Dr. Dan: Welcome to the Medical School Podcast. I'm your host, Dr. Dan, and this is Episode 90.

In this episode, I will be discussing the evolution of the United States Medical Licensing Exam. There are a number of important changes which I am sure you've heard about, but I want to clarify and notify those that did not know about this stuff.

Let me set the background a little bit with the USMLE. In the early 1990s, the USMLE exam for the allopathic schools replaced the NBME, the National Board of Medical Examiner certification examinations and the Federation Licensing Examination program called FLEX. It's been around for a long time as a standalone. That's gone on 20 plus years now.

Of course, in 1999, they began those computerized patient simulations in Step 2. Standardized patients were introduced in 2004. That's only about 10 years now. They're making a lot more changes which is the purpose of this episode. Also in 2004, the USMLE undertook an in-depth review of the program. Everything is moving towards evidence-based. That's the underlying theme here with what's going on with the USMLE. They're doing feedback on the test to make sure that it's valid and actually measuring what it's supposed to measure and that what their targeting is actually relevant to clinical practice today.

There were 5 major recommendations that came back and were adopted in 2009. The first one is to make the USMLE focus on assessments to support state licensing authorities' decisions about a physician's readiness to practice patient care at entry into supervised practice, which means beginning a residency, and entry into unsupervised practice, potentially after internship when you get your license and begin [moonlighting 00:02:15].

They're trying to dovetail with the licensing exam to provide them feedback. That might mean that your individual state board might look closer at the USMLE scores themselves, particularly if they are scrutinizing you for some other kind of behavioral, personality, or disciplinary problem. They might look at your USMLE scores and require some remediation. That's all down the road. Those aren't current changes. I'm just trying to set the five major recommendations now as a backdrop and we'll get to the one big change that they're doing to the Step 3

examination this year, 2014. That's going to be their first big kickoff to implement all these changes.

The second big recommendation is to adopt the general competency schema that is consistent with national standards for the overall design, development, and scoring at the USMLE. It looks like they want a competency-based schema. They have, of course, adopted the ACGME core competencies schemas, that is, there are 6 competencies the Accreditation Council for Graduate Medical Education. That is the group that licenses or accredits the allopathic residency programs. When you become a resident, you will know about that.

Those 6 competencies include medical knowledge, patient care, communication and interpersonal skills, practice-based learning and improvement, professionalism, and systems-based practice. They're trying to get all four of these USMLE Step scores to be ultimately organized around these 6 core competencies that fit in directly with the ACGME competencies.

On a side note, the residencies themselves are ultimately changing how different residents are graded during each rotation that they do as they go through their residency. While it's already basically broken down with these 6 core competencies, they are going into specific metrics of skills for different types of interviews, different types of explanations, communication skills, etcetera, etcetera. Everything is getting studied and is getting a little bit harder. The paperwork demand is going up. That's the only thing I noticed so far.

The third major recommendation for the USMLE changes is to emphasize the scientific foundations of medicine in all components of the USMLE. They're trying to take us back to the USMLE Step 1 Basic Science Material, the hardest test of all of them, right, and emphasize basic science stuff throughout more and more of the tests. It's looking like down the road that the fourth year may not be so much of a break and it already is not for some, depending on what medical school you're at.

The fourth recommendation is to continue and enhance the assessment of clinical skills important to medical practice. They want to focus more clinically. Very hard to do. That's a major challenge. It's so subtle, there's a 15 million things to consider in doing that. My hats off to them for trying.

The last major recommendation, number 5, is to introduce assessment of an examinee's ability to obtain, interpret, and apply scientific and clinical information. What does that sound like? Does that sound familiar to you? It certainly sounds familiar to me. I just got through recording podcast number 48 for the pre-med students on a separate podcast channel talking about changes to the new MCAT that's coming up in 2015. This all sounds the same. They're trying to streamline core competencies, clinically-based data, and how to think like a physician earlier in the educational process to include undergraduate.

They are trying to make Step 3 have science content like Step 1, have science content similarly organized, or at least, conceptually constructed and academically processed and organized on the MCAT. That's where we're going, folks. In a way, it's a little scary. If you want to know more about the MCAT, you can listen to that other episode on the Pre-MedPodcast.com. I highly doubt it if you're a medical student.

Some of the evidence for why they are making these changes makes sense. There's a lot of it out there. I could point you to an article called "The Evolution of the United States Medical Licensing Exam." It's an opinion paper. It came out in JAMA, December 4 of 2013, Volume 310, Number 21, Page 2,245 to 46. One note is that only 15% of interns' experiences were ambulatory-based in this very large study of five national databases. Interns were required to perform a variety of procedures often with general attending supervision.

How similar is that to the Step 2 CS with the standardized patient? If only 15% are ambulatory, the Step 2 CS is really bogus. Eighty-five percent of your work is in the hospital. I would say it's more for many people. I mean all of mine was for both my internships in emergency medicine and the psychiatry were essentially all in the hospital. That USMLE Step 2 CS is ridiculous. Not only that, going into psychiatry, they didn't even make the hospital for credential and didn't make do a patient interview like they did all the other specialties.

There's a lot of inconsistency. They are trying to correct that. There's a lot of complaints about medical education. Believe it or not, there are people smarter than me and possibly you that are out there trying to do the right thing here. That's kind of evident. In response to the second recommendation, I mentioned that the USMLE adopted those 6 competencies for the ACGME. Those are going to be used to guide the test design in the future for the USMLE content

development itself, score reporting, and organize the content within examinations. The organization of the USMLE is going to change based around these 6 core competencies.

What is the first big change, Dr. Dan? What do I need to know now? I don't care about all the science. I care about my test. I want to get through with as little stress as possible, and not to be mean, but I don't care about those coming up behind me. What do I need to know?

What you need to know is in 2014, the Step 3 examination will be changed. It will be divided into two separate examinations organized around these competencies. You can choose to take the test on back-to-back days like people are doing now, or you can choose to separate those days by a set period of time. It's yet to be determined. The paper I'm using as my reference here is one month old, so January 2014, I still don't know how far that is. Go to the website to read more about that, directly to the source.

Initially, there will be a one score and a one pass or fail decision on your score report card. Future plans will likely include two or more separate scores and separate pass or fail requirements. They're going to study this to see if it's valid, to see if this is a good idea or if it's helping us or not. They're going to look for evidence to demonstrate that separate scores are valid representation of important competencies before they keep jerking around with it. Make sense? I hope so. If not, shoot me an email at medicalschoolpodcast.com. I'd be happy to figure this out with you. We'll blunder through it together. This stuff is pretty high level.

I'll tell you what I'll do. I will put a copy of all the current and future USMLE changes and emphasis on the show notes. I will scan it and put it right in there if you'll go to Episode 90. Future design and structural changes in Step 1 and Step 2 will be informed by the feedback in research that they get out of this huge Step 3 change. Changes in the other USMLE exams will not occur before 2016, so you got a couple years. You'll probably be good to go unless you're in the middle of med school now and you haven't taken Step 3. That's usually taken during your intern year of residency.

I hope that helps and God speed on your next exam. You've been listening to the Medical School Podcast. If I can help you with study techniques, go ahead and go

to medicalschoolpodcast.com and sign up for the free speed reading 101 course and look forward to some goodies there. Consider joining us on our next teleconference as well. I'm your host, Dr. Dan.