

## How to Study for Step 2 CS

Step 2 CS has 3 components that are tested on that you are required to pass to receive a passing score. Allow yourself 3-5 days to work through these materials.

1. SEP: English Proficiency
  2. ICE: "Integrated Clinical Encounter" The note, study for this using First Aid for Step 2 CS practice cases and try typing up your own note and checking it against the sample note (details & Template below)
  3. CIS: Communication & Interpersonal skills with standardized patients (checklist on last page)
- **Review THIS:** About Step 2 CS: <https://www.usmle.org/pdfs/step-2-cs/cs-info-manual.pdf>
  - **Review THIS Too:** [https://www.usmle.org/practice-materials/index.html#tab\\_step2cs](https://www.usmle.org/practice-materials/index.html#tab_step2cs)
  - Practice note timed template provided by the NBME (it will erase what you type after 10 min): <https://www.usmle.org/practice-materials/step-2-cs/patient-note-practice2.html>

### **ICE: The note. Practice the format that the NBME prefers, it's slightly different than what you all do on rotations**

"The ICE subcomponent includes assessments of both data gathering and data interpretation skills. Scoring for this subcomponent consists of a checklist completed by the standardized patients for the physical examination portion of the encounter, and global ratings provided by trained physician raters. The patient note raters provide ratings on the documented summary of the findings of the patient encounter (history and physical examination), diagnostic impressions, justification of the potential diagnoses, and initial patient diagnostic studies.

Although it is not feasible to list every action that might affect an examinee's patient note score, the descriptions below are meant to serve as examples of actions that would add to or subtract from an examinee's score.

#### The following are examples of actions that would result in higher scores:

- Using correct medical terminology
- Providing detailed documentation of pertinent history and physical findings. For example: writing "pharynx without exudate or erythema" is preferable to stating that the pharynx is clear.
- Listing only diagnoses supported by the history and findings (even if this is fewer than three)
- Listing the correct diagnoses in the order of likelihood, with the most likely diagnosis first
- Supporting diagnoses with pertinent findings obtained from the history and physical examination

#### The following are examples of actions that would result in lower scores on the patient note:

- Using inexact, nonmedical terminology, such as pulled muscle
- Listing improbable diagnoses with no supporting evidence
- Listing an appropriate diagnosis without listing supporting evidence
- Listing diagnoses without regard to the order of likelihood "

## Step 2 CS Note Template (Copy and paste a bunch for practice!)

1. Read through the practice case script in First Aid for Step 2 CS (You get 15 minutes for patient encounter)
2. set a timer for 10 minutes and type your note here! (You get 10 minutes to type your note on test day)
3. Check your note against the example note in First Aid for Step 2 CS

**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 Exam** 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. :

**Differential Diagnosis** *Based on what you have learned from the history and the 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. Then, enter the positive or negative findings from the history and the physical examination (if present) that support each diagnosis. Lastly, list initial *diagnostic* studies (if any) you would order for this patient (e.g. restricted physical exam maneuvers, laboratory tests, imaging, ECG, etc.):

Diagnosis #1	
History Findings	Physical Exam Findings

Diagnosis #2	
History Findings	Physical Exam Findings

Diagnosis #3	
History Findings	Physical Exam Findings

Diagnostic Study/Studies

## Communication and Interpersonal Skills Behavior List

Functions	Sub-Functions
<b>1. Fostering the Relationship</b>	Expressed interest in the patient as a person
	Treated the patient with respect
	Listened and paid attention to the patient
<b>2. Gathering Information</b>	Encouraged the patient to tell his/her story
	Explored the patient's reaction to the illness or problem
<b>3. Providing Information</b>	Provided information related to the working diagnosis
	Provided information on next steps
<b>4a. Making Decisions: Basic</b>	Elicited the patient's perspective on the diagnosis and next steps
	Finalized plans for the next steps
<i>4b. Making Decisions: Advanced</i>	<i>Sub-functions yet to be developed</i>
<b>5a. Supporting Emotions: Basic</b>	Facilitated the expression of an implied or stated emotion or something important to him/her
<i>5b. Supporting Emotions: Advanced</i>	<i>Sub-functions yet to be developed</i>
<i>6. Helping Patients With Behavior Change</i>	<i>Sub-functions yet to be developed</i>

Test Day Info:

Wear professional, comfortable clothing. Plan for a long day of focusing.

Remember the following items on test day:

1. Scheduling permit
2. Confirmation notice
3. Unexpired government-issued photo ID
4. Standard stethoscope
5. White lab coat

**Good LUCK! You can do this!**