



US•MLE

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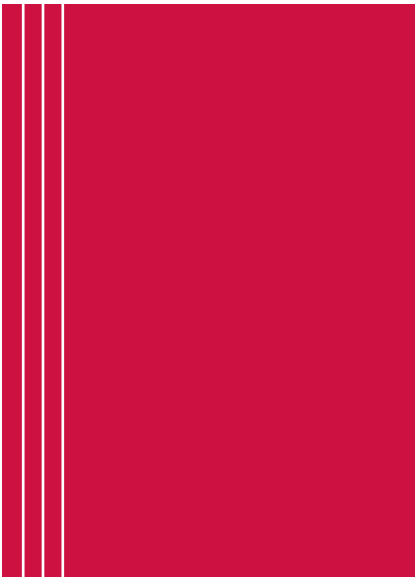
Examination

®

Step 2 Clinical Skills (CS)

Content Description and General Information

A Joint Program of the Federation of State Medical Boards of the United States, Inc.,
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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 management 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 be patient-centered, to address the diagnostic challenges posed, to prepare the patient for next steps, and to document the encounter appropriately.

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 orientation 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* on the ECFMG website (www.ecfmg.org).

The information in this document, as well as other materials, are available at the USMLE website. 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 real patients with a clinical problem. This method of assessment is referred to as a standardized patient examination. 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.

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.

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 patient-centered communication with methods of data collection that demonstrate the examinee's ability to relate to the patient and to list and pursue various plausible diagnoses. Other cases are designed to elicit a process of assisting patients with making decisions and/or with disease or problem management.

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, as well as patients with a variety of backgrounds and personalities. 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.

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.

DESCRIPTION OF THE EXAMINATION

When you arrive at the test center on the day of your examination, bring the Scheduling Permit you received after 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 on the Confirmation Notice you will print after scheduling your appointment.

Information on Clinical Skills Evaluation Collaboration (CSEC) test centers (addresses, maps, and travel information) is available at <http://www.csecassessments.org/test-centers/>.

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 will place in a locker or cubicle all personal belongings, including cell phones, watches, pagers, tablet PCs, iPods/media players, fitness and tracking monitors, any device with transmitting or receiving capabilities (e.g., bluetooth), formulas, study materials, notes, papers, pens/pencils, and your purse or wallet, before you enter the testing room. These items must be stored during the examination.

Each test center contains locked storage. You will be able to place personal items that you might need during breaks at your seat in the orientation room. The proctors will ask you to put all unauthorized items into the locked storage area. 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, (for example, 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. You will have 50 minutes of break time:

- 10-minute break after the 3rd patient encounter
- 30-minute break (which includes a light lunch) after the 6th patient encounter
- 10-minute break after the 9th patient encounter

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 centers.

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 will 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 doorway instructions will indicate whether, in these instances, a physical examination is required.

The Patient Encounter

You will have 15 minutes for each patient encounter.

When you enter the room, you will usually encounter a standardized patient (if not, you will be asked to communicate with a standardized patient over the telephone). By relating to the patient in a patient-centered manner, asking 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, as well as begin to develop an effective physician-patient relationship.

Your role during the examination should be that of at least a first-year postgraduate resident physician with primary responsibility for the care of each patient. You should treat each patient you see as you would a real patient. Communicate in a professional and empathetic manner, being responsive to the patient's needs. Do not defer decision-making to others. It may be helpful to think of yourself working in a setting where you are the only provider present.

As you would when encountering real patients, respond appropriately to the patients' needs for information exchange and understanding and engage them in planning for next steps.

You may introduce yourself however you wish, as either a medical student or as a doctor. You may introduce yourself using your real name. Do not mention the name of your school or institution.

The information you need to obtain in each encounter will be determined by the nature of the patient's problems. Your approach should be focused. You will not have time to do a complete history and physical examination, 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 learn during the encounter.

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 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, 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. Continuing to engage the patient after the announcement to stop has been made may be considered irregular behavior, will be reported to the USMLE, and could jeopardize your continued participation in the USMLE program.

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.
- To place the call, press the yellow speaker button.
- 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, press the yellow speaker button.
- 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. **If you leave the patient encounter early, you may use the additional time for the note.** You will be asked to 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.

Patient notes are written using a standard word processing format. Examinees will not be permitted to handwrite the note, unless technical difficulties on the test day make the patient note typing program unavailable.

You should record pertinent medical history and physical examination findings obtained during the encounter, as well as your initial differential diagnoses (maximum of three). **The diagnoses should be listed in order of likelihood.** You should also indicate the pertinent positive and negative findings obtained from the history and physical examination to support each potential diagnosis.

While it is important that a physician be able to recognize findings that rule out certain serious or life-threatening diagnoses, the task for Step 2 CS examinees is to record only the most likely diagnoses, along with findings (positive and negative) that support them.

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 the diagnostic studies. **Treatment, consultations, or referrals should not be included.**

Occasionally, due to technical or administration problems, you will not be able to type the patient note 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 licensed, board-certified 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 studies are 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.

It is important that you follow the proctor's instructions and comply with all announcements. When you hear the announcement to stop typing, click "Submit" on the computer, or put down your pen. Continuing to type or write after the announcement to stop will be considered misconduct. Remain seated and wait for further instructions. Continuing to type or write after the announcement to stop has been made may be considered irregular behavior, will be reported to the USMLE, and could jeopardize your continued participation in the USMLE program.

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 hos-

pital 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 child's parent or caregiver, or the caregiver of an elderly patient.

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, or if you are instructed not to conduct a physical examination, leave that section of the patient note blank. In those cases where you are instructed to counsel a patient regarding a particular medical problem or issue, you should continue to use patient-centered communication techniques to accomplish the counseling task.

SCORING THE STEP 2 CS EXAMINATION

Step 2 CS is designed to evaluate your ability to engage in a conversation that allows you to gather information relevant for a given patient presentation, and to begin to develop an effective physician patient relationship. During your physical examination, you should attempt to elicit important positive and negative signs. Make sure you engage the patient in discussion of your initial diagnostic impression and the diagnostic studies you will order. The patients may ask questions, and you will see a range of personalities and styles in asking questions and presenting information. You should address each patient's concern as you would in a normal clinical setting.

The ability to engage in patient-centered communication 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. The standardized patients assess communication skills, interpersonal skills, and English-speaking skills via carefully developed rating scales, for which SPs have participated in intensive training.

Your ability to document in the patient note the findings from the patient encounter, diagnostic impression, and initial diagnostic studies 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, justification of those 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: Communication and Interpersonal Skills (CIS), Spoken English Proficiency (SEP), and Integrated Clinical Encounter (ICE). Each of the three subcom-

ponents must be passed in a single administration in order to achieve a passing performance on Step 2 CS.

The CIS subcomponent includes assessment of the patient-centered communication skills of fostering the relationship, gathering information, providing information, helping the patient make decisions about next steps and supporting emotions. CIS performance is assessed by the standardized patients, who record these skills using a checklist based on observable behaviors.

Examinees demonstrate the ability to foster the relationship by listening attentively, showing interest in the patient as a person, and by demonstrating genuineness, caring, concern and respect.

Examinees demonstrate skills in gathering information by use of open-ended techniques that encourage the patient to explain the situation in his/her own words and in a manner relevant to the situation at hand, and by developing an understanding of the expectations and priorities of the patient and/or how the health issue has affected the patient.

Examinees demonstrate skills in providing information by use of terms the patient can understand, and by providing reasons that the patient can accept. These statements need to be clear and understandable and the words need to be those in common usage. The amount of information provided needs to be matched to the patient's need, preference, and ability. The patient should be encouraged to develop and demonstrate a full and accurate understanding of key messages.

Examinees demonstrate helping the patient make decisions by outlining what should happen next, linked to a rationale, and by assessing a patient's level of agreement, willingness, and ability to carry out next steps.

Examinees demonstrate ability to support emotions when a clinical situation warrants by seeking clarification or elaboration of the patient's feelings and by using statements of understanding and support.

The SEP subcomponent includes assessment of clarity of spoken English communication within the context of the doctor-patient encounter (for example, pronunciation, word choice, and minimizing the need to repeat questions or statements).

SEP performance is assessed by the standardized patients using a global rating scale, where the rating 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.

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

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

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

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

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

- Using inexact, nonmedical terminology, such as *pulled muscle*

- Listing improbable diagnoses with no supporting evidence
- Listing an appropriate diagnosis without listing supporting evidence
- Listing diagnoses without regard to the order of likelihood

Appendix A illustrates a blank patient note screen.

Appendix B provides examples of two completed patient notes. The samples also include annotations, highlighting actions that would add to or lower a patient note score.

A program for practicing typing the patient note is available on the USMLE website (www.usmle.org).

Step 2 CS Score Reporting 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/step-2-cs/#reporting>.

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 in the sections titled **Testing Regulations and Rules of Conduct** and **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.

COMMON ABBREVIATIONS FOR THE PATIENT NOTE

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

UNITS OF MEASURE	
C	Celsius
cm	Centimeter
F	Fahrenheit
hr	Hour
kg	Kilogram
lbs	Pounds
mcg	Microgram
mg	Milligram
min	Minute
oz	Ounces
VITAL SIGNS	
BP	Blood pressure
HR	Heart rate
R	Respirations
T	Temperature
ROUTES OF DRUG ADMINISTRATION	
IM	Intramuscularly
IV	Intravenously
po	Orally
MEDICAL ABBREVIATIONS	
∅	Without or no
+ or pos	Positive
- or neg	Negative
Abd	Abdomen
AIDS	Acquired Immune Deficiency Syndrome
AP	Anteroposterior
CABG	Coronary artery bypass grafting
CBC	Complete blood count
CHF	Congestive heart failure
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 or EKG	Electrocardiogram
ED	Emergency department
EMT	Emergency medical technician
ENT	Ears, nose, and throat
EOM	Extraocular muscles

MEDICAL ABBREVIATIONS CONTINUED	
EtOH	Alcohol
Ext	Extremities
f or ♀	Female
FH or FHx	Family history
GI	Gastrointestinal
GU	Genitourinary
h/o	History of
HEENT	Head, eyes, ears, nose, and throat
HIV	Human immunodeficiency virus
HRT	Hormone replacement therapy
HTN	Hypertension
Hx	History
JVD	Jugular venous distention
L	Left
LMP	Last menstrual period
LP	Lumbar puncture
m or ♂	Male
Meds	Medications
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
PA	Posteroanterior
PERRLA	Pupils equal, round and reactive to light and accommodation
PMH or PMHx	Past medical history
PT	Prothrombin time
PTT	Partial thromboplastin time
R	Right
RBC	Red blood cells
ROM	Range of motion
SH or SHx	Social history
SOB	Shortness of breath
TIA	Transient ischemic attack
U/A	Urinalysis
URI	Upper respiratory tract infection
WBC	White blood cells
wnl	Within normal limits
yo	Year-old

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.

APPENDIX A

Patient Note Screen

When 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 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.

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:

HISTORY FINDING(s)	PHYSICAL EXAM FINDING(s)

Add a Row

DIAGNOSIS #2:

HISTORY FINDING(s)	PHYSICAL EXAM FINDING(s)

Add a Row

DIAGNOSIS #3:

HISTORY FINDING(s)	PHYSICAL EXAM FINDING(s)

Add a Row

DIAGNOSTIC STUDIES

Add a Row

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APPENDIX B

Sample Patient Note Styles

Various styles of writing patient notes for the Step 2 CS examination are acceptable. Two examples of patient notes are shown on the following pages. 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, however, would be considered acceptable. In addition, guidelines to help examinees understand patient note scoring are provided in callouts.

Patient Note Example 1

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).

Ms. Bingham is a 24 yo woman who complains of worsening sore throat since yesterday morning. She has never had a similar problem in the past. She has no difficulty swallowing, but notes that swallowing makes the pain worse. Nothing makes it better. There is no SOB or sensation of choking or dysphagia. She has fatigue and has had some anorexia since the symptoms began. She has had some subjective fevers at home but has not taken her temperature. She has had no cough or rhinorrhea. There are no sick contacts at home or at work. She denies seasonal allergies and post-nasal drip.
ROS: No chest pain, cough, wheezing, abdominal pain, N/V, headache
PMHx: none
Meds: none; Allergies: none
PSHx: none
FHx: father with HTN
SHx: married with 2 children, No ETOH or drugs, monogamous with husband

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.

She is in no acute distress, throat clear, abdomen soft, nontender and without distension. There is no notable splenic or hepatic enlargement or tenderness.

DATA INTERPRETATION: Based on what you have learned from the history and physical examination, list 2 diagnoses that might explain this patient's complaint(s). List your diagnoses in order of likelihood. Then, enter the positive or negative findings that support each diagnosis. Lastly, list initial diagnostic tests and management plans for each diagnosis. Include any relevant history, physical examination, laboratory tests, imaging, ECG, etc.

DIAGNOSIS #1: Viral Pharyngitis

HISTORY FINDING(S)	PHYSICAL EXAM FINDING(S)
Sore throat	Tender submandibular lymph nodes
Subjective fever	
Fatigue	
Anorexia	
Pain with swallowing	
Add a Row	

DIAGNOSIS #2: Bacterial Pharyngitis

HISTORY FINDING(S)	PHYSICAL EXAM FINDING(S)
Add a Row	

The physical exam includes a cursory examination of the throat. A higher level of detail such as specific mention of erythema or exudate, and evaluation for regional lymphadenopathy would result in a higher score.

Appropriate supporting information is drawn from the history and PE section above and used to support a likely diagnosis

Including a diagnosis without supporting information will result in a lower score even if the diagnosis is likely.

Patient Note Example 1 (continued)

DIAGNOSIS #3:

HISTORY FINDING(s)	PHYSICAL EXAM FINDING(s)

↑

Add a Row

If only two diagnoses are likely based on the patient's presentation, do not list a third diagnosis.

DIAGNOSTIC STUDIES
Throat Culture
Head/neck CT with Contrast

Add a Row

“Head/neck CT with contrast” is overly aggressive and costly in this clinical scenario, and would result in a lower score.

Patient Note Example 2

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).

75-y-o woman with sudden onset back pain last night while lifting turkey from oven.

-pain in midline, mid-thoracic

-sharp, stabbing in nature

-worse with movement or deep breath, better with rest

-not improved with acetaminophen

-no symptoms in legs, no fever or chills

-had minor back pain in past that resolved on its own

-Post-menopausal due to hysterectomy at age 40, not on HRT

PMH: fracture of foot bone last year

Meds: acetaminophen for occasional headache and daily multivitamin

History can be presented in either narrative or listed format for full credit.

PHYSICAL EXAMINATION:

those parts of examination

The examinee has described the findings relevant to the back pain, and is not required to report a complete physical examination.

Well-nourished woman looks her age, alert and lucid; Appears in pain, especially with movements; point tenderness over T8; straight leg test negative; sensation intact on bilateral feet. No weakness of ankle, knee or hip musculature. Deep tendon reflexes 2+ at patella and ankle; Plantar reflexes down.

DATA INTERPRETATION:

Based on what you have

explain this patient's complaint(s). List your di

appropriate. Then, enter the positive or negative

each diagnosis. Lastly, list initial *diagnostic* studies (if a

maneuvers, laboratory tests, imaging, ECG, etc.).

"Pulled back muscle" is an inexact, non-medical term. The most likely diagnosis, vertebral fracture related to osteoporosis, has been overlooked, despite strong evidence from the history and physical examination. This will result in a lower score.

DIAGNOSIS #1: Pulled back muscle

HISTORY FINDING(s)	PHYSICAL EXAM FINDING(s)
Sudden onset back pain with lifting	ROM limited by pain
Pain worse with movement	



Add a Row

Patient Note Example 2 (continued)

DIAGNOSIS #2: Herniated disc/nerve root compression

HISTORY FINDING(s)	PHYSICAL EXAM FINDING(s)
Sudden onset back pain	ROM limited by pain
Occurred when lifting object	
Pain worse with movement	
↑	
↓	

Few facts in the history and physical suggest this diagnosis, so it is appropriately listed lower than more likely diagnoses.

DIAGNOSIS #3: Epidural abscess

HISTORY FINDING(s)	PHYSICAL EXAM FINDING(s)
Back pain	
↑	

This diagnosis is poorly supported. Listing diagnoses that are not supported by the history will result in lower score.

DIAGNOSTIC STUDIES
Imaging of back/spine
Add a Row