Clinical Skills Exam:
Location:
In Chicago:
The building is a Bank building only yards away from the Cumberland CTA station on the blue line. It’s a 45 min ride by CTA (train) from downtown Chicago’s “magnificent mile” but it’s only two stops from O’Hare. Maps available online.
It’s a business area; very safe. The hotels nearby are expensive, and I complained about the so-called ‘special price’ of $99 per night at the Marriott. I stayed for $80 at the Clarion, and they were easily able to provide a shuttle ride to the test in the am. They knew exactly where it was. It’s not a long walk, but you’d have to cross a GIANT road to get there--I don’t recommend it, and there was massive construction going on at the time. The Clarion Barcelo was very nice with coffee and irons and ironing boards in each room.
The USMLE website has a list of nearby hotels, phone numbers, and prices. I got a better deal by going through the UNMC travel agency (for Chicago)

Test day:
They constantly call you “doctor” just to try to stroke your ego and appease your being there. You may not use your own pen. You will cover up your affiliation on your coat. You will put a number on your left arm, like running a race.
You will have a locker in a locked room with very limited access during the test in which to put your things.

Items:
Review the CSE website. Bring your scheduling permit and a gov’t photo ID with your name and signature EXACTLY as on your registration. Change your registration name early (online) if you don’t have ID that matches it exactly.
Bring your stethoscope, white coat, extra munchies and drinks if you like. I had no problems carrying a stethoscope onto the plane.
All other testing materials are provided in every room, and they will orient you to operation of the equipment and lights.

Food:
For lunch they feed you a nice sandwich buffet with sides and dessert, but they had almost no vegetarian options. This is being addressed. They assure me they will not run out of food. They offer a variety of soda/water. I’d bring a favorite soda since they always run out of something. There are some vending machines in that building in Chicago.

THE TEST:
The info on the door-setting:
You must wait for the start of “time” before you can look at the door sheet.
You may be in ED/clinic/hospital/telephone/3rd party settings
You will get a setting and a very, very brief CC, some history if necessary. For example: Ms. Smith is a 23 y.o. female who has come to your clinic with a CC of palpitations. Was seen recently in ED for this, RN reports EKG and CBC from ED were normal.
The instructions read something like, “perform a focused history and physical
exam on this patient in the time permitted.” They may vary for a psych case or
one of the 3rd party cases in which you may not be required to do a physical exam.
Take all the time you want before entering the room, but, of course, the clock is
ticking.

In the room:
Typical clinic exam room, except:
One way glass and cameras (which I never saw). Not intrusive at all.
It is stocked with tendon hammers, tuning forks, etc.

The patient encounter/interview:
Essentially, just do the usual focused interview and exam based on the CC.
As you know, take into account pt age, race, pertinent SH, RF, behaviors. You
may need to look for substance abuse in some cases.
I was told that you may introduce yourself as ‘doctor’, ‘student doctor’ or
whatever you’re comfortable with. Odd, since we’re not doctors yet.

Physical exam and findings:
All necessary equipment is in the room.
No feedback is given outside of actual exam findings—the patients will never
go out of character.
“You can accept the vital signs as accurate, and do not need to repeat them unless
you believe the case specifically requires it. However, if you do repeat the vital
signs, continue to consider the vital signs as originally listed when developing
your differential diagnosis and work-up plan.” --From CSE website.
“…certain parts of the physical examination must not be done: rectal, pelvic,
genitourinary, 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.”—CSE website. See the miscellaneous note below.

The main difference between this OSCE and ours, regarding physical exam, is
that there are no findings ‘given to you’, and you actually need to listen and feel
because they may have patients with real findings, and they’ll fake taking breaths,
for example, so you won’t hear breath sounds in certain places. You will NOT be
handed a card stating “you saw cotton wool spots” or “you heard a 3/6 systolic
ejection murmur” and so on, nor will the patient tell you of findings.

You won’t get results from any tests you request, but you’ll almost always have to
plan to order some. Since you don’t get results, you usually won’t lock in a
diagnosis before you leave the patient encounter.

Wrapping up:
Give the patient appropriate feedback and a plan. They often ask “Is it my heart,
doc?” or “Is this serious?” or “Do I have alzheimers?” My understanding is that
they always want you to discuss/wrap things up with the patient. You
probably shouldn’t just say, “I’ll go discuss this with the doctor…” as many of my classmates told me they have done on past UNMC OSCE’s.

“Examinees should let the standardized patients know what diagnoses they are considering and what diagnostic tests they plan to order.”—from CSE website.

Once you leave, that’s it. You cannot go back in.

Writing the note:
If you finished the pt encounter early, you can use your extra time on your note. You’ll always have the same note template, see the link below.
By hand or computer. Easy to use. See the online examples: http://www.usmle.org/orientation/PatientNote/PNmain.htm

Acceptable abbreviations are listed at the write-up desk at each station (and is avail on the CSE website). You may use other super-common abbreviations, but be careful of some you assume are common. I’ve heard from others that the Nebraska Н (with a line through it) for ‘normal’ is kind of unique to this area and not necessarily widely used.

It’s no use to write things you would have asked or done—no credit—just like in real life you wouldn’t type in your SOAP note—“I should have asked about smoking”—might as well just leave it out. There’s no real assessment and plan section, just one for DDx and a section for immediate diagnostic workup.

Differentials:
Most to least likely
Up to five, do not need 5 to get full credit.

Next diagnostic tests:
Up to five, do not need 5 to get full credit.
Do not list procedures at this point, no matter how tempting.—e.g., placement of chest tube. In their words, “Treatment, consultations, or referrals should not be included in your workup plan.”—from CSE website.

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

Miscellaneous:
“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.”—from CSE website.

“There may be cases involving a child or an elderly patient in which the interaction is with a caregiver. In these cases, data gathering will not involve a direct physical examination. For these and other cases the examinee may be asked to conduct the encounter via telephone.”—from CSE website
They are very well-trained: I had a pt with an acute abdomen, and I asked her to lie on her back so I could do an abdominal exam, but she wouldn’t move from her side or straighten her legs. So I walked around to the other side of the table (to her back) and lightly bumped it with my hip, and she ‘jumped in pain’, for a positive peritoneal sign.

Reference: Mastering the Objective Structured Clinical Examination and the Clinical Skills Assessment (2nd ed.) by Jo-Ann Reteguiz and Beverly Cornel-Avendano, On reserve in library and a limited number are available for purchase in the bookstore.

Very helpful for preparing for patient encounters, but inaccurate as far as the test and test day details are concerned. The interstation section is out of date. I am not certain, but I do not think we will be asked to interpret many (if any) tests, read EKG’s etc. I did not encounter any stations in which we were told specifically to go in and talk with a patient, but not to do a physical exam, like case # 6 about end of life. However, I still think this topic is fair game.

Nice review of physical exam techniques. Nice overview of how to approach a CC and formulating appropriate questions so you can get all the points regarding pertinent positives and negatives and consider appropriate workup. For example, I think the very first case about dementia is very appropriate.


Issues:

1) Everything is recorded. As far as I know, you need to write the USMLE people in order NOT to consent to using your videotaped encounters for ‘educational’ purposes. I asked specifically about this, and Dr. Caverzagie is looking into it further. I don’t want to wind up on 60 minutes with a bar through my face as an example of ‘what not to do’.

2) Expense of hotels.

3) Vegetarian meals

If you have completed all the UNMC OSCEs, then you should feel quite at home with the new CSE. It is just another set of simulated patient scenarios, much as we have had at UNMC. You will be able to apply your practiced ICE skills, physical exam skills, interviewing skills, and basic medical knowledge, and you shouldn't have any problems.

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