Preparing for the SUNY Downstate Clinical Skills Assessment

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Purpose of the SUNY Downstate Assessment

The primary purpose of the exercise is to assess your **clinical skills** of history-taking, physical examination & communication. This is a Downstate summative exam of these skills.

The secondary purpose is to prepare for USMLE Step 2 CS Examination
Clinical Reasoning

• Clinical reasoning is a key to success on this assessment.
• Creating a list of differential diagnoses based on the history, hypothesis testing with physical exam.
• Goal is not to reach one single diagnosis.
Downstate’s Clinical Skills Assessment Logistics

- 8 patient encounters
- Each patient encounter - 15 minutes
- Patient note - 10 minutes
- Warning announced when 5 minutes left
- You may leave room early, but once you leave you may not go back in.
Preparation for Step 2 CS Exam

- The format and timing of the Downstate Assessment is very similar to that of Step 2 CS Exam.
- Gain familiarity with the challenging pace and time limits common to both exams.
- As Step 2 CS changes formats, we change the exam accordingly.
Case Content Selection

• Cases are designed to cover a wide variety of organ systems and ages of patients.
• Some cases require a physical examination and others require only a history or counseling.
Description of Ruth L. Gottesman
Clinical Skills Center - AECOM

• Resembles a large clinic with 23 examination rooms
• Each room has exam table, stool, wall-mounted oto-ophthalmoscope, sink, paper towel dispenser, sphygmomanometer, reflex hammer, tuning fork, disposable items, clocks
• Outside each room on the door, the is a folder containing basic introductory information about the patient including the patient’s name, age, chief complaint, and vital signs.
• There is another copy of the information sheet in each room.
Other Important Information

• For each encounter, there will be an announcement 5 minutes before the end
• Once you leave the room, you cannot go back – DON’T LEAVE EARLY!
• No breast, pelvic, rectal, male GU, or corneal reflex examination performed on the SPs
  – If these examinations are necessary, include them in the proposed management section in the write-up
Focused History = Good HPI
History of Present Illness

• Begin at the beginning - "Can you tell me more"
• Has this ever happened before?
• Develop a timeline of change
• Explore the chief complaint & the organ system to which it relates
• Include past treatments and their effects/outcomes
• Question the basis of any past diagnoses
• Include present medications - Ask about all pills they are taking – some may not be considered medications if not prescribed by a physician (e.g., Motrin in the Bennet cases)
• Define/quantify in “lay” terms (e.g. SOB, CP, diarrhea)
• Pertinent positives and negatives from PMH, FH, SH
Patient Centered then Doctor Centered

• Let the patient tell his/her story - use facilitation techniques ("uh huh", "tell me more", etc).
• Summarize & ask for clarifications if necessary
• Generate hypotheses
• Then closed ended questions – obtain pertinent positives/negatives to test hypotheses
Focused Physical Examination

• No need to examine a body part just because it’s there. Let the differential diagnosis guide the physical exam
• No rectal, breast, pelvic or GU exams
• Establish diagnosis
• Assess severity of illness
  – e.g., vital signs in case of pneumonia
• Look for complications or related findings
  – e.g., head trauma in an elderly patient with a fall and hip fracture
Do what you normally do!
Listen to your patient...he/she will tell you what the next question is!
Time Management

- Reading information on outside of door
  - 10-15 seconds
- History
  - 8 minutes
- Physical examination
  - 5 minutes
- Closing and counseling
  - 2 minutes
- Post-encounter note
  - 10 minutes
Getting Started

• Knock on the door before entering the room

• Proper introduction sets the tone for the encounter

• Greet patient by name (Mr./Ms. as defaults)

• Identify your role

• Inquire about comfort of the patient

• Use proper draping technique of patient
Getting Started (continued)

• Make comfortable eye contact

• Eye level generally at same level or below that of the patient (dependent upon position of patient)

• Shake hands firmly (assuming that the patient does not have pain in the right hand/arm)

• Smile

• Make patient comfortable
Beginning the Narrative

- Start with open-ended questions
- Direct questions to patient’s chief complaint
- Use open-ended questions when possible
- Always ask for clarification of terms
  - Clarify “somewhat,” “rarely,” “sometimes,” “often”
- Use lay language
- Ask one question at a time
- Provide patient with appropriate time to think and answer question
- Use transitional statements when necessary
  - Avoid the use of “like to,” “have to,” or “want to”
Empathy Counts!

Look and listen for opportunities to show it!
Empathy

In the Bennet case:

• Expresses concern about taking care of the tavern if he/she is ill
  – *perfect spot for empathy*

• Afraid to die
  – *good opportunity for empathy*
The Closing

- Summarize the patient’s condition
- Ask if they have any questions
- Explain what you think might be going on
- Address what they might be worried about
- Do not give false reassurances
- End with statement such as, “Is there anything else that you would like to ask me?”
Improved Interviewing

• Listen more
• Talk less
• Interrupt infrequently
Interpersonal Skills

• Skills in interviewing and collecting information
• Skills in counseling and delivering information
• Rapport (connection between doctor and patient)
• Personal manner and non-verbal communication
Patient Note

• History *(pertinent positives/negatives)*
• Physical Examination *(pertinent positives/negatives)*
• Differential Diagnosis
  • *List the 3 most likely diagnoses in order of likelihood*
  • *Need to support each with evidence from the history and the physical exam.*
  • *Remember that relevant epidemiologic information are pertinent to probability of a diagnosis and go in supporting evidence section (e.g., person with possible MI - high cholesterol increased likelihood of MI; age 24 decreases chance of MI)*
  • *Be careful if the diagnosis seems obvious!*
• Diagnostic Work-Up- In no particular order
  • *Blood tests (ONLY single tests), radiographic studies, etc.*
  • *Cannot include:* treat, hospitalize, call a consult, or make a referral
USMLE Step 2 CS Exam
Step 2 CS
On Your Exam Day

- Dress conservatively; use little perfume or aftershave
- Use deodorant (scented/unscented)
- Arrive early about 30 minutes before the scheduled time
- Bring your Scheduling Permit and an unexpired government issued ID (e.g., passport or driver’s license) – *make sure name is the same on all documents!* The only acceptable differences are the presence of a middle name, middle initial or suffix on one document and its absence on the other.
USMLE Step 2 CS

- Bring a clean white laboratory coat and wear professional clothing
- Bring your stethoscope
- No electronic devices are allowed. These include cell phones, pagers, PDAs, or two-way communication devices. All watches of any type
- Once the orientation has begun, you may not leave the test area until the examination is over.
- A small storage cubical in a locked area and a coat rack are available. Luggage may not be stored at the center.
For the Step 2-CS Exam...

- Introduce yourself as a medical student

But

- Think like a PGY1
Step 2-CS
At The Center

- 5 cases
  - 30 minute LUNCH/DINNER break
- 3 cases
  - 15 minute SNACK break
- 3-4 cases
Step 2-CS Exam Scoring

- After each encounter, the standardized patient (SP) completes checklists/rating scales which document your skills in the physical examination and your interpersonal/communication skills.

- In addition, the SP uses rating scales to assess your English speaking skills.

- The patient note is read by a physician who evaluates the quality of the documentation including the differential diagnosis, defense of each diagnosis, and management plans.
Step 2-CS Score Reporting

- **Integrated Clinical Encounter (ICE)** includes the physical examination checklist and the patient note - *(Data Gathering & Data Sharing)*

- **Communication/Interpersonal Skills (CIS)** includes the communication checklist

- **Spoken English Proficiency (SEP)** includes the spoken English rating scale

You must pass all three of the above in a single test administration in order to receive a passing score on the examination.
Step 2-CS
Score Reporting

- For Examinees who test March 23, 2014 through May 17, 2014
  - the reporting period is June 18, 2014 – July 16, 2014

- For Examinees who test May 18, 2014 through July 12, 2014
  - the reporting period is August 13, 2014 – September 10, 2014

- For Examinees who test July 13, 2014 through September 6, 2014
  - the reporting period is October 8, 2014 – November 5, 2014

- For Examinees who test September 7, 2014 through November 1, 2014
  - the reporting period is December 3, 2014 – December 31, 2014

- For Examinees who test November 2, 2014 through December 31, 2014
  - the reporting period is February 4, 2015 – February 25, 2015
The CIS subcomponent of Step 2-CS assesses a range of competencies. It divides communication skills into a series of functions. These functions have been further divided into sub-functions. The Communication and Interpersonal Skills (CIS) scale focuses on five functions:

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

• Summary
  • (Function #1)
• Questions
  • (Function #3)
• Reassurance
  • (Function #5a)
• What Happens Next?
  • (Functions #3, 4a)
Patient Note

- Examinees are asked to document relevant history and physical examination findings and to list initial diagnostic studies to be ordered.

- Examinees are asked to create a reasoned, focused differential (maximum of three diagnoses) listed in order of likelihood and to indicate the evidence obtained from the history and physical examination that supports (or refutes) each potential diagnosis.

- The Patient Note provides examinees with an opportunity to document their analysis of a patient's possible diagnoses.
**CLINICAL SKILLS EVALUATION**

**PATIENT NOTE**

**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:** 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. 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 each listed diagnosis (e.g. restricted physical exam maneuvers, laboratory tests, imaging, ECG, etc.).

**DIAGNOSIS #1:**

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<tr>
<th>HISTORY FINDING(s)</th>
<th>PHYSICAL EXAM FINDING(s)</th>
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**DIAGNOSIS #2:**

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<th>PHYSICAL EXAM FINDING(s)</th>
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**DIAGNOSIS #3:**

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**DIAGNOSTIC STUDIES**

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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 “vibratory and fine-touch sensation intact,” is preferable to stating that the neurologic exam is “normal”

- 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:

• Using inexact, nonmedical terminology, such as heart burn
• Listing improbable diagnoses with no supporting evidence
• Listing an appropriate diagnosis without listing supporting evidence
• Listing diagnoses without regard to the order of likelihood
• Using symptoms or signs as diagnoses, such as “angina,” “syncope,” “anemia,”
Top 10 – “Do’s” to Remember

- *Listen* to your patient
- *Speak* less; *interrupt* infrequently
- *Speak only* in English
- *Wash* your hands
- *Examine directly* on the skin
- *Perform only* focused exams
- *Summarize* your findings
- *Provide* proper closure
- *Leave the room promptly* after time is called
- *Include all* data to support your diagnoses
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