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# ASSESSMENT OF CLINICAL SKILLS IN MEDICINE AND LAW

by Jayne W. Barnard

In thinking about professional licensing exams, four issues quickly emerge: timing, format, content, and usage. Every profession approaches these issues differently. In the legal profession, the approaches often differ from state to state.

This article focuses on clinical skills testing for the medical profession so that lawyers involved in bar admission might learn from the experiences of our colleagues involved in similar work. Over the last two decades, American medical schools, the National Board of Medical Examiners (NBME), and the Federation of State Medical Boards (FSMB) have worked in tandem to develop a coordinated approach to the testing and licensure of doctors. The benefits of this system include a single national test with a single pass/fail standard that is recognized in all 50 states, well-established procedures for license portability, a high-quality staff that provides test design and administration, and remarkable clarity and a shared understanding about what skills and substantive knowledge are essential for a beginning doctor.

The timing and format of the U.S. Medical Licensing Examination (USMLE) are themselves of some interest. The exam is divided into three parts: Step 1 is typically taken by students at the end of the second year of medical school; Step 2 is typically taken early in the fourth (or senior) year; and Step 3 is typically administered after the internship (first

post-graduate) year. Each step of the exam is substantively different, and the structure is progressive. That is, a student must pass Step 1 before she can take Step 2, and so on. All three steps are designed to form a comprehensive examination.

Step 1 is an eight-hour multiple-choice exam focusing on basic scientific principles. Step 2 is a nine-hour multiple-choice exam that requires the student to consider hypothetical patients and provide “a diagnosis, a prognosis, an indication of the underlying mechanisms of the disease, and the next step in medical care, including preventive measures.”<sup>1</sup> Many of the questions involve the interpretation of tables, lab data, imaging studies, specimens, etc. The purpose of Step 2 is to determine whether the student is ready to “[provide] patient care under supervision.”<sup>2</sup>

Step 3 is a two-day exam designed to determine whether the student is ready to practice medicine *without* supervision.<sup>3</sup> It tests not only substantive knowledge, but also clinical judgment.<sup>4</sup> The test includes 500 multiple-choice questions. It also includes nine case simulations in the form of a “virtual dialogue” with a computer-simulated patient. The “patient” initially presents with certain symptoms. The candidate then selects from a menu the necessary tests or other courses of action that she wishes to prescribe. A simulated clock advances the

time in the scenario, allowing for “follow-up visits” and counseling based on the patient’s “test results.” A case simulation may thus cover weeks or months in the simulated patient’s life, while taking only 20 or 25 minutes in real time. “Encounters” with patients may occur in clinics, offices, nursing homes, hospitals, or emergency departments, or on the telephone. Once a decision is made and entered into the computer, the candidate—as in real life—is not permitted to go back in time and correct her errors, but she can change the patient’s orders to compensate for her mistake or to reflect an updated management plan.

These three tests are not inexpensive. The charge to the medical student is \$435 for Step 1, another \$435 for Step 2, and \$610 for Step 3.

## THE CLINICAL SKILLS EXAMINATION

The most intriguing aspect of the USMLE is one that is still in development but scheduled to take effect with the medical school graduating classes of 2005. This test—called variously the Clinical Skills Assessment Exam (CSAE), the Standardized Patient Exam (SPE), the Clinical Skills Exam (CSE), or simply USMLE Step 2 CS—is a daylong, hands-on test involving “standardized patients.” These patients—actually actors and others who have been coached to describe their symptoms and emotional state—will present themselves *in person* to the candidate just as they would do at an ambulatory clinic. The candidate will then spend about 15 minutes gathering a history,

conducting a physical examination, and providing feedback and counseling to the patient. After each live-patient encounter, the candidate will have ten minutes to record her findings before moving on to the next patient. Over the course of the testing day, the candidate will have 10-12 live-patient encounters.

The purpose of the CSE is to assess the candidate’s communication skills as well as her technical skills. Some of the communications skills—including

English language proficiency, empathy and patience—will be assessed by the standardized patient using a checklist. (In addition, there will be a random review of tapes of the patient encounters, to check on the accuracy of the patients’ scoring.) Other communication skills—such as precision and accuracy in recording medical observations—will be assessed by a physician/scorer. Technical skills—including taking a history and performing a medical exam—will be assessed both by the standardized patient and by a physician. Scoring on the exam will be pass/fail.<sup>5</sup>

THE CSE IS A RADICAL INNOVATION. ALTHOUGH A SIMILAR TEST HAS BEEN REQUIRED OF FOREIGN MEDICAL GRADUATES SINCE 1998, AND HAS BEEN USED IN CANADA SINCE 1992, THE IDEA THAT EVERY U.S.-BORN MEDICAL STUDENT SHOULD BE REQUIRED TO DEMONSTRATE NOT ONLY HER BOOK KNOWLEDGE AND CONVENTIONAL TEST-TAKING SKILLS BUT ALSO THE “PEOPLE” SKILLS THAT RELATE CLOSELY TO CLINICAL JUDGMENT HAS BEEN DIFFICULT FOR MANY CRITICS TO DIGEST.

## CRITICISMS OF THE CLINICAL SKILLS EXAM

The CSE is a radical innovation. Although a similar test has been required of foreign medical graduates since 1998, and has been used in Canada since 1992, the idea that every U.S.-born medical student should be required to demonstrate not only her book knowledge and conventional test-taking skills but also the “people” skills that relate closely to clinical judgment

has been difficult for many critics to digest. Medical students understandably have objected to the cost of the CSE—\$975 each time the test is taken, not including travel and lodging<sup>6</sup>—and the problems associated with having to travel long distances to a handful of testing sites.<sup>7</sup> (Altogether, the fees for all four steps of the USMLE will total \$2,455.) Students also have questioned the CSE's validity, insisting that results of field trials must be published in a peer-reviewed journal before the test can be administered in a licensure context.<sup>8</sup>

The American Medical Association has also opposed the administration of the CSE, primarily on the ground that clinical testing is better administered by medical schools than by licensing agencies.<sup>9</sup> Perhaps not surprisingly, this position has been rejected by the Association of American Medical Colleges, which recently endorsed the CSE.<sup>10</sup> The American Medical Association has also questioned the validity of the Clinical Skills Exam.<sup>11</sup> The question that recurs is whether any exam can meaningfully differentiate between students who are likely to perform adequately as physicians and those who are likely to fail for lack of clinical—as opposed to cognitive—skills. A subsidiary question is whether validity can be established in the absence of longitudinal tracking of students who have taken the exam.

Some critics have argued that many medical students already face student-loan debt loads approaching \$100,000 and that adding yet another test to the process, plus related test-preparation costs, could

deter some students from pursuing a medical career.<sup>12</sup> Supporters respond that the cost of the exam will be just a drop in the bucket of a doctor's overall debt burden, and will have no impact on students' decisions to practice medicine. However, to try to address the cost concern, the Association of American Medical Colleges has suggested that some form of "tax" be applied to practicing physicians to help defray the cost of the exam.<sup>13</sup>

Another concern about the Clinical Skills Exam relates to the cost-benefit equation. The projected pass rate for the CSE is 93 to 95 percent on the first try, with an ultimate pass rate of 98 to 99 percent in subsequent tries.<sup>14</sup> Critics ask if there isn't a less intrusive, less expensive way to identify the tiny portion of the medical student population whose language skills, interpersonal skills, and technical skills would likely interfere with their ability to practice medicine safely. The answer from the perspective of the AAMC seems to be "no."<sup>15</sup>

## EFFORTS TO DERAIL THE CSE

During 2002, the FSMB and the NBME found themselves defending the Clinical Skills Exam against challenges from organized medical student groups<sup>16</sup> and from the American Medical Association. Supporters pointed to 15 years of field trials involving thousands of U.S. medical students.<sup>17</sup> They argued that "[p]ilot studies nearing completion indicate that a national high-stakes clinical skills examination is practical, and that it identifies students who lack even the minimum requirements to enter post-

graduate training.”<sup>18</sup> They defended both the reliability and validity of the Clinical Skills Examination. On the important subject of validity, they noted that a similar test in Canada had been shown to correlate positively with physicians’ overall performance:

A study undertaken by Canadian researchers showed that scores on the Quebec Licensing Examination, which includes a clinical skills examination, could be used to predict the future practice patterns of physicians. Lower performers tended to prescribe more inappropriate medications, display[ed] poorer pain management skills, referred significantly fewer women for mammograms, and referred fewer of their patients for consultation in practice.<sup>19</sup>

They also pointed to the fact that “as many as 25% of medical school graduates report never having been observed by a faculty member while interviewing a patient.”<sup>20</sup> Obviously, part of the intent of the exam is to correct deficiencies in medical school curricula and clinical training. Another objective is to minimize malpractice claims that research has shown to be strongly associated with failure to establish doctor-patient rapport.<sup>21</sup>

As part of the reaction to the medical students’ anti-test campaign, the FSMB commissioned a survey testing the public’s response to the idea of a clinical skills exam. The survey, conducted by Harris Interactive in December 2002, found that 97 percent

of the medical consumer-respondents consider clinical skills very important or extremely important when selecting a physician and 87 percent of the respondents want to see students pass a clinical skills exam before receiving their medical license.<sup>22</sup> While it is fair to suggest that the results of the survey were predictable, conducting a formal survey is also a measure of the FSMB’s commitment to the idea of clinical skills testing.

“A STUDY UNDERTAKEN BY CANADIAN RESEARCHERS SHOWED THAT SCORES ON THE QUEBEC LICENSING EXAMINATION, WHICH INCLUDES A CLINICAL SKILLS EXAMINATION, COULD BE USED TO PREDICT THE FUTURE PRACTICE PATTERNS OF PHYSICIANS. LOWER PERFORMERS TENDED TO PRESCRIBE MORE INAPPROPRIATE MEDICATIONS, DISPLAY[ED] POORER PAIN MANAGEMENT SKILLS, REFERRED SIGNIFICANTLY FEWER WOMEN FOR MAMMOGRAMS, AND REFERRED FEWER OF THEIR PATIENTS FOR CONSULTATION IN PRACTICE.”

### THE STATUS TODAY

A lot of politicking has gone on in the past year between the various constituencies interested in the process of medical licensure. As of October 2003, the medical students’ anti-test campaign had all but petered out. According to Dr. Peter Scoles, Senior Vice President of the NBME, “every state medical board has signed on to this [exam],” student resistance to the exam is now limited to negotiations about some possible cost-reducing adjustments, and plans are proceeding towards full implementation in June 2004.<sup>23</sup> “[The students now] accept that this [exam] will happen,” says Dr.

Scoles. “The real story is that all the medical regulatory bodies now agree that these [clinical] competencies matter.”

### APPLICATION TO THE ORGANIZED BAR

It seems to me there are four useful lessons to be learned from the story of the Clinical Skills Exam for medical school graduates:

- (1) it is possible, though costly, to develop a format for testing communication and interpersonal skills for large numbers of applicants in a professional licensure context;
- (2) reliability is not the biggest challenge in such tests; the more difficult question is whether licensing agencies can validly identify (and therefore exclude) persons who would likely cause harm in the practice of their profession;
- (3) resistance is inevitable when one proposes such a test;<sup>24</sup> and
- (4) attempting to measure a person's ability to function in a real-world human environment—quite a different question from whether a person has mastered a body of material and can apply it when asked in a testing environment—is a worthwhile effort for any profession.

Why are these lessons of interest to bar examiners? Recently, law school clinicians have suggested that some form of “clinical skills” testing would work (and would be desirable) in the legal profession, too. Elaborating on their ideas, the *JOURNAL OF LEGAL EDUCATION* (the official publication of the Association of American Law Schools) recently published a comprehensive proposal for adapting some of the features of physician licensure testing to lawyers.<sup>25</sup> In a nutshell, under this proposal, clinical skills testing would go beyond traditional performance testing and include both research and writing skills, but also simulations of interviewing, negotiating, advocating, and counseling a client. Some portion of the test would involve the use of “standardized clients” and be administered in much the same way as the medical CSE. The test would occur at the

beginning of the third year of law school, providing opportunities to pass the test successfully before settling down to prepare for the “regular” bar exam in the summer following graduation.<sup>26</sup>

The proposal contemplates an extensive period of test development and refinement, but emphasizes—as does the medical CSE—the importance of interpersonal skills, communication skills, patience, empathy, precision, and organization.

There is no question that ideas like this are provocative—and expensive. For now, it will be useful to watch how the medical CSE story unfolds. ☐

## ENDNOTES

1. United States Medical Licensing Examination, 2003 USMLE Bulletin, Examination Content, available at [www.usmle.org/bulletin/2004/examinationcontent.htm](http://www.usmle.org/bulletin/2004/examinationcontent.htm) (last visited July 2, 2004).
2. United States Medical Licensing Examination Step 2, available at [www.usmle.org/step2/default.htm](http://www.usmle.org/step2/default.htm) (last visited July 2, 2004).
3. United States Medical Licensing Examination Step 3, available at [www.usmle.org/step3/default.htm](http://www.usmle.org/step3/default.htm) (last visited July 2, 2004).
4. United States Medical Licensing Examination, Step 3 Purpose and Content, available at [www.usmle.org/step3/purpose.htm](http://www.usmle.org/step3/purpose.htm) (last visited July 2, 2004).
5. United States Medical Licensing Examination, 2004 USMLE Bulletin, Scoring and Score Reporting, available at [www.usmle.org/bulletin/2004/scoring.htm](http://www.usmle.org/bulletin/2004/scoring.htm) (last visited July 2, 2004).
6. Clinical Skills Examination: Frequently Asked Questions, available at [www.usmle.org/news/cse/step2csfaqs1103.htm](http://www.usmle.org/news/cse/step2csfaqs1103.htm) (last visited July 2, 2004).
7. Attention Medical Students, available at [www.amsa.org/meded/nbme.cfm](http://www.amsa.org/meded/nbme.cfm) (last visited July 2, 2003). Currently sites have been or are being constructed in Philadelphia, Atlanta, Chicago, Los Angeles and Houston.
8. American Medical Association, Medical Student Section, CSAE Position Statement, available at [www.ama-assn.org/ama/pub/category/7654.html](http://www.ama-assn.org/ama/pub/category/7654.html) (last visited July 2, 2004).
9. AMA Policies on the Clinical Skills Assessment Examination, available at [www.ama-assn.org/ama/pub/category/8744.html](http://www.ama-assn.org/ama/pub/category/8744.html) (last visited July 2, 2004):

It is the policy of the AMA to (1) support continued efforts to develop and validate methods for assessment of clinical skills; (2) continue its participation in the development and testing of methods for clinical skills assessment; and (3) recognize that clinical skills assessment is best performed using a rigorous and consistent examination administered by the medical school, and should not be used in evaluation for licensure of graduates of LCME- and AOA-accredited medical schools.

10. *See* Jerome J. Cohen, M.D., ***A Word from the President: Clinical Skills Under Scrutiny***, AAMC REPORTER (Dec. 2002), available at [www.aamc.org/newsroom/reporter/dec02/word.htm](http://www.aamc.org/newsroom/reporter/dec02/word.htm) (last visited July 2, 2004).
11. Barbara A. Gabriel, ***Proposed New Clinical Exam Draws Cost, Efficacy Concerns***, available at [www.aamc.org/newsroom/reporter/aug02/clinicaexam.htm](http://www.aamc.org/newsroom/reporter/aug02/clinicaexam.htm) (last visited July 2, 2004) (quoting Frank A. Simon, M.D. director of the AMA's Division of Undergraduate and Graduate Medical Education Policy) ("The AMA endorses [a suspension of the CSE until it is] demonstrated to be valid in that it identifies people who would pass the USMLE but run into difficulty in the safe practice of medicine").
12. Steve Perlstein, ***Medical Examiners Push for Clinical Skills Test: Students Say It's Too Expensive***, OB GYN News, Mar. 15, 2003.
13. Gabriel, *supra* note 11.
14. Jay Greene, ***Skills Test Moving Forward: Pilot Studies Prove Effective***, AM. MED. NEWS, Oct. 8, 2001, available at [www.ama-assn.org/amednews/2001/10/08/prsc1008.htm](http://www.ama-assn.org/amednews/2001/10/08/prsc1008.htm).
15. Cohen, *supra* note 10 ("Unfortunately, there is [no less expensive test] that meets the level of psychometric reliability required for deciding who can practice medicine").
16. These groups include the American Medical Student Association, the student section of the Association of American Medical Colleges, the student section of the American Medical Association, and the National Medical Student Association.
17. A public statement from the Federation of State Medical Boards and the National Board of Medical Examiners regarding the American Medical Association's decision to oppose the use of a test of clinical skills for licensure purposes, available at [www.fsmb.org/cse\\_info/AMA\\_Response.html](http://www.fsmb.org/cse_info/AMA_Response.html) (last visited July 2, 2004).
18. *Id.*
19. United States Medical Licensing Exam, Validity of the Clinical Skills Examination (CSE), available at [www.usmle.org/news/cse/csevalidity21903.htm](http://www.usmle.org/news/cse/csevalidity21903.htm) (last visited July 2, 2004).

20. USMLE Information, available at [www.utm.edu/Medicine/Acad\\_Affairs/Students/USMLE.htm](http://www.utm.edu/Medicine/Acad_Affairs/Students/USMLE.htm) (last visited July 2, 2004).
21. *See* Julie Ishida, "Hands-On Testing for New Docs: Communication, Clinical Skills to be Measured," ***The Washington Post***, July 29, 2003 at F1 (describing studies showing that better communication between doctors and patients led to better outcomes).
22. Press Release, "Americans Overwhelmingly Support New Medical License Test; Field Trials Show Fairness, Reliability of Test," Feb. 5, 2003, available at [www.usmle.org/news/cse/newsrelease2503.htm](http://www.usmle.org/news/cse/newsrelease2503.htm) (last visited July 2, 2004).
23. Telephone interview with Dr. Peter Scoles, Senior Vice President, National Board of Medical Examiners, Oct. 24, 2003.
24. *See 2002 NBME Annual Report*, Message from the President, available at [www.nbme.org/AnnualReport/2002/president.htm](http://www.nbme.org/AnnualReport/2002/president.htm) (noting that, after announcing the implementation of the CSE as of 2004, "the NBME faced challenges during 2002 unlike any it has faced in more than three decades").
25. Jayne W. Barnard and Mark Greenspan, M.D., ***Incremental Bar Admission: Lessons from the Medical Profession***, 53 J. LEGAL ED. 340 (2003).
26. Barnard and Greenspan, *supra* note 25 at 358-63.



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