breath)?
- Do you have any CP (Chest Pain)?
- Do you ever cough up blood or phlegm?
- Do you have any abdominal pain?
- Any D/C (Diarrhea or Constipation)?
- Any changes in your urinary habits?
- Any changes in your urine color?

You will be surprised sometimes that you missed something in the HPI and ROS helped you in recovering it, also this help you to concentrate on one or two systems.

**Challenging Patient:**
You’ll find a special section in the first 55 pages of the First Aid book, talking about how to deal with challenging patients.

One example is: “Doctor, I want to go to the rest room” we call this physiologic need. Therefore you have to say: “please go ahead”

Another example is: “Doctor, May I answer my mobile phone” so your answer should be the following: “If it’s urgent, please go ahead”

**Writing PN:**
When you leave the room, you will find a desk near the door, with a computer and a paper on it. You have to choose one way to write the PN, typing or writing. You can’t change the way you chose on the first encounter for the following encounters.

You have to practice a lot in order to be able to write PN on time. Keep in mind that you have only 10mins.

On both the computer and paper you’ll find 4 components: History, Physical exam, DD, and Work up.

In the history you have to write the followings: HPI, PMH, PSH (Past Surgical History), Meds, Allergies, FH, and SH.

**Remember that** the template, mentioned above, is just what you wrote before you enter the room to help you organize your questions and ideas during the encounter. In addition to, it help you in writing the PN. It’ll be ruined after you finish the encounter and write your patient note. It’s not taken in consideration for grading your performance.

**Note:** trust me, you won’t remember any thing from the history when you come out of the room, if it’s not written in your template during the encounter.

**Hint:** you can use abbreviations to make it easy to write fast while patient is talking.

In the Physical Ex. section, you have to write the positives and negatives (there is a table at Page 55 in the First Aid book that you can learn from)

In the DD section, you have to write the 1st 5most common and appropriate diagnosis.

In the work up you have to put the appropriate work up.

Don’t write any thing if you are not sure that it could be a DD or appropriate work up.
**SOME SKILLS THAT YOU SHOULD HAVE:**

**LANGUAGE SKILLS:**

It’s very important to practice talking, listening and writing as much as you can. If you can travel and do a rotation (elective) before your exam that would be a good idea.

**INTERPERSONAL SKILLS:**

- Knock the door before you enter, then enter to the room with the SP name in mind.
- When you enter the room, draw a smile on your face and shake the SP hand if possible, and don’t forget to introduce yourself to the SP.
- Start the encounter with covering the SP legs with a blanket.
- Try to keep eye contact in 75% of the encounter time.
- When you finish from HPI and want to ask about PMH tell the patient that you are going to ask him some questions about his PMH. This just to orient the patient (let him know) that you are going to ask about different field.

Remember to do the same whenever you move from one cluster of questions or examinations to another.

- Do not interrupt the patient (exception is the bipolar patient)
- Keep the SP personal space (60cm) empty. If you want to enter into it to examine him, tell him that you are doing so. For example, tell him “I’m going to examine your eyes, listen to your lungs, heart…etc” then enter to his personal space.

N.B.: a personal space is an imaginary special area around a person, which you can not break into without taking his permission by telling him what you are going to do and why. If you forget to do that, then you are not respecting that persons privacy.

- If you need to examine the chest tell the SP to untie his gown by himself. If he can’t, offer him/her your help.
- If you need the SP to do something start with “May you please…. ” And finish with “thank you”.
- Don’t forget to tell the SP to wear the gown again.
- Wash your hands before and after the physical exam.

**Hint:** you can think of what you should exam and what is the DD while washing your hands.

- Don’t use medical terms when you are talking with the patient. (keep them for the PN)
- Close the encounter by saying “Mr/Mrs……………… from your history and physical exam your symptoms are probably because of a heart problem (for example) we will need to do some investigations to decide what the definite diagnosis is.
- Ask the SP if he has any question or concern before you leave the room.
- You are a doctor not a judge, so don’t judge patient with bad SH.
- If patient smoke, drink or take drugs, write down in the write lower corner of the template that he does so. This will remind you to council him and tell him not to do so. (Say for example: Et-OH/Drugs are hazardous to your health, there are programs that you can join to get rid of it)
- Don’t repeat painful maneuvers on examination. You want get anything but causing pain for the SP.
- Keep in mind that the exam is focused, so you can’t do a full exam. You can just examine 1 or 2 systems (example: heart and abdomen, chest and heart, just neurological…etc) You can’t even do a complete neurological exam. You can just examine do some parts of it.
How to Prepare for the Exam? First Aid

- Start by reading the first 55 pages of the book First Aid for CS Exam. They contain the upper mentioned information in more details. With examples of questions that you can use for each symptom. In addition to, what to tell the patient during the physical exam and how to write the PN. Also it include information of how to register and pay for the exam and schedule an appointment.
- The book contain a section called Mini Cases. Let’s say you are going to take a history from an SP with an abdominal pain. Read the abdominal pain from the mini cases. After reading this section you’ll be able to give DD and Work up.
- Find someone to practice with him every day. You will pretend that you are the SP, and he will take the history and PE from you. Then do the opposite. You’ll find 27 cases (practice cases) in the First Aid book.
- When you finish this book you’ll be able to approach any patient by taking his history, examine him, and discussing the DD and work up.
- The more you practice, the more you get used to approach any patient until this process become like the running blood in your vessels.
- You can use the Kaplan CS book if you need to practice more cases.
- Don’t forget to use the USMLE CD which they will send to you after you register. The CD contents are available online, you can download them from the down mentioned website. Also it’s available in GBS and every student who took one of the USMLE STEPS exams.

How to Register for the Exam?

- Go to www.ecfmg.org. 
- Click IWA link which lies right above OASIS in the mid top of the webpage. You register throw the IWA.
- After that you have to download the Form 183 which is a form that must be filled by the Dean or Vice Dean of our university. (glue your photograph 5*5cm² in the provided space in this application) have madam Maha (secretary of the Dean) to seal this application after being signed by the dean. The seal should cover half of your photograph.
- Send this form (183) to the mentioned address in its bottom.
- The application will cost 1200$, which you can pay online through credit card.

Finally I hope you all get the best scores in every exam you take, and I ask God to help us in passing the real exam, and that he accept us, and finally send us to the paradise.

Best luck

DMBKH