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Step 2 Clinical Skills (CS)

Content Description and General Information

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INTRODUCTION

The United States Medical Licensing Examination (USMLE), through its three Steps (Step 1, Step 2, and Step 3), assesses a physician's ability to apply knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills that are important in health and disease and that constitute the basis of safe and effective patient care.

Results of the USMLE are reported to medical licensing authorities in the United States and its territories for use in granting the initial license to practice medicine. The USMLE is sponsored by the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME).

Step 2 of the USMLE assesses the ability of examinees to apply medical knowledge, skills, and understanding of clinical science essential for the provision of patient care under supervision, and includes emphasis on health promotion and disease prevention. Step 2 ensures that due attention is devoted to the principles of clinical sciences and basic patient-centered skills that provide the foundation for the safe and effective practice of medicine.

There are two components of Step 2, Clinical Knowledge (CK) and Clinical Skills (CS). Step 2 CK uses the multiple-choice examination format to test clinical knowledge. Step 2 CS uses standardized patients to test medical students and graduates on their ability to gather information from patients, perform physical examinations, and communicate their findings to patients and colleagues.

This document is intended to help examinees prepare for the Step 2 CS component of the USMLE. Persons preparing to take the Step 2 CS examination should also view the video available at the USMLE website (www.usmle.org).

Information on eligibility, registration, and scheduling is available in the USMLE *Bulletin of Information*, which is posted on the USMLE website. Students and graduates of international medical schools must also consult the ECFMG *Information Booklet* and the ECFMG website (www.ecfmg.org).

The information in this document, as well as other materials, is available at the USMLE website and also via CD from your registration entity. Changes in the USMLE program may occur after the release of this document. **If changes occur, information will be posted on the USMLE website. You must obtain the most recent information to ensure an accurate understanding of current USMLE policy.**

STEP 2 CS CASE DEVELOPMENT

Standardized Patient–Based Examinations

The patients you will see are people trained to portray a clinical problem. This method of assessment is referred to as a standardized patient examination. Most medical school programs in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME) use standardized patients for instruction; many of these institutions use standardized patients for evaluation as well.

Standardized patients have been used since 1998 in the ECFMG Certification process, and have also been incorporated into the Medical Council of Canada's medical licensure examination for Canadian and international medical graduates. The standardized patient–based testing method was established more than 35 years ago, and its procedures have been tested and validated in the United States and internationally.

Examination Blueprint

As part of the test development process, practicing physicians and medical educators develop and review cases to ensure that they are accurate and appropriate. These cases represent the kinds of patients and problems normally encountered during medical practice in the United States. Most cases are specifically designed to elicit a process of history taking and physical examination that demonstrates the examinee's ability to list and pursue various plausible diagnoses.

The cases that make up each administration of the Step 2 CS examination are based upon an examination blueprint. An examination blueprint defines the requirements for each examination, regardless of where and when it is administered. The sample of cases selected for each examination reflects a balance of cases that is fair and equitable across all examinees. On any examination day, the set of cases will differ from the combination presented the day before or the following day, but each set of cases has a comparable degree of difficulty.

The intent is to ensure that examinees encounter a broad spectrum of cases reflecting common and important symptoms and diagnoses. The criteria used to define the blueprint and create individual examinations focus primarily on presenting complaints and conditions.

Presentation categories include, but are not limited to, cardiovascular, constitutional, gastrointestinal, genitourinary, musculoskeletal, neurological, psychiatric, respiratory, and women's health. Examinees will see cases from some, but not all, of these categories. The selection of cases is also guided by specifications relating to acuity, age, gender, and type of physical findings presented in each case.

Your Step 2 CS administration will include twelve patient encounters. These include a very small number of nonscored patient encounters, which are added for pilot testing new cases and other research purposes. Such cases are not counted in determining your score.

When you take the Step 2 CS examination, you will have the same opportunity as all other examinees to demonstrate your clinical skills proficiency. The examination is standardized, so that all examinees receive the same information when they ask standardized patients the same or similar questions. An ongoing mechanism of quality control is employed to ensure that the examination is fair to all. The quality control approach focuses on consistency in portrayal and scoring of the individual cases, and utilizes both observation of live encounters and review of digital recordings.

DESCRIPTION OF THE EXAMINATION

When you arrive at the test center on the day of your examination, bring the Scheduling Permit you received when your registration was completed, your Confirmation Notice, and an unexpired, government-issued form of identification that includes a photograph and signature, such as a current driver's license or passport. Your name as it appears on your Scheduling Permit must match the name on your form(s) of identification exactly. The only acceptable differences are variations in capitalization; the presence of a middle name, middle initial, or suffix on one document and its absence on the other; or the presence of a middle name on one and middle initial on the other.

If you do not bring acceptable identification, you will not be admitted to the test. In that event, you must pay a fee to reschedule your test. Your rescheduled test date(s) must fall within your assigned eligibility period.

The time you should arrive at the test center is listed in the Confirmation Notice you will print after scheduling your appointment.

Please note that, as part of the Step 2 CS registration process, you acknowledge and agree to abide by USMLE policies and procedures, including those related to confidentiality.

Please bring only necessary personal items with you to the center. You may not possess cellular telephones, watches of any type, pagers, personal digital assistants (PDAs), two-way communication devices, or notes or study materials of any kind at any time during the examination, including during breaks. These items must be stored during the examination.

Each test center contains a locked storage area with small open cubicles. Coat racks are also available. Each examinee is assigned one of the cubicles in which all personal items must be stored during the examination. Examinees are not permitted access to the cubicles at any time during the examination, including breaks. Luggage may not be stored in the center. There are no waiting facilities for spouses, family, or friends; plan to meet them elsewhere after the examination.

Wear comfortable, professional clothing and a white laboratory or clinic coat. The proctors will cover with adhesive tape anything on the laboratory coat that identifies either you or your institution.

The only piece of medical equipment you may bring is an unenhanced standard stethoscope, which is subject to inspection by test center staff. All other necessary medical equipment is provided in the examination rooms. Do not bring other medical equipment, such as reflex hammers, pen lights, or tuning forks to the test center. If you forget to bring a laboratory coat or stethoscope, a limited number of coats and stethoscopes are available at each test center. However, it is strongly recommended you bring your own.

As more fully explained in the *Bulletin of Information*, unauthorized possession of personal items while you are in the secure areas of the test center is prohibited, and unauthorized items will be taken away. However, in certain limited circumstances, exceptions to this policy may be made for medical reasons, provided that permission is granted in advance of test administration. If you believe that you have a medical condition that requires you to use medication, an external appliance, or electronic device in the secure areas of the test center, you will need to submit a written request. Information on how to submit a request is available in the USMLE *Bulletin of Information*. Examples of appliances and devices to which this policy applies include non-standard stethoscopes, (eg, electronic or digitally amplified or otherwise enhanced non-standard stethoscopes), insulin pumps, inhalers, syringes, medications (oral, inhaled, injectable), TENS units, breast pumps, hearing aids, wheelchairs, canes, crutches, and casts.

Each examination session begins with an on-site orientation. **If you arrive during the on-site orientation, you may be allowed to test; however, you will be required to sign a Late Admission Form. If you arrive after the on-site orientation, you will not be allowed to test.** You will have to reschedule your testing appointment and will be required to pay the rescheduling fee.

The clinical skills evaluation centers are secured facilities. Once you enter the secured area of the center for orientation, you may not leave that area until the examination is complete.

Throughout the examination day, staff members, wearing identifying name tags, will direct you through the examination. You must follow their instructions at all times.

Examination Length

Your Step 2 CS administration will include twelve patient encounters. The examination session lasts approximately 8 hours, and two breaks are provided. The first break is 30 minutes long; the second break is 15 minutes long. You may use the restrooms before the exam and during breaks. A light meal will be served during the first break. The test center is unable to accommodate special meal requests. However, you may bring your own food, provided that no refrigeration or preparation is required. Smoking is prohibited throughout the center.

Equipment and Examinee Instructions

The testing area of the clinical skills evaluation center consists of examination rooms equipped with standard examination tables, commonly used diagnostic instruments (blood pressure cuffs, otoscopes, and ophthalmoscopes), non-latex gloves, sinks, and paper towels. Examination table heights are approximately 32-33 inches, and are not adjustable. Outside each examination room is a cubicle equipped with a computer, where you can compose the patient note.

There is a one-way observation window in each examination room. These are used for quality assurance, training, and research.

Before the first patient encounter, you will be provided with a clipboard, blank paper for taking notes, and a pen. There will be an announcement at the beginning of each patient encounter. When you hear the announcement you may review the patient information posted on the examination room door (examinee instructions). You may also make notes at this time. DO NOT write on the paper before the announcement that the patient encounter has begun.

The examinee instruction sheet gives you specific instructions and indicates the patient's name, age, gender, and reason for visiting the doctor. It also indicates his or her vital signs, including heart rate, blood pressure, temperature (Celsius and Fahrenheit), and respiratory rate, unless instructions indicate otherwise. You can accept the vital signs on the examinee instruction sheet as accurate, and do not necessarily need to repeat them unless you believe the case specifically requires it. For instance, you may encounter patient problems or conditions that suggest the need to confirm or re-check the recorded vital signs and/or perform specific maneuvers in measuring the vital signs. However, if you do repeat the vital signs, with or without additional maneuvers, you should consider the vital signs that were originally listed as accurate when developing your differential diagnosis and work-up plan.

You may encounter a case in which the examinee instructions include the results of a lab test. In this type of patient encounter the patient is returning for a follow-up appointment after undergoing testing.

The Patient Encounter

When you enter the room, you will usually encounter a standardized patient. By asking this patient relevant questions and performing a focused physical examination, you will be able to gather enough information to develop a preliminary differential diagnosis and a diagnostic work-up plan.

You will be expected to communicate with the standardized patients in a professional and empathetic manner. As you would when encountering real patients, you should answer any questions they may have, tell them what diagnoses you are considering, and advise them on what tests and studies you will order to clarify their diagnoses.

The elements of medical history you need to obtain in each case will be determined by the nature of the patient's problems. Not every part of the history needs to be taken for every patient. Some patients may have acute problems, while others may have more chronic ones.

You will not have time to do a complete physical examination on every patient, nor will it be necessary to do so. Pursue the relevant parts of the examination, based on the patient's problems and other information you obtain during the history taking.

The cases are developed to present in a manner that simulates how patients present in real clinical settings. Therefore, most cases are designed realistically to present more than one diagnostic possibility. Based on the patient's presenting complaint and the additional information you obtain as you begin taking the history, you should consider all possible diagnoses and explore the relevant ones as time permits.

If you are unsuccessful at Step 2 CS and must, therefore, repeat the examination, it is possible that during your repeat examination you will see similarities to cases or patients that you encountered on your prior attempt. **Do not assume** that the underlying problems are the same or that the encounter will unfold in exactly the same way. It is best if you approach each encounter, whether it seems familiar or not, with an open mind, responding appropriately to the information provided, the history gathered, and the results of the physical examination.

Physical Examination

You should perform physical examination maneuvers correctly and expect that there will be positive physical findings in some instances. Some may be simulated, but you should accept them as real and factor them into your evolving differential diagnoses.

You should attend to appropriate hygiene and to patient comfort and modesty, as you would in the care of real patients. Female patients will be wearing bras, which you may ask them to loosen or move if necessary for a proper examination.

With real patients in a normal clinical setting, it is possible to obtain meaningful information during your physical examination without being unnecessarily forceful in palpating, percussing, or carrying out other maneuvers that involve touching. Your approach to examining standardized patients should be no different. Standardized patients are subjected to repeated physical examinations during the Step 2 CS exam; **it is critical that you apply no more than the amount of pressure that is appropriate** during maneuvers such as abdominal examination, examination of the gall bladder and liver, eliciting CVA tenderness, examination of the ears with an otoscope, and examination of the throat with a tongue depressor.

You should interact with the standardized patients as you would with any patients you may see with similar problems. The only exception is that certain parts of the physical examination MUST NOT BE DONE: rectal, pelvic, genitourinary, inguinal hernia, female breast, or corneal reflex examinations. If you believe one or more of these examinations are indicated, you should include them in your proposed diagnostic work-up. All other examination maneuvers are completely acceptable, including femoral pulse exam, inguinal node exam, back exam, and axillary exam.

Another exception is that you should not swab the standardized patient's throat for a throat culture. If you believe that this diagnostic/laboratory test is indicated, include it on your proposed diagnostic workup.

Excluding the restricted physical examination maneuvers, you should assume that you have consent to do a physical examination on all standardized patients, **unless you are explicitly told not to do so** as part of the examinee instructions for that case.

Announcements will tell you when to begin the patient encounter, when there are 5 minutes remaining, and when the patient encounter is over. In some cases you may complete the patient encounter in fewer than 15 minutes. If so, you may leave the examination room early, but you are not permitted to re-enter. **Be certain that you have obtained all necessary information before leaving the examination room.** Re-entering an examination room after leaving will be considered misconduct.

Telephone Patient Encounters

Telephone patient encounters begin like all encounters; you will read a doorway instruction sheet that provides specific information about the patient. As with all patient encounters, as soon as you hear the announcement that the encounter has begun, you may make notes about the case before entering the examination room.

When you enter the room, sit at the desk in front of the telephone.

- Do not dial any numbers.
- Push the speaker button above the yellow dot on the phone to be connected to the patient caregiver or patient.
- You will be permitted to make only one phone call.
- Do not touch any buttons on the phone until you are ready to end the call – touching any buttons may disconnect you.
- To end the call on a phone case, press the speaker button above the yellow dot.
- You will not be allowed to call back after you end the call.

Obviously, physical examination of the patient is not possible for telephone encounters, and will not be required. However, for these cases, as for all others, you will have relevant information and instructions and will be able to take a history and ask questions. As with other cases, you will write a patient note after the encounter. Because no physical examination is possible for telephone cases, leave that section of the patient note blank.

The Patient Note

Immediately after each patient encounter, you will have 10 minutes to complete a patient note. **Note: If you leave the patient encounter early, you may use the additional time for the note.** You will be asked to handwrite or type (on a computer) a patient note similar to the medical record you would compose after seeing a patient in a clinic, office, or emergency department.

You should record pertinent medical history and physical examination findings obtained during the encounter, as well as your initial differential diagnoses. Finally, you will list the diagnostic studies you would order next for that particular patient. If you think a rectal, pelvic, inguinal hernia, genitourinary, female breast, or corneal reflex examination, or a throat swab, would have been indicated in the encounter, list it as part of your diagnostic workup. **Treatment, consultations, or referrals should not be included in your work-up plan.**

Appendix A illustrates a blank patient note page similar to what you will be asked to complete if you write the note by hand. Appendix B illustrates a blank patient note screen similar to what would appear to examinees who choose to type their notes. Appendix C provides sample patient note styles. A program for practicing typing the patient note is available on the USMLE website (www.usmle.org).

Typically you will be able to choose, for each patient encounter, whether to write the patient note by hand or type it on a computer. Occasionally, due to technical or administration problems, the option of typing the patient note may not be available for one or more patient encounters. When this happens, examinees will be required to write their patient notes by hand.

All examinees should be prepared for the possibility that they may have to write one or more patient notes by hand.

Patient notes are rated by physicians who are well trained at reading notes and can interpret most handwriting. However, extreme illegibility will be a problem and can adversely impact a score. Everyone who writes patient notes by hand should make them as legible as possible.

If you have a case for which you think no diagnostic workup is necessary, write "No studies indicated" rather than leaving that section blank.

You will not receive credit for listing examination procedures you WOULD have done or questions you WOULD have asked had the encounter been longer. Write **ONLY** the information you elicited from the patient through either physical examination or history taking.

When you hear the announcement to stop writing, put down your pen **immediately** or click "Submit" on the computer. Continuing to write after the announcement to stop will be considered misconduct. Remain seated until all examinees' patient notes have been collected.

Other Case Formats

The kinds of medical problems that your patients will portray are those you would commonly encounter in a clinic, doctor's office, emergency department, or hospital setting. Although there are no young children presenting as patients, there may be cases in which you encounter—either in the examination room or via the telephone—a parent or caregiver of a child.

In some instances you may be instructed to perform a physical examination that relates to a specific medical condition, life circumstance, or occupation. Synthetic models, mannequins, or simulators provide an appropriate format for assessment of sensitive examination skills such as genital or rectal examination, and may be used for these cases. In such cases, specific instructions regarding the use of these devices will be provided. If you encounter any case for which you decide no physical examination is necessary, leave that section of the patient note blank.

TESTING REGULATIONS AND RULES OF CONDUCT

You cannot discuss the cases with your fellow examinees, during breaks or at any time. Conversation among examinees in languages other than English about any subject is strictly prohibited at all times, including during breaks. Test center staff will be with you to monitor activity. To maintain security and quality assurance, each examination room is equipped with video cameras and microphones to record every patient encounter.

The USMLE program retains the right to remove any examinee from the examination who appears to represent a health or safety risk to the standardized patients or staff of a clinical skills evaluation center. This includes, but is not limited to, examinees who appear ill, are persistently coughing or sneezing, have open skin lesions, or have evidence of active bleeding. Examinees who are not feeling well are encouraged to seek medical advice prior to arrival at the center and, if consistent with medical advice, should consider rescheduling the date of their examination. This can be done at the website of your registration entity.

Clinical skills evaluation center staff monitor all testing administrations for the Step 2 CS examination. You must follow instructions of test center staff throughout the examination. Failure to do so may result in a determination of irregular behavior. The USMLE *Bulletin of Information* provides a complete description of irregular behavior and the consequences of a finding of irregular behavior. You must become familiar with the *Bulletin of Information* before you take your examination.

Irregular behavior includes any action by applicants, examinees, potential applicants, or others when solicited by an applicant and/or examinee that subverts or attempts to subvert the examination process. Specific examples of irregular behavior include, but are not limited to:

- ❑ Seeking and/or obtaining unauthorized access to examination materials;
- ❑ Providing false information or making false statements on application forms or other USMLE-related documents;
- ❑ Taking an examination without being eligible for it or attempting to do so;
- ❑ Impersonating an examinee or engaging someone else to take the examination for you;
- ❑ Giving, receiving, or obtaining unauthorized assistance during the examination or attempting to do so;
- ❑ Making notes of any kind during the examination, except on the blank paper provided to you;
- ❑ Failure to adhere to any USMLE policy, procedure or rule, including instructions of the test center staff;
- ❑ Disruptive or unprofessional behavior at the test center;
- ❑ Interacting with any standardized patient outside of that standardized patient's given case portrayal, before, during, or after the examination;
- ❑ Conversing with other Step 2 CS examinees in any language other than English at any time while at the test center;
- ❑ Possessing unauthorized materials, including notes and study guides, photographic equipment, communication or recording devices, pagers, cellular phones, watches of any type, and personal digital assistants (PDAs) during any part of the testing session, including during breaks;
- ❑ Altering or misrepresenting examination scores;
- ❑ Any unauthorized reproduction by any means, including reconstruction through memorization and/or dissemination of copyrighted examination materials and examination content (this includes the reproduction and dissemination of examination content on the Internet, email, and listservs);
- ❑ Providing or attempting to provide any information, including that relating to examination content, that may give or attempt to give unfair advantage to individuals who may be taking the examination;
- ❑ Engaging in behaviors that could constitute a real or potential threat to a patient's safety, such as careless or dangerous actions during physical examination.

Instances of possible irregular behavior are thoroughly investigated and actions may be taken under the USMLE policies and procedures on irregular behavior. Please refer to the appropriate USMLE *Bulletin of Information* for Rules of Conduct and Irregular Behavior.

SCORING THE STEP 2 CS EXAMINATION

Step 2 CS is designed to evaluate your ability to gather information that is important for a given patient presentation. During your physical examination of the standardized patient, you should attempt to elicit important positive and negative signs. Make sure you discuss with the patient your initial diagnostic impression and work-up plan. The patients may ask questions concerning their complaints. You should address each patient's concern as you would in a normal clinical setting.

The ability to communicate effectively with patients, demonstrating appropriate interpersonal skills, is essential to safe and effective patient care. Step 2 CS is intended to determine whether physicians seeking an initial license to practice medicine in the United States, regardless of country of origin, can communicate effectively with patients. Carefully developed rating scales, as well as intensive training in their use, are used by the standardized patients to assess communication, interpersonal skills, and English-speaking skills.

Your ability to document in the patient note the findings from the patient encounter, diagnostic impression, and initial patient work-up will be rated by physician raters. You will be rated based upon the quality of documentation of important positive and negative findings from the history and physical examination, as well as your listed differential diagnoses and diagnostic assessment plans. As is the case with other aspects of Step 2 CS scoring, physician raters receive intensive training and monitoring to ensure consistency and fairness in rating.

Scoring of the Step 2 Clinical Skills Subcomponents

USMLE Step 2 CS is a pass/fail examination. Examinees are scored in three separate subcomponents: Integrated Clinical Encounter (ICE), Communication and Interpersonal Skills (CIS), and Spoken English Proficiency (SEP). Each of the three subcomponents must be passed in a single administration in order to achieve a passing performance on Step 2 CS.

The ICE subcomponent includes assessment of:

- ♦ Data gathering – patient information collected by history taking and physical examination
- ♦ Documentation – completion of a patient note summarizing the findings of the patient encounter, diagnostic impression, and initial patient work-up

Data gathering is scored by checklists completed by the standardized patients. The checklists are developed by committees of clinicians and medical school clinical faculty and comprise the essential history and physical examination elements for specific clinical encounters. The patient note is scored by trained physician raters. Copies of the patient note template, sample patient note styles, and software to practice typing the note are available on the USMLE website. (See also Appendices A – C.)

The CIS subcomponent includes assessment of:

- ♦ Questioning skills – examples include:
  - • use of
    - - open-ended questions, transitional statements, facilitating remarks
  - • avoidance of
    - - leading or multiple questions, repeat questions unless for clarification, medical terms/jargon unless immediately defined, interruptions when the patient is talking
  - • accurately summarizing information from the patient
- ♦ Information-sharing skills – examples include:
  - • acknowledging patient issues/concerns and clearly responding with information
  - • avoidance of medical terms/jargon unless immediately defined
  - • clearly providing
    - - counseling when appropriate
    - - closure, including statements about what happens next
- ♦ Professional manner and rapport – examples include:
  - • asking about
    - - expectations, feelings, and concerns of the patient

  - support systems and impact of illness, with attempts to explore these areas
- showing
  - consideration for patient comfort during the physical examination
  - attention to cleanliness through hand washing or use of gloves
- providing opportunity for the patient to express feelings/concerns
- encouraging additional questions or discussion
- making
  - empathetic remarks concerning patient issues/concerns
  - patient feel comfortable and respected during the encounter

CIS performance is assessed by the standardized patients, who provide a global rating of these skills using a series of generic rating scales. The domains included in these scales are, in part, based upon the scales used in the former Clinical Skills Assessment (CSA) of the Educational Commission for Foreign Medical Graduates, with enhancements based upon national consensus statements on essential communication skills and upon review of other commonly used rating forms.

The SEP subcomponent includes assessment of:

♦ Clarity of spoken English communication within the context of the doctor-patient encounter (eg, pronunciation, word choice, and minimizing the need to repeat questions or statements)

SEP performance is assessed by the standardized patients using rating scales and is based upon the frequency of pronunciation or word choice errors that affect comprehension, and the amount of listener effort required to understand the examinee's questions and responses.

Step 2 CS Score Report Schedule

Step 2 CS examinees are grouped into testing periods according to the dates on which they test. The first results for a given testing period will be issued on the first day of the corresponding reporting period, and it is expected that results for the vast majority of examinees who take the exam during the testing period will be reported on this date. However, it is important to note that there will likely be a small number of examinees for whom scoring and quality assurance are not completed by the first day of the reporting period; these will typically be examinees who took the exam in the latter part of the testing period. Results for these examinees will be reported each week throughout the reporting period, and should be reported no later than the last day of the score reporting period.

This schedule allows USMLE staff to enhance the quality assurance and data collection/scoring procedures performed prior to score reporting. Additionally, it provides examinees, as well as others who rely on Step 2 CS results, with guidelines regarding when a result will be reported for a given exam date. These guidelines allow examinees to plan their exam registration and scheduling in order to have their results in time to meet specific deadlines, such as those related to graduation or participation in the National Resident Matching Program (NRMP), or "the Match." Information about testing periods and corresponding reporting periods is available at http://www.usmle.org/Examinations/step2/step2cs_reporting.html.

TERMS USED IN THE STEP 2 CS EXAMINATION

Lists similar to the one below will be available on-site for reference during Step 2 CS administrations.

UNITS OF MEASURE

kg	kilogram
g	gram
mcg	microgram
mg	milligram
lbs	pounds
oz	ounces
m	meter
cm	centimeter
min	minute
hr	hour
C	Celsius
F	Fahrenheit

VITAL SIGNS

BP	blood pressure
HR	heart rate
R	respirations
T	temperature

COMMON ABBREVIATIONS FOR THE PATIENT NOTE

Note: This is not intended to be a complete list of acceptable abbreviations, but rather represents the types of common abbreviations that may be used on the patient note. There is no need to use abbreviations on the patient note; if you are in doubt about the correct abbreviation, write it out.

Abbreviation	Meaning
yo	year-old
m	male
f	female
b	black
w	white
L	left
R	right
hx	history
h/o	history of
c/o	complaining of
∅	without or no
+	positive
-	negative

Abbreviation	Meaning
Abd	abdomen
AIDS	acquired immune deficiency syndrome
AP	anteroposterior
BUN	blood urea nitrogen
CABG	coronary artery bypass grafting
CBC	complete blood count
CCU	cardiac care unit
CHF	congestive heart failure
cig	cigarettes
COPD	chronic obstructive pulmonary disease
CPR	cardiopulmonary resuscitation
CT	computed tomography
CVA	cerebrovascular accident
CVP	central venous pressure
CXR	chest x-ray
DM	diabetes mellitus
DTR	deep tendon reflexes
ECG	electrocardiogram
ED	emergency department
EMT	emergency medical technician
ENT	ears, nose, and throat
EOM	extraocular muscles
ETOH	alcohol
Ext	extremities
FH	family history
GI	gastrointestinal
GU	genitourinary
HEENT	head, eyes, ears, nose, and throat
HIV	human immunodeficiency virus
HTN	hypertension
IM	intramuscularly
IV	intravenously
JVD	jugular venous distention
KUB	kidney, ureter, and bladder
LMP	last menstrual period
LP	lumbar puncture
MI	myocardial infarction
MRI	magnetic resonance imaging
MVA	motor vehicle accident
Neuro	neurologic
NIDDM	non-insulin-dependent diabetes mellitus
NKA	no known allergies
NKDA	no known drug allergy
NL	normal/normal limits
NSR	normal sinus rhythm
P	pulse/heart rate
PA	posteroanterior
PERLA	pupils equal, react to light and accommodation
po	orally
PT	prothrombin time
PTT	partial thromboplastin time
RBC	red blood cells
SH	social history
TIA	transient ischemic attack
U/A	urinalysis
URI	upper respiratory tract infection
WBC	white blood cells
WNL	within normal limits

APPENDIX A
Patient Note

If you write the patient note by hand, you will fill out a form similar to this after each patient encounter.

HISTORY: Include significant positives and negatives from history of present illness, past medical history, review of system(s), social history, and family history.

PHYSICAL EXAMINATION: Indicate only pertinent positive and negative findings related to the patient's chief complaint.

DIFFERENTIAL DIAGNOSES: **In order of likelihood** (with 1 being the most likely), list up to 5 potential or possible diagnoses for this patient's presentation (in many cases, fewer than 5 diagnoses are likely):

1.
2.
3.
4.
5.

DIAGNOSTIC WORKUP: List immediate plans (up to 5) for further diagnostic workup:

1.
2.
3.
4.
5.

APPENDIX B
Patient Note Screen

If you type the patient note, you will use a program similar to the one pictured below. You can practice using the patient note software by using the program provided on the USMLE Orientation Materials CD and at the USMLE website (www.usmle.org). The patient note screen that appears during the actual examination will have a status bar for each field, indicating how much space remains.

Patient Notes

Room Number: 15

Candidate Name: Doe, John — USMLE ID: 1-234-567-8

Candidate Number: 20

HISTORY – Include significant positives and negatives from history of present illness, past medical history, review of system(s), social history and family history.

PHYSICAL EXAMINATION - Indicate only pertinent positive and negative findings related to the patient's chief complaint.

DIFFERENTIAL DIAGNOSIS - **In order of likelihood** (with 1 being the most likely), list up to 5 potential or possible diagnoses for this patient's presentation (in many cases, fewer than 5 diagnoses are likely):

1
2
3
4
5

DIAGNOSTIC WORKUP - List immediate plans (up to 5) for further diagnostic workup:

1
2
3
4
5

Submit

APPENDIX C
Sample Patient Note Styles

Various styles of writing patient notes for the Step 2 CS examination are acceptable. Two examples of handwritten patient notes are shown on the following pages; these demonstrate some of the acceptable variations in style. These examples are not meant to represent ideal or perfect patient notes, nor should they be assumed to be complete or accurate with respect to content. Both formats and styles, however, would be considered acceptable.

Patient Note Example One

Patient Note Example One is written primarily in a narrative style. The History section is written in complete or nearly complete sentences, and the Physical Examination section also has fairly complete phrases. Note that only four studies are ordered under the Diagnostic Workup section; this is acceptable.

This note uses some abbreviations not included in the list of common abbreviations that is posted at each writing station, but they are common enough to be recognizable by the practicing physicians who rate the notes. The note is written in cursive script, but it is legible.

Patient Note Example Two

Patient Note Example Two is written in a telegraphic or “bullet” style. There are no complete sentences, although there are some complete phrases. In some parts of the History section, in particular, one or two words stand alone. The writer of this note has chosen to transcribe the patient's blood pressure from the examinee instruction sheet. You may wish to include vital signs if they are particularly relevant to the case.

In this note only four items are listed in both the Differential Diagnosis and in the Diagnostic Workup sections; again, this is acceptable. This sample also contains some abbreviations or symbols not included in the list of common abbreviations posted at each writing station, but, as in Example One, they are generally recognizable. This note is printed throughout, although a mixture of cursive script and printing is also acceptable, provided both are legible.

Patient Note Example 1

HISTORY: Include significant positives and negatives from history of present illness, past medical history, review of system(s), social history and family history.

48 year old ♀ c/o chest pain. Began 1.5 hrs. ago, pain is burning in character, no radiation, slight SOB, sl N/and diaphoresis. Pain resolved after 20 mins. ∅ treatment. No pain now. Has had several similar episodes over past 2-3 mos. Usually after a heavy meal or exertion with some relief with antacids. Has Hx of elevated cholesterol but no follow-up or treatment. Play tennis weekly, ex-smoker x 3 yrs. (30 packs/yrs). Denies ↑ unusual stress. Mother c̄ NIDDM & brother with unknown heart problem. No Hx HTN, DM but has not seen MD x 2 yrs.

PHYSICAL EXAMINATION: Indicate only pertinent positive and negative findings related to patient's chief complaint.

No obvious distress, minimizing symptoms, anxious to leave.

BP of 160/80 noted.

Chest - no tenderness, clear BS bilaterally without wheezes, rhonchi or rales.

Heart - apical impulse not displaced, regular rhythm, no (M) or rubs.

Abdomen - nondistended, BS ⊕, no masses or organomegaly, tenderness in epigastrium ∅ rebound.

DIFFERENTIAL DIAGNOSES: In order of likelihood (with 1 being the most likely), list up to 5 potential or possible diagnoses for this patient's presentation (in many cases, fewer than 5 diagnoses are likely).

1. Esophageal reflux disease
2. Peptic ~~ulcer~~ ulcer
3. Coronary artery disease
4. Cholecystitis
5. Musculoskeletal chest pain

DIAGNOSTIC WORK UP: List immediate plans (up to 5) for further diagnostic workup.

1. Stool for OB
2. EKG
3. CXR
4. Upper GI endoscopy
5.

Patient Note Example 2

HISTORY: Include significant positives and negatives from history of present illness, past medical history, review of system(s), social history and family history.

48 YO ♀ - CHEST PAIN X 90 MINS

HPI
- BURNING
- NO RADIATION
- s/ SOB
- s/ NAUSEA & DIAPHORESIS
- RESOLVED SPONTANEOUSLY
- SIMILAR EPISODES 2-3 MOS, AFTER HEAVY MEAL OR EXERTION

PMH
- SOME RELIEF c̄ ANTACIDS
- ↑ CHOLESTEROL, NO FOLLOW-UP OR TREATMENT
- TENNIS WKLY
- SMOKED 30 PK YRS, STOPPED 3 YRS AGO
- NO UNUSUAL STRESS
- MOTHER c̄ NIDDM, BROTHER c̄ UNKNOWN HEART
- NO hx HTN, HAS NOT SEEN MD X 2 YRS

PHYSICAL EXAMINATION: Indicate only pertinent positive and negative findings related to patient's chief complaint.

BP 160/80 NO OBVIOUS DISTRESS, ANXIOUS TO LEAVE

CHEST NON-TENDER, CLEAR BS BILAT, NO WHEEZES CRACKLES OR RALES

HEART PMI NON-DISPLACED, REG RHYTHM, NO (M) OR RUBS

ABD BS⊕ NONDISTENDED, NO MASSES OR ORGANOMEGALY TENDERNESS IN EPIGASTRUM W/O REBOUND

DIFFERENTIAL DIAGNOSES: In order of likelihood (with 1 being the most likely), list up to 5 potential or possible diagnoses for this patient's presentation (in many cases, fewer than 5 diagnoses are likely).

1. ESOPHAGEAL REFLUX DISEASE
2. PEPTIC ~~ULCER~~ ULCER
3. CORONARY ARTERY DISEASE
4. CHOLECYSTITIS
5. MUSCULOSKELETAL CHEST PAIN

DIAGNOSTIC WORK UP: List immediate plans (up to 5) for further diagnostic workup.

1. STOOL FOR OB
2. EKG
3. CXR
4. UPPER GI ENDOSCOPY
5.

APPENDIX D
Clinical Skills Evaluation Collaboration (CSEC) Center Addresses

Travel information about each location is available at
www.usmle.org/Examinations/step2/cs/CSECAddresses.html

CSEC Center – Atlanta
Two Crown Center
1745 Phoenix Boulevard
Suite 500, 5th Floor
Atlanta, GA 30349

CSEC Center – Chicago
First Midwest Bank Building, 6th Floor
8501 West Higgins Road, Suite 600
Chicago, IL 60631

CSEC Center – Houston
Amegy Bank Building, 7th Floor
400 North Sam Houston Parkway
Suite 700
Houston, TX 77060

CSEC Center – Los Angeles
Pacific Corporate Towers
100 North Sepulveda Boulevard, 13th Floor
El Segundo, CA 90245

CSEC Center – Philadelphia
Science Center
3624 Market Street, 3rd Floor
Philadelphia, PA 19104