So You Are Ready for the Step II CS Exam? One Student's Advice

Strategies to ensure you pass the first time

The USMLE Step 2 Clinical Skills exam is unlike any exam you have taken in the past. Please consider these strategies I have learned through a hard and humbling way—taking the exam three times! Contrary to popular belief, it's not guaranteed that you will pass the test. Contrary to popular belief, this test is not "just an English proficiency exam" or a "touchy-feely exam" to test your bedside manners—*it is an exam to test your abilities to function as a clinician, i.e., your CLINICAL SKILLS*. Medical students from the bottom to the top of the class can fail this exam. However, I believe any medical student can guarantee they pass if they learn their weaknesses beforehand. Do not be influenced by your peers who might say, "Just go take it…it's a waste of time and money anyway" or "If I cannot pass this test by now I do not deserve to be doctor". Believe me, these comments influenced my preparation and I paid—literally!

1. **Be aware of the time constraints and the emphasis on ruling out important differential diagnoses:** Fifteen minutes in the room will go fast if you are doing everything you should be doing. Do not settle for a single diagnosis. Diagnoses are easy to make for this exam because most are simple complaints—browse a casebook. I made the mistake of being too confident in my top differential diagnosis and I would stop asking further questions once I thought I knew what the patient had. Do not do this. Make sure to rule out other important possibilities by asking further questions. The CS is not a pure knowledge exam with a single best answer. On all twelve cases you can come up with the correct diagnosis and still fail. Sounds strange, but the NBME is most interested in you demonstrating ***how*** you arrived at your diagnosis by ruling out other important possibilities through careful and thoughtful history taking and physical examination. The NBME can only measure this by checking boxes if you asked the appropriate questions and performed the appropriate physical exam. The standardized patient (SP) will turn to the computer once you leave the room to evaluate you by checking off these boxes. It doesn't matter how nice you were or how seamless your physical exam skills were. You must demonstrate your problem-solving skills to the SP.

2. **Memorize the head-to-toe review of systems (ROS) for every patient:** I cannot stress this enough. You likely cannot spit out a ROS from head to toe succinctly and from memory. Make sure you can for this exam. The cases are complaints you have heard of before but I guarantee the patients are unlike what you are used to. In medical school, we are taught to ask open-ended questions. You will go nowhere in this exam after the first couple of such open-ended questions. The SP's appear to be trained to ensure you discover problems by asking specific questions (i.e., closed-ended). It is still important to begin with open-ended questions, but then quickly move to closed-ended questioning. Unless the SPs are prompted by closed-ended questions you will miss checklist points. In order to remedy this challenge, use a memorized ROS to ensure you do not miss anything or implement the ROS when you are stumped. This will save time

and you will gain checklist points. Do your ROS for every patient because even though it might be a straight-forward complaint the cases seem to be designed so that the student is tested if they considered all common and important possibilities (i.e., differential diagnoses). The importance of the ROS being memorized instead of focused allows very little contemplating—it's mindless. You will not forget to cover a system that is pertinent and you can use the time to be thinking about other pertinent questions to ask. Asking the right questions is crucial to earn checklist points and nail the diagnosis. Even Osler taught this 100 years ago noting that ~70% of the time a carefully-taken history alone would yield the diagnosis. How many times have you gone back to the patient to ensure you knew the answer before you presented the case to an attending or resident? Why did you go back? Because you knew the answer was a pertinent part of the history or even crucial for the differential order. Unfortunately, during the exam you will be a little stressed because you know it's an exam and this time you cannot return to ask a question.

3. **Memorize the Physical Exam (PE) from head to toe:**
   Although your PE will be focused you should still have an efficient and systematic PE protocol or framework memorized so that once again you will not forget to do a PE maneuver. For instance, on my 3rd CS attempt, for every patient I stepped in front of as I began my PE I stated to the patient "I am now examining your skin". Say everything you are doing so that the SP knows you are doing it. Sounds strange, but if the SP doesn't know you are doing it you will miss checklist points. If you examine the chest bring the patient's gown down. Do not listen over or underneath the gown—you will likely lose checklist points with either of these methods. Always ask permission to do a PE and untie/retie the gown yourself.

4. **Prohibited PE maneuvers:**
   Do not forget to recommend to the SP a breast exam at a later time if a breast exam is pertinent (or any other prohibited exam). By doing this the SP knows you are thinking of it. Also include the PE maneuver in your work-up.

5. **Know a succinct neurological exam:**
   Somewhere along my medical training I missed learning how to write a succinct yet complete neuro exam. It was not until my third attempt that I learned this format for writing up the neuro exam which also aids in performing the neuro exam because it's memorized. See the end for the framework and normal responses. If you think a full neuro exam is relevant (e.g., HA, dementia), do the neuro maneuvers first instead of mixing them into your head to toe PE exam. You will not have time to do both complete exams so do what is most important first then tack on what else is relevant.

6. **Memorize a framework/template for the note write-up:**
   The patient note (PN) can also be challenging because you have a mere ten minutes to compose it. There is no computerized template! Unfortunately, in real life (like Wishard and the VA) there are computerized templates we've been accustomed to use and, therefore, we are not well-trained to efficiently write a note de novo in our sleep. To do an excellent note you must practice your PN beforehand. Know how to write or type for

each system normal findings. You do not want to find yourself taking time thinking of what you did or did not do in the room while composing the PN. There is just not enough time. See the end for a PN framework.

7. **Female patients:**
   Every female SP merits an OB/GYN history. Believe me, every patient that I asked about menarche had an answer without looking at me strangely for asking. It will not take long to ask a few questions even if it does not seem relevant. You will likely gain some checklist points.

8. **Pediatric Case:**
   In addition to your standard history and ROS (do it here as well), ask the following: birth history, milestones, immunizations (ensure up-to-date), last check-up, eating habits, sick contacts at home and daycare.

Final Thoughts

Since I have practiced and implemented these strategies I believe I have performed better H&P's during my shifts at the local ED. I am more confident in my presentation to the attending and miss less information pertinent to the differentials. Consequently, I have found more enjoyment in my job as well. If you implement these strategies, particularly a memorized ROS, you too will be a better clinician because of it. Even if you performed well on your 3rd or 4th-year OSCE, you still need to practice. (My medical school found no deficiencies during my 4th-year OSCE). The first time I failed the test because I was aloof. The second time I read the entire prep book but did not practice. The third time I practiced until I was exhausted. Please take time to practice with anyone willing to simulate an SP. In addition to practicing, the last piece of advice I have is: "If you think of it (a possible differential diagnosis), then do it (ask the pertinent ROS question or perform the PE maneuver to help you rule it in or out)". You will have thoughts (DDx) cross your mind during each patient encounter, and I strongly encourage you to pursue the possibility by digging deeper into the patient's history and PE. Relax, be confident, and have fun!

ROS: fevers, chills, night sweats, appetite change, weight change, fatigue, depression, headache, visual changes, seizures, pain or difficulty swallowing, thyroid problems, shortness of breath, chest pain, heart racing (palpitations), cough, wheeze, abdominal pain, nausea, vomiting, diarrhea, blood in your urine or stool, moving your bowels okay, painful urination, increased frequency of urination, kidney stone, pain in your joints, numbness, weakness, tingling, rash.

TIP: Every SP will answer each question one at a time. Be careful on your time. Practice while driving so that you can know your ROS forward and backward!

Sample PN Structure:
CC
HPI
PMH (include hospitalizations)
PSH (include trauma)
ALL
MEDS
SH (include occupation, exercise, alcohol, tobacco, drugs, sex)
FH
ROS negative except as above (I typed this every case because the positives are in the HPI)

PE
Vitals wnl (within normal limits)
Gen:
HEENT: oropharynx wnl, no icterus or injection
Neck: no carotid bruit, JVD, thyromegaly, or LAD
Chest: symmetric excursion, CTA & P bilaterally, normal effort, tactile fremitus wnl
Heart: PMI nondisplaced, normal S1 & S2, no m/r/g, reg rhythm
Abd: soft NT/ND/BS normoactive, no HSM or RT
Ext: no cyanosis, clubbing, or edema
Neuro:

- MS: A&O x 3, short and long-term memory intact
- CN: II-XII intact
- Motor: tone wnl, power 5/5 throughout
- Sensory: intact to light touch throughout
- Reflexes: DTRs 2+ babinski downward
- Cerebellar: gait wnl, romberg negative

Skin: no trauma, ulcers, or rash