United States Medical Licensing Examination (USMLE) Step 2 CS for International Medical Graduates

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By

Sherif Shazly

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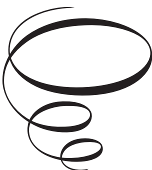

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Step 2 CS for International Medical Graduates

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This section briefly provides the basic clinical knowledge that you may need to be able to ask appropriate questions and suggest a reasonable differential diagnosis. You generally do not have to study particularly deeply. Instead, you just need to know about common complaints, their clinical features and work-up. We strongly recommend that you read this section before you practice. Do not waste your time reading in the same way that you prepare for a USMLE CK exam. This exam is not meant to test your clinical knowledge as deeply.

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questions should also not be redundant. Furthermore, do not use mnemonics for all cases. It will be difficult for you to remember more than 50 mnemonics and to recall the meanings of all the As, Es, and Ss in these mnemonics as well! Accordingly, your efforts to recall these mnemonics, and the questions associated with them, will make you look confused and distracted. Instead: (1) only keep mnemonics for challenging cases; (2) use a mixture of mnemonics for some cases and figures (illustrations) for others (use different strategies); and (3) use a mnemonic/figure that is related to the complaint itself, so you can remember the correct mnemonic for the case (e.g. a figure of a sleeping person for an insomnia case). The stress of an actual encounter can make things harder than they seem when you practice with a colleague. So, try to choose the easiest approach for you and practice it several times.

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PREFACE

USMLE CS, the only interactive test in the series of USMLE exams, has been always a source of anxiety for IMGs. USMLE CS is more challenging to IMGs compared to AMGs, being a complex test of knowledge, language, culture, communication, and personality. Therefore, IMGs tend to experience many difficulties during exam preparation that are not typically recognized by AMGs.

However, many IMGs do not realize that the USMLE CS exam is a feasible exam that is designed to assess if an examinee can meet the minimum requirements to practice in the USA. Despite all these challenges, 4 out of 5 IMGs pass the exam. However, most IMGs who fail the exam are not incompetent; they simply do not understand what the exam is about. Most IMGs who fail their first attempt pass the exam at the second attempt just because they have realized the structure and the challenges of the exam. Unfortunately, IMGs are distracted by so many student notes, net advice and recommendations from prior examinees. They never know what source is reliable, or when they do not have to search for more.

This book provides a comprehensive study guide for IMGs. Unlike other sources, the book addresses specific needs of IMGs and describes the shortest ways to prepare for the exam comfortably and confidently without wasting time or effort. The book is concise, targeted and simple. In addition to physical examination videos, this resource is quite sufficient for your preparation.

We hope this book will meet the expectations of IMGs and facilitate their exam preparation. Your feedback is definitely welcomed.

SECTION I:

EXAMINATION COMPONENTS

In this section, we are going to explain the 3 elements of the exam that you should pass. It is important to consider the 3 elements equally in your preparation because high performance in 2 of them will not compensate for poor performance in the third element. It is generally known that the most challenging element for IMGs is the "communication" part. However, the good news is that it is the easiest component to improve with efficient practice.

I Spoken English Proficiency (SEP) score

Because the TOEFL examination is no longer required for an ECFMG certificate, the SEP element has been established to assess your language competency. It is intuitive that this element is evaluated by the SP (standardized patient). This part should not scare IMGs because the expectations are so simple: understand the SP and make the SP understand you. No more. Here are some hints to help you pass this part of the evaluation:

- You do not have to demonstrate an American accent if you do not really have it. Accents are not part of your evaluation. You should not try to make your accent sound American if it is not. Otherwise, you will be distracted and your accent may even become harder to understand.

- If you are not 100% fluent in English (which is usually the case for IMGs), speak slowly. Slow speech minimizes the impact of your native accent and makes your words easy to understand. Clear pronunciation is what really matters.

- When the SP talks, you should listen carefully and pay attention in order to understand. It is usually not difficult but because the SP will sometimes describe an event using multiple sentences, it is

important not to get lost. Do not distract yourself by thinking of the next question or trying to write down his/her words at the same time. Listen, listen and listen, then write briefly.

- During your practice, try to ask the routine questions the same way every time, using the same words and structure, so you can recall them easily in the exam. This includes introductory and closure sentences, the review of systems (ROS), questions on past history, family history, etc.
- Use the simplest question formulation possible (e.g. do you have, did you have) as long as it is applicable.
- As will be detailed later, you should have briefly reviewed the SP's history with them by the end of the information gathering. This should help you to recognize and correct any misunderstood information during history taking.

If you practice English within an English-speaking community, you may be able to evaluate your performance prior to the exam. In general, this part should not be challenging. All that you need is to speak English. Again, do not be afraid of your accent, but try to speak slowly and clearly if your accent is pronounced.

II Communication and Interpersonal Skills (CIS) score

There are over 20 points that the SP is asked to check after you leave the encounter. You should pay attention to each one of them and cover them all each time you practice. Print this checklist and ask your study partner to use it to evaluate your performance at the end of each case you practice. It is a common mistake for candidates only to pay attention to asking all the relevant questions and diagnosing the case without receiving/giving any feedback on their communication skills. These points include:

- **Knocking on the door:**

  Once you finish reading the door note, your first step is to knock on the door. It is hard to miss this because all the examinees will be knocking on the door at the same time. Once you are invited to enter the room, you can open the door and start.

- **Professional dress and appearance:**

  You should dress formally. A classic shirt and pants, a tie and a clean white coat (medical or lab) are appropriate. This is another point that can be easily fulfilled. Also, you should not smell. Therefore, you need to use a deodorant stick or spray, and perhaps some mint chewing gum. On the other hand, you should not use strong perfumes. In brief, look professional and clean and do not smell. That is all!

- **Introducing yourself:**

  Once you step into the room, your first sentence should be close to that the following: "*Hello/Hi. Mr./Mrs. Y? My name is X, I am the physician in the office today, nice to meet you.*"

  Then shake hands. The next step is to introduce your role: "*I am here to ask you some questions and do a brief physical examination, is that okay?*"

  So to fulfill this part, you should introduce both yourself and your role. You should smile appropriately. Feel free to choose introductory sentences that you are comfortable with and keep using them in your practice. Never use sentences like "How are you?" or "Are you okay?", because the SP may respond to your question by reporting his/her complaints, and this will disturb your introduction.

- **Eye contact:**

  This may be the most challenging part in the communication section because you need to keep comfortable eye contact with the SP and write down notes on the blue sheet at the same time. These hints will help you to fulfill this point:

  - Your eye contact should be comfortable. Look kindly and do not stare!

  - If you are uncomfortable keeping eye contact with the SP, fix your eyes on the SP's forehead.

- If you need to look at your blue sheet or write down some notes, try to practice looking/writing quickly and from time to time. Most importantly, do not do either when you or the SP is talking; although loss of eye contact is unavoidable at times, it should not be while the SP is expecting you to listen and pay attention.

- Write down positive points during history taking, using as few words as you can. Use (X) if the data are negative, e.g. Family History: X, Allergy: X.

- When you go to wash your hands, do not turn your back to the SP. Instead, try to keep eye contact while washing your hands. It is always a good idea to hold one question back to ask the SP while washing your hands so that you keep the conversation running.

- During the PE (physical examination), you should talk to the SP before each step to explain what you are going to do. It is generally advisable not to talk to the SP when there is no eye contact (e.g. standing behind him or turning your back).

Address the SP using their last name:

The last name of the SP will be written on the door note. It is a very common mistake to forget to write it down on your sheet. Do not forget that! Write it clearly at the top of your sheet so you can find it when you need it.

After knocking on the door, your first question before introducing yourself will be: "*Mr./Mrs. X?*" Once he/she says "*Yes*", you will begin to introduce yourself. You should always check that the patient in the room is the correct patient.

Try to use the SP's last name on as many occasions as you can (e.g. obtaining permission to do the PE, transition from one part to the next in the history taking, encounter closure).

Paying attention:

This part is also covered under 'eye contact'. Your goal is to listen carefully to the SP. Do not turn your back on them. When the SP is

asking you to address his/her worries, you should focus on responding to his/her concerns satisfactorily. Do not take this lightly. The SP's impression of your care, kindness and attitude is the essence of the examination. It is also important to recognize the SP's facial expression and discuss their worries whenever you feel there is an indication of one, e.g. "patient looks anxious or tearful". Never interrupt the SP. Interrupting the SP is not the best way to save your time!

- **Showing empathy:**

Your facial expression should always be a SMILE. Keep smiling unless it is not appropriate (e.g. the SP is telling some bad news, if they have been exposed to assault). You should show empathy whenever needed. Examples include:

- When the SP mentions his/her complaint, you should express empathy, e.g. "*I am sorry to hear what you have been through. I will do my best to address your problem.*"

- When the SP starts to cry while recalling a bad memory, you should stop asking questions and remain silent, showing appropriate facial expressions and offering the SP a tissue and a glass of water. You may also apologize for the stressful question. Do not resume asking questions until the SP looks better and gives you permission to continue.

- When the SP looks worried or concerned about a serious medical and social issue, you should express your understanding of his/her concern. Stop and ask more about these concerns. Respond to them in a way that relieves the SP's stress if appropriate (avoid false reassurances).

- **Non-judgmental attitude:**

You should always express a respectful attitude. Use neutral words to respond to the SP's answers or after each part of your PE (e.g. okay, alright). Avoid informative words (e.g. nice, good, great, excellent). Do not give unnecessary reactions while trying to give yourself some time to think ahead of your next question. Practicing neutral words is important in order to allow your brain to use them

naturally. Also, be careful not to show any negative attitudes towards the SP's answers.

- **Appropriate draping:**

All SPs are draped. The following is required to manage draping appropriately:

- You are required to obtain permission before untying a gown or lifting it to expose any part of the body.
- You are only allowed to expose the part you examine. For example, if you want to do an abdominal examination and then a lower extremity examination, expose the abdomen, do your exam, and then cover the abdomen and expose the legs. Once you are done with your PE, retie the gown immediately.
- Do not overexpose any body part you examine.
- If you are going to expose/examine the abdomen, lift the SP's gown up slowly while lifting her/his white drape at the same time to avoid any inappropriate exposure.
- Any part of the body you examine or touch should be exposed. If the SP covers his/her arm or leg with a dressing or a stocking, you should ask him/her to remove it so you can see and examine the area appropriately.

  In general, draping should reflect your respectful attitude. Try to do it in an appropriate manner even if you are running out of time. This point is more important than the PE itself.

- **Open-ended questions:**

You are required to ask a few open-ended questions in each encounter. Usually, the SP will respond verbosely. NEVER interrupt him/her. Listening appropriately is a part of your evaluation. The most useful situations for open-ended questions are:

- After you introduce yourself, you may ask the SP: "*How can I help you?*" Then when he/she reports his/her complaints, you

may respond by saying: "*Can you tell me more about this?*" (i.e. about the complaint).

- After you finish data gathering and review these data with the SP, you may ask him/her: "*Do you have any other complaints/concerns that we have not discussed?*" This is actually important not only as an opportunity to ask another open-ended question but also to allow the SP to give you information that covers the questions you forget to ask!

- **Non-leading questions:**

You should avoid leading questions. This does not mean that you cannot ask focused questions. You just need to avoid questions that may encourage a certain answer. You should ask: *"Do you have a headache?"* and not "*You have a headache, right?*" or "*You have a headache. Am I correct?*"

Make this point a part of your daily practice.

- **Avoiding multiple questions:**

Do not use multiple elements in one question to save time. For example, have you been experiencing vomiting or diarrhea?

- **Avoiding interruption:**

As mentioned above, you should avoid interrupting when the SP talks. You should bear in mind that the SPs may be particularly verbose in some encounters. This is usually intentional, in order to evaluate your response. Always remember that bad communication may impact your score more than any question or PE that you miss out if you run out of time because of the SP's verbosity!

- **Paraphrasing:**

Paraphrasing means that you repeat the SP's answer(s) to clarify/confirm a good understanding of it. You only need to paraphrase an answer two or three times per encounter to fulfill this item. It is always useful to verify information if you doubt your understanding of one of the answers.

- **Using layman's terms:**

This is another challenging point that can be overcome with practice. Avoid medical terms (e.g. dysuria, past medical history, family history) and use simple words instead (e.g. pain with urination, your health in the past, questions about your family). If using a medical term is unavoidable (e.g. a diagnosis or a diagnostic approach), you should explain it immediately after using it. Always provide your explanation before the SP asks you for it by saying, "*what does that mean?*"

- **Transitional phrases:**

You should not ask questions randomly. Instead, you should use certain phrases when you want to move to another section of your history taking. Examples of transition phrases are:

- When you complete your analysis of the complaint and begin the review of systems (ROS): "*Mr. X, I would like to ask you some questions about your health in general. Is that okay?"*
- When you finish the ROS and you want to ask the SP about their past medical history: "*Mr. X, I would like to ask you some questions about your health in the past. Is that okay?"*
- When you want to ask about family history: "*Mr. X, I would like to ask you some questions about the health of your family. Is that okay?"*
- When you want to ask about social and sexual history: "*Mr. X, I would like to ask you some questions about your social/sexual life. **Your response to these questions is confidential**. Is that okay?"*

- **Explanation of physical examination:**

Because you may be running late by the time you start the PE, you may forget to fulfill this item. This is unacceptable because if you miss explaining your PE steps, the SP gets a bad impression about your attitude and respect for the patient.

- Before doing the PE, you should ask for permission to start.

- Do NOT touch the SP without explaining what you are going to do. Do not catch his/her hand/leg while you are still getting permission. Do not worry about having to give the SP much information. However, you need to explain your examination in layman's terms: "*Can I listen to your heart? Can I press on your belly? Tell me if you feel any discomfort*".

- It is intuitive that any special test should be explained adequately. Do not perform a test (especially if it is painful or awkward) without adequately explaining it, e.g. otoscopy, ophthalmoscopy.

□ **Appropriate reassurance:**

You should respond to the SP's concerns professionally. Your answers should be reasonable. Reassurance is required as long as it is appropriate. However, never falsely reassure the SP. For example, if a serious disease is a possibility, you should not deny this or promise full recovery. On the other hand, do not give horrifying answers. In general, be conservative because you cannot confirm a diagnosis without ordering further work-up. Your answer should not be definite and you should tell the SP that you still need to run some tests to reach the final diagnosis.

□ **Summarization of history:**

At the end of the data gathering, you should briefly review the SP's medical history with them before proceeding to the PE. You do not have to waste much time on this item; you should only review the most significant positive (and sometimes negative) information quickly. This also helps you to correct any information that you previously misunderstood. If the SP finds what you summarize acceptable, you can ask him/her if he/she has any other (important) information to add. After that, you can ask for permission to start the PE. Alternatively, you may review their history after you finish your PE. However, I advise that you review the data with the SP before the PE so you give more time for "closure" after you finish your PE. Furthermore, any misinterpretations of the SP's medical history are better corrected before you start examining them.

- **Conveying diagnostic impressions:**

  This is the first topic you should cover in your "closure". After you complete your PE, you should convey your impressions to the SP:

  - Do not give a single diagnosis. Instead, mention possibilities.
  - Begin with the most likely diagnosis.
  - Express your impressions using layman's terms. It is okay not to explain a disease if it is commonly known to the general population. However, always explain the meaning/definition of your diagnosis when needed.
  - Do not let the SP ask you for explanations whenever possible. Be proactive. Present your explanations immediately. However, it is okay if the SP asks for explanations. Do not get frustrated!
  - In case you are not sure of your differential diagnoses, discuss the most common differential diagnoses in general terms. You may use general words like "*inflammation of your stomach, your liver or the gall bladder, which is close to the liver*".

- **Discussing diagnostic tests:**

  This should be your second topic of "closure". Once you explain your diagnosis to the SP, you should explain how you are going to verify your diagnosis:

  - Explain the diagnostic tests that you are going to order. These tests should correspond to the clinical scenario; do not mention tests that are irrelevant to this particular case.
  - You should not forget to discuss and explain any inconvenient or invasive procedures that you may order. For example: rectal, pelvic or breast examinations, or endoscopies. You should explain the test in layman's terms. For example: *"we need to do an upper endoscopy. This is a tiny camera in a tube that is inserted through your mouth to see the inside of your stomach"*. You should be ready to explain terms like MRI and pelvic ultrasound in layman's terms.

- You should address the SP's fears of inconvenient procedures. You should offer appropriate reassurances (e.g. the use of sedation/numbing medications with endoscopic procedures) in these situations.

- If you are not certain what the diagnosis/diagnoses of this encounter is/are, discuss the most common causes and their work-up. Blood tests, urine tests, ultrasounds and CT scans are always easy to recall in vague encounters.

- It is important to know that "closure" is not a good time to show your deep clinical knowledge. The more you talk, the more you will mention complex medical facts and medical terms that you should explain or you will be asked to explain. Be wise and conservative and do not try to impress the SP with your medical knowledge. Again, practicing will help you to adjust to this habit.

Addressing questions and concerns:

- After conveying your impressions and explaining further diagnostic work-up, you should always ask the SP if he/she has any further questions or concerns.

- At this time, the SP may ask you one or more challenging questions. Again, think and answer professionally. Provide reasonable reassurances and offer help when appropriate.

- The management of challenging questions will be discussed later in this book.

Patient education:

You should offer advice and health education whenever it is prudent to do so. Examples of patient education and recommendations include:

- Information about the hazards of smoking/alcoholism and recreational drugs. You should then advise the SP to quit. You should inform the SP that your hospital offers programs to help them with quitting and you should offer to give the SP a pamphlet of this program if he/she accepts the concept ("*Are*

you interested in quitting smoking? YES = we have a wonderful program in the hospital that will help you to quit smoking. I will give you their contact information after we finish if you are interested”).

You may counsel the SP about his/her social habits during history taking or at the end of the encounter. It is generally wise to reduce the items you need to cover at “closure”, particularly in long encounters.

- Cessation of medications that may precipitate his/her problem, like beta blockers with erectile dysfunction and OCCPs with deep vein thrombosis.

- Health education examples include recommendations for prenatal care for pregnant women, diet and exercise for diabetic patients, and foot care for diabetic patients (risk of diabetic foot).

III Integrated Clinical Encounter (ICE) score

This part evaluates your skills in data gathering, PE and note writing.

- **Data gathering:**

After you leave the encounter, the SP completes a checklist that has all the questions you should have asked. Any irrelevant questions will not be considered. Your goal is to meet these expectations within the limited time of the encounter. This is why you should always modify your sequence of questions based on the story of the SP. Irrelevant questions will not affect your score but they do waste your time!

A similar checklist is filled out to cover elements of the PE. This checklist differs according to the clinical presentation of the SP. Any irrelevant steps you take do not impact your score but they will waste your time. The PE is the most likely part you will make sacrifices in if you run out of time after taking too long in the history taking. Therefore, if you think you do not have enough time, examine the region of interest first (e.g. chest examination if the primary complaint is a cough, legs if the primary complaint is knee pain). You may also do a quick general examination first. A

detailed PE should never be a reason to miss “closure” because “closure” includes 4-5 points of your CIS checklist. Accordingly, if you have to do one thing imperfectly because of time, it should be the PE, not the “closure”. If you cannot do all the elements of the PE, do not miss the most relevant part(s) of the PE. Remember that a quick examination may be acceptable but a careless examination is not; do not mistreat the SP or poorly drape him/her. Avoid any possible injuries to the SP by any means while conducting an otoscopy or ophthalmoscopy.

- **Data interpretation:**

Your ability to summarize your findings and expect a differential diagnosis is the only part that is not evaluated by the SP. This means that the SP’s impressions are the biggest part of your success or failure. Writing patient notes will be discussed separately. However, the following points are important to know:

- A good blue sheet helps a lot. The definition of “good” means that you do not write so many abbreviated words that you cannot understand them later. You need to write as few words as you can that are enough for you to remember positive findings. Use the sign “X” to indicate a “negative” answer.

- When you write the SP’s history of present illness (HPI), it is ideal to start with their personal information, the complaint and an analysis of this complaint. Then, you should write down relevant positive information about “other symptoms”. This should be followed by all important negatives that help to exclude relevant differential diagnoses (e.g. if the complaint is chest pain and the SP denies an associated cough, this is relevant!). So, before writing your note, conduct your differential diagnosis of this complaint in general. Your understanding of differential diagnoses of each complaint will help you to perform professionally in the encounter and to list the relevant positives and negatives. Your HPI should cover all the symptoms of all relevant differential diagnoses either by reporting that they are present or that they are absent.

- When you write about the PE, you should know how to report a PE of each system in detail. If the system you describe is not the system related to the complaint, you may just write briefly

about your PE. However, if it is the primary system related to the complaint, you have to mention both positive and negative findings. For example, only comment on breath sounds under chest examination if the complaint is not primarily respiratory/ cardiac. However, if the SP has chest complaints, you have to do and write a full PE of the chest and the heart including all positives and negatives.

- When you write your possible differential diagnoses, try to avoid extremely unlikely diagnoses unless you have a strong reason to consider them. In general, you have to write down 3 differential diagnoses. But you may write only 2 if there are no more relevant differential diagnoses.

- Always consider the order of your diagnoses. Your first diagnosis should be the most relevant to the case followed by the second and then the third.

- You should practice completing your notes in around 8 minutes, because in the actual exam, you may take some time to think of your differential diagnoses. The good news is if you finish your encounter in less than 15 minutes, the time you save is added to your note writing time. However, you should work on your writing time when you practice because a long encounter means a long note to write as well.

SECTION II:

MANAGEMENT OF THE ENCOUNTER

In this section, we are going to illustrate how an encounter is managed. Some encounters may vary according to the primary complaint. However, these are the basic principles that you need to follow when you practice so you become confident in the real exam.

I At the door

- **Standing in front of the door:**

  Once the exam begins, you will be asked to stand in front of the door that corresponds to the number assigned to you. You are not allowed to slide the door note's cover off until you hear the announcement. You will be given 12 sheets of paper at the beginning of the exam, 2 pens that you should keep in your coat pocket and a stethoscope. Always remember to keep the stethoscope around your neck at all times so you do not forget to take it with you inside the encounter. Sometimes, you may forget to take your stethoscope with you if you leave it at your desk when you are writing patient notes. PLEASE DO NOT DO THAT BECAUSE YOU CANNOT GO BACK TO YOUR DESK AFTER YOU STEP INTO THE ENCOUNTER. You are advised to bring your own stethoscope because the number of stethoscopes may be limited. You are not allowed to write anything on the blue sheet until you hear the announcement to start.

- **The door note:**

  Once you hear the announcement, slide the cover off. You will find a door note that contains the SP's last name, age, complaint and vital signs.

Unlike AMGs, IMGs do not enter the room immediately. Instead, you may spend 30-60 seconds to prepare before you step in. Efficient practice and calmness can help you to minimize this preparation period. Do not panic because you have these few seconds before you start. These few seconds help you to calm down, concentrate, organize your thoughts, and write mnemonics that will guide you to manage an encounter efficiently. This will eventually save you time and make you look more confident and efficient.

There are many ways to prepare your blue sheet. I will suggest one of them here but you may modify it according to your preference. You should know that the blue sheet is not a particularly large space and that it already has some printed sentences that shrink your available space even more (so expect that and practice accordingly!).

Once you are allowed to write on your blue sheet (after the announcement), you may divide your sheet into 4 parts plus a header:

- Use the header to write the SP's last name (NEVER FORGET THIS) and age on the left side. On the right side of the header, you may write any abnormal vital signs (or "WNL", which means "within normal limits" to remind yourself that you reviewed the vital signs and they were all normal). You may also write down which systems you are likely going to examine for this complaint so you can keep them in front of you. If you forget to look up vital signs, you can still review them on your computer after you finish the encounter. However, it is better to identify any abnormal vital signs before you step in because this may change your expectation of the possible diagnosis.

- In the first quarter of your sheet, you may write HPI as a title (analysis of the complaint). The questions per complaint may vary and you may need to remove or add some questions. However, the following mnemonic is suitable for most complaints (write down these letters, each on a separate line):

  O = Onset

  P = Progress

C = Consistency

F = Frequency

D = Duration

A = Alleviating factors

A = Aggravating factors

A = Associated factors

In pain cases, you should add 4 essential questions:

S = Site

S = Severity

Q = Quality

R = Radiation

- In the second quarter, you may write a mnemonic, draw a figure, or simply write down differential diagnoses so you remember which questions you need to ask to cover your differential diagnosis.

- In the third quarter, you may just write (ROS). Do not write anything in this quarter when you interview the SP unless positive information is provided. This is because, in the patient notes, you report ROS as negative if you do not receive any "yes" responses from the SP. You do not have to recall ROS questions; simply ask them briefly and systematically going from the top downwards (head to toe). Practice helps you to recall these questions effortlessly.

- In the fourth quarter, you need to write a mnemonic for the rest of the questions:

  P = Past history

  A = Allergies

M = Medications

H = Hospitalizations (prior hospitalizations)

S = Sleep issues

F = Family history

O = Occupation and OBGYN history

S = Social history

S = Sexual history

A = Appetite

W = Weight change (recent)

E = Exercise and diet

T = Travel history

- **Starting the encounter:**

  Once you finish preparing your sheet, knock on the door. The SP will invite you to come in. You can open the door now. Always remember, a smiling face should be your default facial expression unless empathy is indicated. A smile should be your first presentation. After you open the door, check the SP's identity, e.g. "*Mr. X?*" If the answer is "yes", you can enter the room and start the encounter.

II Inside the encounter

- **Introduce yourself:**

  Start the encounter by introducing yourself.

  For example: "*Hello, I am Dr. X, the physician in the office today, nice to meet you.*"

  Then shake hands.

"I am here to ask you some questions about your health and do a physical examination. Is that okay?"

Keep smiling. Then ask:

"Do you feel comfortable in the room?"

You will be answered with "*Yes*". Sometimes, you might offer to dim the room's lights in cases where the patient has a headache or similar. You should try to make your patient as comfortable as possible.

Then you are ready to discuss his/her complaint:

'So Mr./Mrs. X. How can I help you today?'

Choose your own way to express these 4 sentences, but in the end, you should keep them the same every time you practice to train your brain to use them smoothly. Do not use questions like "*how are you?" or "are you fine?"*

- **Address complaints:**

Once you have listened to the SP's complaint, express empathy if needed by your facial expression and by sentences like *"I am sorry to hear about what you are experiencing"* and show support, saying *"I will do my best to help you with this."*

- **Ask an open-ended question:**

After showing empathy and support, ask your first open-ended question: "*Can you tell me more about that?"*

In some encounters, the SP will respond with much information that may answer some of your questions before you ask them. Follow the SP and do not interrupt them. If you feel that you did not catch all the information, you may review it once again by asking routine HPI questions. Otherwise, do not ask them if the SP has already given you the answer in advance.

- Ask first and second quarter questions:

Next, start asking questions to analyze his/her complaint:

O = Onset: When did this pain start? Do you recall any particular events that may have precipitated this complaint?

P = Progress: Is it getting better or worse?

C = Consistency: Is it continuous or does it come and go? (Ask questions F & D if it comes and goes).

F = Frequency: How many times has this complaint occurred/how frequent is this complaint?

D = Duration: How long does it last each time?

A = Alleviating factors: Is there anything that alleviates this complaint?

A = Aggravating factors: Is there anything that aggravates this complaint?

A = Associated factors: Did you notice any other symptoms?

In pain cases, you should add 4 essential questions:

S = Site: Please, can you point to where you feel this pain?

S = Severity: On a scale from 1 - 10, 10 being the worst, how bad is your pain?

Q = Quality: How does it feel (e.g. sharp, aching, crampy)?

R = Radiation: Does this pain travel elsewhere?

Then, ask specific questions that cover each differential diagnosis (see below). Do not forget to paraphrase intermittently.

For pediatric cases, ask if the SP is the legal guardian of the child or not.

- **Begin the third quarter questions:**

Remember, sheet quarters help you not to forget transitional phrases. When you transition from one quarter to another, explain

this to the SP. Begin the third quarter by saying: *"I want to ask you some questions about your health in general, is that okay?"*

Unless you feel confused about the case, you may only ask 1 or 2 questions per system to cover it. Frequent irrelevant questions do not improve your score and do waste your time. However, be sure to cover all systems. Sometimes, you may be surprised by extremely important data that you forget to ask about when you cover the ROS!

The systems you need to cover are:

- **General:** fever, tiredness
- **Cranial:** weakness, numbness, dizziness, headache, blurring
- **Chest:** pain, cough
- **Heart:** heart palpitations, shortness of breath (SOB)
- **GIT:** change in bowel habits, blood in stool, abdominal pain
- **Urinary:** changes in urination, blood in urine, change in the color of urine
- **Musculoskeletal:** joint pain
- **Dermatological:** skin and hair changes

- **Begin the fourth quarter questions:**

To cover your fourth quarter questions, follow your mnemonic. Start this part with a transitional sentence like *'I want to ask you some questions about your health in the past. Is that okay?'* You need to transition from family to social and then sexual history using similar sentences.

P = Past history, which includes: (1) past similar complaints (did you experience this problem before?); (2) past medical history (do you have any chronic medical issues?); and (3) past surgical history (have you had surgery before?)

A = Allergy: do you have any allergies?

M = Medications: are you currently on any medications? (you may ask why if necessary)

H = Hospitalizations: have you been hospitalized before?

S = Sleep: do you have any problems with sleeping?

F = Family: can I ask you some questions about your family? Are your parents alive and well? Do they have any health issues? Are there any serious health issues in the family?

O = Occupation: what do you do for a living? **+ O =** OBGYN history (see below)

S = Social history (ask permission to ask social questions, and confirm that the information will remain confidential):

Do you smoke? Drink alcohol? Use recreational drugs? How much?

> If the SP reports that he/she drinks alcohol, ask about the frequency. Occasional drinking, particularly of beer (e.g. 1 or 2 glasses at the weekend), does not indicate a need for further questioning or counseling. However, heavier drinking (e.g. on a daily basis) warrants you asking the CAGE questions:
>
> C = do you feel you want to cut your drinking? A = do you feel annoyed by others' comments? G = do you feel guilty about that? E = do you use alcohol as an eye opener? Accordingly, you may counsel alcohol cessation.
>
> You may counsel the SP on smoking/alcohol/recreational drugs cessation immediately (explain the hazards of this habit, ask the SP if he/she wants to quit, explain to the SP that your hospital offers a good program to help cessation and that you can help him/her to contact this program if they are interested).