



TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

School of Medicine

Third-Year Clerkship OSCE Manual

Content Description and General Information

Samuel J. Campbell, MD, FACS

Assistant Dean for the Clinical Sciences Curriculum

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Introduction

The OSCE (Objective Standardized Clinical Encounter) Experience in your Third-Year Clerkships is designed to 1) assess your ability via simulated patient encounters, 2) create a patient-centered encounter, 3) address the diagnostic challenges posed, 4) prepare the patient for the next steps, and 5) document the encounter accurately. The former USMLE Step 2CS Exam identified 72 common signs and symptoms and our Third-Year OSCE cases cover many of the same topics. Appendix A lists the 72 common presenting signs and symptoms. Appendix B provides a screenshot depicting your note format.

Your OSCE score will represent 15% of your Final Clerkship Grade. Successful passage of the OSCE component requires a minimum passing score of 70.

The Capstone OSCE Experience, the Longitudinal Clinical Skills Encounter (LCSE), occurs during your sixth Clinical Clerkship. The LCSE will have six OSCE stations. Successful passage of the LCSE is a graduation requirement.

OSCE Structure

In a standardized patient encounter, you will determine the patient's presenting symptom, perform a focused History and (usually) Physical examination, develop a working differential diagnosis, and create a list of the next steps in the patient's workup. The standardized patients (SP) will evaluate you using a checklist. The SP's checklist is an evaluation of your communication and interpersonal skills (CIS). After the encounter, you will document your patient's history, physical examination, differential diagnoses, and the next steps in your patient's workup. Your written note will serve as a second component of the grading of an OSCE, which corresponds to the integrated clinical encounter (ICE) component. Your OSCE occurs during week eight of your Third-Year Clerkship except for Psychiatry, which is during the Friday of week seven. You have a total of fifteen (15) minutes for the patient encounter. You have ten (10) minutes for the written note. If you finish the patient encounter before the fifteen-minute time limit, you may apply the additional time on your note.

Description of the Examination

Timing

You should arrive at least 15 minutes early at the Simulation Center on your home campus. Your Clerkship Coordinator will advise you as to the start time of the examination. The OSCE encounters are timed events, so do not arrive late for your exam. OSCEs occur at the same time on each campus for each Clerkship according to the schedule listed below

Clerkship	Time
Family Medicine	Week 8, Wed am
Internal Medicine	Week 8, Wed pm
Obstetrics and Gynecology	Week 8, Tues pm
Pediatrics	Week 8, Mon am
Psychiatry	Week 7, Friday am
Surgery	Week 8, Tues am

Location

Your OSCE encounter will occur in the designated Testing Area. Your Clerkship Coordinator will instruct you regarding campus-specific information.

Policies and Procedures

The Clerkship OSCEs and LCSE are conducted under the SOM OP 30.01, Grading Policy, SOM OP 30.01, Appendix F, SOM OP 30.03, Electronic Devices, and SOM OP 30.09, Educational Record and Grade Appeal Policy. All OSCEs are graded on a 100-point scale (30% contributed by the Communication and Interpersonal Skills (CIS) component, 70% by the Integrated Clinical Encounter (ICE) component). The final scores are converted to a 15-point scale. **No electronic devices are allowed during the OSCE**, including the Patient Encounter and Note Writing tasks of the OSCE. **A score of 70% is required for passing the OSCE**. SOM OP 30.01 provides guidelines for actions in MSIII Clerkships for the failure of an OSCE.

Table 1: Guidelines for Actions in MSIII Clerkships

Academic Condition	Course of Action
Failure of single component other than clinical performance (i.e., NBME exam or OSCE)	Repeat component A four-week elective for credit in Year 4 concluded by repeat of component is recommended. Failure to remediate a failed component will result in assignment of a final grade of FA and referral to the SPPCC.
Failure of clinical performance OR failure of two or more components (including failing the same subject exam on two separate occasions)	Assign clerkship grade of FA and refer for review by campus SPPCC Year 3/4 subcommittee with options for courses of action as described in SOM OP 40.04, Student Promotion .
Failure of overall Clerkship	Assign clerkship grade of FA and refer for review by campus SPPCC Year 3/4 subcommittee with options for courses of action as described in SOM OP 40 04 Student Promotion

Clothing

Wear comfortable, professional attire with a clean, white lab coat. Men should have a necktie, and women should have closed toe shoes. Follow the TTUHSC policies regarding clinical encounters. *For example, for COVID precautions (May 24, 2021), gloves, a mask, and a face shield were required. As of August 9, 2021 gloves and a mask are highly recommended.*

Equipment

The only required medical equipment is your stethoscope. The Sim Center provides all other necessary medical equipment.

Onsite Equipment and Examinee Instructions

The Testing Area of the Sim Center will consist of a standardized exam room. An examination table, chair, BP cuffs, otoscopes and ophthalmoscopes, gloves, sinks, towels, and antibiotic foam dispensers are in the standardized room. You may need to adjust the table for your patient's comfort during the examination. You are expected to use any drapes as necessary to protect your patient's modesty. Outside the exam room, you are provided a clipboard with a blank paper for taking notes. You are expected to bring your pen for taking notes during the encounter. A note detailing the patient's name, age, gender, and reason for visiting the doctor will be facing away from you at the doorway. 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 may not look at the note in advance of the announcement that the patient encounter has begun. You can accept the vital signs on the examinee instruction sheet as accurate and do not need to repeat them unless you believe the case specifically requires it. 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, you must perform a physical examination.

The Patient Encounter

You will have 15 minutes for each SP encounter. Once the announcement "Students, you may begin" is given, you may look at the information sheet and begin your encounter. You must

knock on the door before entering. You should introduce yourself and begin your conversation after closing the exam door. You should treat each SP as you would an actual patient. The SP will be evaluating you based on the encounter using the Communication and Interpersonal Skills (CIS) Checklist. The CIS Checklist is found in Appendix C. Communicate in a professional and empathetic manner, responsive to the patient's needs. You should respond appropriately to the patient's needs and ask the patient questions and communicate using nonmedical jargon. You will need to communicate the working diagnoses and next steps in the workup of the patient's problem. You should determine the patient's willingness to participate in the following clinical steps and gauge their understanding of their present illness.

Physical Examination

Perform a directed physical examination based on your patient's history and potential differential diagnoses. Glove or wash your hands or use antimicrobial foam before examining the patient. You must respect and protect the patient's comfort and modesty. You will need to move their drapes to avoid unnecessary exposure. It is an expectation that you listen with a stethoscope directly on the skin and not on the gown or through clothing. You must apply no more pressure than the amount of pressure appropriate when performing tasks such as the abdominal exam, examination for Murphy's sign, Obturator or Psoas sign, eliciting CVA tenderness, and examining the ears with an otoscope. Interact with the standardized patients as you would with any patients you may see with similar problems. **Do not perform the following: rectal, pelvic, genitourinary, inguinal hernia, female breast, throat swab for culture, or corneal reflex examinations. If indicated, you should include them in your proposed diagnostic workup.** All other examination maneuvers are entirely acceptable, including femoral pulse exam, inguinal node exam, and axillary exam. The overhead speaker will make announcements when to begin the patient encounter, when 5 minutes remain, and when the patient encounter is over. If you complete the patient encounter in fewer than 15 minutes, you may leave the examination room early to begin your note. Be sure that you have obtained all necessary information before leaving the examination room. You are not permitted to re-enter the examination room. Re-entering an examination room after leaving will be considered misconduct.

Telephone/Video Patient Encounters

Telephone/video patient encounters may occur during the Pediatric OSCE and LCSE. These encounters begin like all encounters with a case-specific doorway instruction sheet. Once the announcement "Students, you may now begin," you make notes about the case before entering the exam room. Upon entering the room, sit at the desk in the front of the room. You should conduct the encounter via phone or video link and take a history and ask pertinent questions. Because no physical exam is possible, leave that section of the note blank. 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 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 and your initial differential diagnoses (maximum of three). List your diagnoses 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. Do not list information or findings not documented in the History or Physical Exam!

Finally, you will list the diagnostic studies you should order for that particular patient. If you think a rectal, pelvic, inguinal hernia, genitourinary, female breast, corneal reflex examination, or a throat swab would have been indicated and performed during the encounter, list it as part of the diagnostic studies.

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

Special Circumstances

During much of the COVID Pandemic, Virtual Video OSCE encounters were conducted. Many Clerkships required the student to state what examination maneuvers they would next perform. The SP would then give the findings. Family Medicine wanted their students to document what they could see. If the OSCEs return to a virtual format, your Clerkship Director will instruct you on their Clerkship's expectations for the physical examination procedures. The Internal Medicine Clerkship may begin an EKG and X-ray component to their OSCE examination. The EKG and X-ray component may represent 15% of your OSCE grade.

Scoring of Your OSCE

You are assessed for your Communication and Interpersonal Skills (CIS) by the Standardized Patient (SP). The CIS portion of your Clerkship OSCE counts 30%. The remaining 70% is your performance in the Integrated Clinical Encounter (ICE). Your ICE is evaluated by a Clerkship Director using a grading rubric. Typically, the rubric is based on written documentation, required pertinent positives and negatives determined by the History, and a focused Physical Exam. The grading rubric uses a Does, Partially Does, and Does Not Do grading system. Thus "enough documentation" (i.e., 3 out of 5 items) results in a does checkmark, partial documentation (i.e., 1-2 items), no documentation (i.e., 0 items) results in a does not do.

A grade of 70 is the minimum passing score for the OSCE.

Rules of Conduct and Testing Regulations

The SOM OP 30.03 Electronic Devices in the Classroom and SOM OP 40.03 Student Conduct outline your duties as a student. No smartphones or other electronic "smart device" is permitted in the testing area. The Medical Student Honor Code of Professional and Academic Conduct prohibits your discussing the case at any time. Your Clerkship Coordinator and Sim Center staff will conduct the OSCE testing. You must follow the instructions of your Clerkship Coordinator and Sim Center Staff.

Appendix A: Common Presentations Formerly Used on USMLE Step 2CS

(this list is a guide for the cases presented on Clerkship OSCEs)

Please note that this list shows examples, and does not represent all possible presenting signs and symptoms that may be encountered during a Step 2 Clinical Skills examination.

Abdominal distension	Irritable infant/child
Abdominal pain	Jaundice
Abnormal menses	Jaw pain
Abnormal movements	Joint pain
Altered bowel habits (e.g., constipation, diarrhea, fecal incontinence)	Joint swelling
Back pain	Leg swelling
Bloody stools/melena	Loss of appetite
Breast-related complaints	Mass/lump
Chest pain/discomfort	Memory loss
Child and adolescent behavior concerns	Mood disorder
Confusion	Mouth and lip changes
Cough	Muscle pain
Decreased sensation in extremities	Nasal discharge
Dental pain	Nausea/vomiting
Difficulty walking	Neck pain
Dyspareunia	Palpitations
Dysphagia	Post-operative complications
Ear-related complaints (e.g., pain, tinnitus, hearing loss)	Postpartum concerns/complications
Easy bruising	Pregnancy-related concerns/complications
Epistaxis	Pruritus
Evaluation after a fall	Rash
Extremity pain	Seizure
Eye complaints (e.g., pain, visual changes)	Sexual dysfunction
Fatigue	Shortness of breath
Fevers, chills and/or night sweats	Sinus pain/pressure
Flank pain	Sleep issues
Genital complaints (e.g., discharge, lesions, pain)	Sore throat
Hallucinations	Substance use
Headache	Syncope
Hematemesis	Trouble concentrating
Hemoptysis	Urinary complaints (e.g., frequency, dysuria, retention, incontinence)
High blood pressure	Vertigo/dizziness/lightheadedness
Hot flashes	Weakness
Indigestion	Weight gain
Infant spitting up	Weight loss
	Wheezing

APPENDIX B

Communication and Interpersonal Skills (CIS) Checklist

Below, note the exact checklist used by SPs to evaluate your patient-centered interviewing skills. The CIS checklist is identical in all clerkships, with slight modifications for phone/video interview formats.

School of Medicine - SP Checklist

Communication & Interpersonal Skills (CIS)	0	1	2	N/A	SP Comments
<i>Fostering Relationships</i>					
1. Knocking/Door Procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Introduced Self/Clarified Role	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Grooming/Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Nonverbal Communication <i>(Body language, eye contact, distance)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Nonverbal Communication <i>(Care, concern, respect, confidence)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Patient's Preferred Title	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Proper Draping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Focus on Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Gathering Information</i>					
9. Chief Complaint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Questioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Avoided/Clarified Medical Jargon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Proper Use of Continuers, Transitions, and Paraphrasing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Addressed Additional Concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Assessed Impact on Patient's Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Providing Information</i>					
15. Summarized Significant Information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Additional Information and Encouraged Questions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Check for Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Making Decisions</i>					
19. Clearly State Next Steps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Counseled Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Mutual Plan of Action	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. Managed Challenge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Additional Comments/Feedback</i>					

Rating System

0 = no requirements met

1 = some/half requirements met

2 = all requirements met

N/A = does not apply to the case

SP Comments = detailed explanation of the rating (if necessary)

School of Medicine – SP Checklist Notes

Communication & Interpersonal Skills (CIS)

Fostering Relationships

1. **Knocking/Door Procedure**
 - Knocked before entering the room (*does not have to wait for SP to say "come in"*)
 - Door completely closed before saying SP name or personal details (HIPAA)
2. **Introduced Self/Clarified Role**
 - Introduced Self
 - Provided their specific role in your care (*i.e. "I'm a third-year medical student ____ helping Dr. _____, and I am going to be performing a physical examination on you today."*)
3. **Grooming/Hygiene**
 - No body odor, breath odor, etc.
 - Professional attire (*white coat pressed, appropriate clothes underneath*)
4. **Nonverbal Communication (*Body Language, Eye Contact, Distance*)**
 - Eyes at same level as patient (*at or below patient's eyes*)
 - Approximately 2 feet from patient (*not too close, not too far*)
 - Sitting in front of you (*not to the side*)
 - Posture (*i.e. no arm crossing, hands in pockets*)
 - Appropriate facial expressions, amount of eye contact and vocal tone (*remaining in emotional contact*)
5. **Nonverbal Communication (*Care, Concern, Respect, Confidence*)**
 - Displayed confident and competent manner
 - Avoided talking too fast/rushing patient encounter
 - Engaged and attentive listening
 - Non-judgmental attitude
 - Remained focused on patient
6. **Patient's Preferred Title**
 - Addressed you with a title and your last name (*i.e. Mr. or Ms. _____*)
 - Clarified pronunciation of name (*if applicable*)
 - Asked you your preferred title
7. **Proper Draping**
 - Ask for permission and explained what they were doing when adjusting draping
 - Offered assistance for gown adjustments (*i.e. tying, untying*)
8. **Focus on Patient**
 - Listened attentively and actively
 - Refocuses conversation back to patient/exam
 - Pain level management (*if applicable*)

Gathering Information

9. Chief Complaint

- Asked why you are here today in an open-ended question format (i.e. "What brings you in today?")
- Asked about timeframe (i.e. "How long has this been going on?")

10. Questioning

- Overall clear/concise questioning – one question at a time
- Mixture of question types
 - Open-ended
 - (i.e. "What caused you to come in today?" "What makes the pain worse?")
 - Close-ended
 - (i.e. "Have you been feeling nauseated?" "Have you noticed any change in your sleep habits?")
 - Non-leading
 - (i.e. "Have you ever used tobacco products?" "Any nausea or vomiting?")

11. Avoided/Clarified Medical Jargon

- Provide immediate explanation of medical terminology (if you have to ask, then they do not get credit)
 - (i.e. explain meaning of hypertension or dyspnea)

12. Proper Use of Continuers, Transitions, and Paraphrasing

- Paraphrase – repeat back in patient's words/show understanding
- Transitions – provide transitional phrases to let patient know what is next
 - (i.e. "Next I'm going to examine your abdomen")
- Continuers – open-ended statements to help patient know when to continue providing information
 - (i.e. "Tell me more" or "Mhmmm, continue")

13. Addressed Additional Concerns

- Asks about patient's concerns and/or questions regarding symptoms and chief complaint

14. Assessed Impact on Patient's Life

- Specifically asked patient about impact on life
- Acknowledged and addressed physical, psychological, and social impacts
- Identified specific impact and showed empathy to patient

Providing Information

15. Summarized Significant Information

- Provided patient with a summary of specific information from encounter

16. Diagnosis

- Give impression/thoughts
- Deliver diagnosis
 - *(It is OK to prompt/ask student about diagnosis, but they do not receive credit if they say "Let me go talk to my attending")*
- Provide justification and evidence for clinical diagnosis

17. Additional Information/Encouraged Questions

- Explained diagnosis, plan, and treatment
- Observed and acknowledged patient concerns/facial expressions
- Decreased patient uncertainty and addressed questions about diagnosis

18. Check for Comprehension

- Restate and clarify diagnosis
- Asked patient to restate discussion and plan

Making Decisions

19. Clearly State Next Steps

- No medical jargon or terminology (unless immediately explained)
- Describe planned tests and purpose of tests
- Discuss and schedule follow up visit

20. Counseled Patient

- Address concerns
- Explain importance of action plan
- Identify patient's support network *(if applicable)*

21. Mutual Plan of Action

- Establish plan/follow through that works for both parties
- Acknowledge importance of teamwork

22. Managed Challenge


- Case specific *(i.e. diagnosis, emotions, questions, treatment plan, etc.)*

APPENDIX C: Patient Note Screen

7/1/2021

SIMULATIONIQ - Evaluations

Home / Evaluations



StudentA, Fake
Step 2 CS Note Sample (Step 2 CS Note)

Patient Notes

Evaluations

POST ENCOUNTER

POST ENCOUNTER

HISTORY: Describe the history you just obtained from this patient. Include only information (pertinent positives and negatives) relevant to this patient's problem(s). * Top

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. * Top

DIAGNOSTIC REASONING: Based on what you have learned from the history and the 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 (# 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)

Top

↑
↓

Diagnosis#2*

History Finding(s)	Physical Exam Finding(s)


Top

↑
↓

Diagnosis#3*

7/1/2021

SIMULATIONiQ - Evaluations

History Finding(s)	Physical Exam Finding(s)
	
<input type="radio"/> Diagnostic Study/Studies*	
General Comments	

Top

Top

APPENDIX D

Common abbreviations for the Patient Note (courtesy of USMLE Step 2CS exam description)

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 E

Guidelines for writing a patient note in the proper format

These guidelines provide you with guidance in structuring your note to permit documentation of important information within the OSCE exam.

1. Chief Complaint (Hint: Use simple abbreviations (CC, etc.) to organize your note)

Two choices are available: Direct quote from the patient or inclusion in the first sentence.

Examples:

A. CC: "I'm having trouble breathing."

B. Mr. X is a 58 yo Hispanic male complaining of (or "presenting with") shortness of breath (or SOB) for the past two months.

Note: if you choose option A, make sure this is a direct quote from the patient; it is not acceptable to write the presentation in quotation marks (e.g., "SOB"). If you choose option 2, you can use qualifiers (e.g., severe shortness of breath) to add detail using fewer characters.

Exceptional Case: Obstetrics and Gynecology

At TTUHSC Ob/Gyn OSCE notes must use a specific format for the first sentence as follows:

XX y/o G0 (use appropriate descriptor (GXPX) for the patient) LMP [WHEN, best if the specific date, ok if "x days/weeks/months ago"], using [details about contraceptive use] who complains of [INSERT chief complaint]

2. History of Present Illness (HPI)

This section is best presented as a short paragraph that shows the information you collect from the patient in a logically organized manner. The best strategy is to use one of the standard mnemonics (OPPQRST or OLDCARTS, for example) to structure your response. Although these mnemonics are most commonly associated with acute events, such as pain, they provide helpful guides for any presentation.

Remember that ONSET and DURATION/CHRONOLOGY can often seem to be the same (for example, if the pain is constant since onset), but the pain is only felt for specific periods or began after a particular event such as a fall. LOCATION information should include any radiation. QUALITY should consist of descriptors of the nature of the presenting condition, and the severity of the presentation (including pain or discomfort) should be QUANTIFIED. Relevant ALLEVIATING/PALLIATIVE or AGGRAVATING/PROVOCATIVE events should be documented with any associated clinical information (e.g., febrility, etc.). TIME characteristics, including any similar prior events, are essential to document.

Once this paragraph is complete, it is helpful to present supporting information as a series of coordinated labeled responses as follows:

3. Past Medical/Surgical/Psychiatric/Neurological History. Use appropriate abbreviations (PMH/PMHx; PSH/PSHx) from the approved list where applicable. It is best not to include prior history before this point to avoid unnecessary biasing of your decision-making. If a patient has a previous history that would typically involve medication, make sure that you inquire about this medication and note it below. In most cases other than psychiatric patients, the first two items will suffice.

4. Allergies and Medications: These items, even if negative, should always be included. Allergies could consist of both drug allergies and other allergies, depending on their relevance to the case. Medications include OTC meds, such as Tylenol, as well as prescription drugs. Prescription drugs related to a prior medical history must be included.

5. Family History: Include relevant information about family members that informs decisions about the presentation.

6. Social History: You will need to decide which information is relevant here. At the very least, you should list occupation, living conditions, and substance use.

7. Review of Systems: If an item is not listed in writing, it is not available for credit. Omission of any pertinent material, either positive or negative, will not be covered by the phrase "ROS negative or non-contributory except as in the HPI." An organized method for listing the systems in the head-to-toe direction can be helpful to avoid missing a critical system.

Here is a method for organizing your ROS:

- a) General/constitutional: how does the patient appear, are they feeling weak, tired, have they lost or gained weight without trying, any fever?
- b) HEENT: visual changes, eye pain, eye redness, hearing change, earache, tinnitus, nosebleeds, dry mouth, hoarseness, oral ulcers, sore throat)
- c) Neck: neck pain or swollen glands
- d) Pulmonary/Respiratory: chronic cough, decreased exercise tolerance, difficulty breathing, coughing up blood (hemoptysis), sputum production, wheezing
- e) Breast: breast mass, breast pain/tenderness, nipple discharge, skin changes
- f) Cardiovascular: chest pain, leg pain when walking, leg swelling, night awakening due to trouble breathing, palpitations, SOB
- g) Gastrointestinal: abdominal pain, change in bowel habits, constipation, diarrhea, nausea, vomiting, rectal bleeding, trouble swallowing
- h) Genitourinary: vaginal discharge, menstrual irregularities, difficulty starting/stopping the urinary stream, dysuria, change in the urinary stream, increased frequency, blood in urine, loss of bladder control, urinary retention, urethral discharge, impotence, penile lesion, testicular mass, testicular pain
- i) Musculoskeletal: decreased range of motion, joint pain, joint redness, joint swelling, joint stiffness, muscle wasting, muscle weakness, muscle aches, muscle pain
- j) Neurological: Loss of bowel control, dizziness/vertigo, headaches, numbness/tingling, passing out, seizures, tremor
- k) Psychiatric: Anxiety, change in sleep pattern, depression, hallucinations, suicidal ideation
- l) Endocrine: change in appetite, cold intolerance, increased thirst, increased urination, hair changes, sexual dysfunction
- m) Hematology: easy bruising, enlarged lymph nodes, prolonged bleeding

Special cases: Pediatrics

Birth history, developmental progress, dietary history, and immunization status will often be needed for pediatric patients.

8. Physical Exam: This physical exam needs more of your attention as the historical data we received from the USMLE on our students' performance on Step 2CS identified the PE as one area of underperformance. It is worthwhile noting that the standard form previously used on Step 2CS allocated the same maximum number of characters for the PE section as the History section (950 characters on Step 2CS). Yet, we consistently observe on clerkship OSCEs that the actual number of characters used for the PE section is around 50% of the number used for the History section.

Organize your PE, for example, like this list:

- a) Vital Signs (with comments) – always list the VS and comment whether within normal limits or not for each.
- b) General: describe the patient, including the level of distress
- c) HEENT
- d) Neck
- e) CV
- f) Lungs
- g) Abdomen
- h) Genitourinary (in OSCEs, you will not perform these exams, but include them as a part of your diagnostic follow-up)
- i) Extremities
- j) Neurological
- k) Psychiatric
- l) Skin
- m) Lymphatic

9. Diagnostic Impression: You must list up to three potential diagnoses in order of priority. If you have trouble coming up with three diagnoses, this can be because you are deciding too quickly, resulting in an inability to develop a reasonable list of choices. A useful mnemonic to help to consider a broad set of possible causes is VINDICATE.

Mnemonic	System / Cause	Alternative
V	Vascular	
I	Infectious	
N	Neoplastic	
D	Degenerative	
I	Iatrogenic	Intoxication
C	Congenital	
A	Autoimmune	
T	Traumatic	
E	Endocrine	Metabolic

After documenting your diagnoses, you will list supporting information from your History and physical examination. You can list up to eight items from each prior section. It is critical that there is no disconnect between the supporting information and previous documentation, and the chief complaint should be one piece of supporting information from the history. Supporting

documentation for diagnoses will not be accepted if no documentation in either the history or physical examination exists.

10. Diagnostic Workup/Studies: List laboratory tests, imaging, follow-up exams (e.g., pelvic/breast) along with a rationale for each test (such as to rule in/rule out one of the diagnoses). Your diagnostic workup should include items related to each of your listed diagnoses.

Treatment plans will not be accepted unless your Clerkship Director notifies you that their particular Clerkship has Treatments as an expectation.

AMBOSS and USMLE World have sections previously dedicated to Step 2CS that you may use for ultimate preparation for your Clerkship.