## Those MCC examination blues

I am now a fourth-year resident in internal medicine and have just completed the Medical Council of Canada Qualifying Examination (MCCQE) Part II examination. In 1994 I wrote to *CMAJ* about my dissatisfaction with the Medical Council of Canada's purpose in holding the exam.[1]

The exam itself, a 6-hour objective structured clinical exam, better known as OSCE, covers 20 scenarios involving all aspects of clinical medicine. Although intended to reflect the "real world" of the "average physician's experience," the exam does not. Half of the 5-minute scenarios, which I am not allowed to describe because this was an exam, would normally require at least 15 minutes of a "real" physician's time to form a sensible impression of the patient's problem and arrive at a safe plan of action.

The exam is also a farce because the person taking it can ignore just about everything involved in being a physician, things like thoughtful patient communication and a multidisciplinary focus. As long as they do not literally offend or physically harm the mock patient, those taking the exam merely need to ask the "right" questions to earn the necessary number of check marks.

Four vital clinical skills — the rectal, pelvic/genital, breast and fundoscopic examinations — are also excluded from the evaluation process. Physicians writing the test merely have to state that they would do the rectal examination, and then the OSCE preceptor says that it is "normal." This appears counterintuitive, because all 4 of the examination techniques are part of the screening recommendations for cancer and other common diseases, and they are poorly taught or tested during residency training.

After paying the $1200 fee to do Part II of the MCCQE, I am no further ahead in terms of knowledge, ability or licensure. I must still pass my Royal College licensing exams in my specialty, as must all specialists other than family physicians, in order to practise. At that point, I will merely be a specialist without a general licence, unable to practice general medicine.

I have now become cynical about my finite career.

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**Reference**

1. Ray J. The Part II examination: more thoughts [letter]. *Can Med Assoc J* 1994; 150:1541.

## A message for Mr. Rose

Matthew Rose is to be commended for his effort and motivations in the article "Lead, follow or get out of the way: What is the physician's role in a changing society?" (*Can Med Assoc J* 1996;155:209-11). It is encouraging to see medical students addressing some of the fundamental problems facing the medical profession. The letters by Drs. John F. Anderson and G. Allan Taylor (*Can Med Assoc J* 1996;155:1235-6) illustrate opposite sides of a fundamental problem facing the practising clinician when cost cutting is driven by ideology rather than a reasoned process.

While physicians are being encouraged to spend wisely and protect the public purse, they are legally responsible not for the public well-being but for maintaining a patient-specific standard of care. Any deviations from this standard can have serious repercussions, a point of no concern to governing bodies that wish to emphasize cost cutting and queue forming.

Rose would do well to remember that, although the public and the government emphasize the importance of cost-effective medicine, it is the lives of one's patients and one's professional career that are at stake. The governments responsible for current cutbacks are not sued for consequences of their cost cutting, and it seems highly unlikely they will defend physicians who run aground while trying to save society money.

Macroallocation decisions can be made at the micro level, but they then become the responsibility not of society but of the individual physician. The advantages of this system are almost entirely realized by the government. I can see no advantages for physicians.

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## Canadian infant mortality: 1994 update

In our recent article"Recent trends in Canadian infant mortality rates: effect of changes in registration of live newborns weighing less than 500 g" (*Can Med Assoc J* 1996; 155:1047-52), we showed that the increase in the Canadian infant mortality rate in 1993 was explained by a simultaneous increase in the registration of newborns weighing less than

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500 g as live births. In fact, after adjusting for this birth-weight category, we found that the infant mortality rate declined between 1987 and 1993. In this letter, we update our findings with recently published data for 1994.[1] In that year, the crude infant mortality rate was 6.3 per 1000 live births, whereas it was 6.4 per 1000 in 1991, 6.1 per 1000 in 1992 and 6.3 per 1000 in 1993.

We used methods described in our article. First, we recalculated the infant mortality rate for Canada (not including Newfoundland) after excluding newborns weighing less than 500 g registered as live births. Second, Poisson regression was used to model infant mortality rates. A crude Poisson model included terms for province or territory, sex and year, whereas an adjusted model included an additional variable for the proportion of registered live births accounted for by newborns weighing less than 500 g. Finally, the significance of trends in low-birth-weight categories between 1987 and 1994 was assessed with the use of the $\chi^2$ test.[2]

After excluding registered live births of newborns weighing less than 500 g, the infant mortality rate was higher in 1994 than in 1993 (5.7 per 1000 live births in 1994 versus 5.4 per 1000 in 1993, Table 1). The adjusted Poisson model also showed a higher rate in 1994 than in 1993 (Fig. 1).

As well, the proportion of registered live births of newborns weighing 500 g to 2499 g (of all live births of newborns with a known birth weight) increased from 5.5% to 5.9% from 1987 to 1994 ($\chi^2 = 44.7$, $p < 0.01$). A statistically significant trend toward higher proportions of infants with low birth weight was observed between 1987 and 1994 in the following birth weight categories: less than 500 g, 500 to 749 g, 750 to 999 g, 1750 to 1999 g and 2250 to 2499 g (Table 2).

The increasing proportion of registered live births of newborns weighing less than 500 g is consistent with our previous findings. There does not appear to be a simple explanation for the patterns of change within the low-birth-weight categories. The pooling of data from all provinces and territories may distort simpler patterns of change within each province or territory. In any case, the increase in the overall proportion of low-birth-weight newborns is cause for concern.

The increase in the infant mortal-

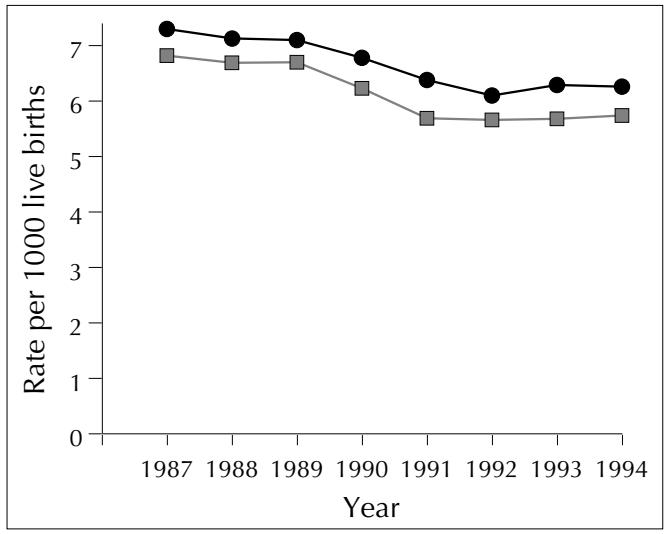


**Fig. 1: Crude (circles) and adjusted (squares) infant mortality rates in Canada from 1987 to 1994. The crude model contains terms for year, province and sex, whereas the adjusted model also includes a variable for the proportion of newborns weighing less than 500 g registered as live births.**

**Table 1: Perinatal and infant mortality rates per 1000 live births in Canada* from 1987 to 1994**

| | Year; rate per 1000 live births | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Index | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 |
| Infant mortality† | 7.3 | 7.1 | 7.1 | 6.8 | 6.4 | 6.1 | 6.3 | 6.2 |
| Neonatal mortality‡ | 4.5 | 4.5 | 4.6 | 4.6 | 4.1 | 3.9 | 4.1 | 4.2 |
| Postneonatal mortality§ | 2.8 | 2.6 | 2.5 | 2.2 | 2.3 | 2.2 | 2.1 | 2.0 |
| Stillbirths ≥ 20 weeks' gestation | 6.2 | 6.2 | 6.4 | 6.0 | 5.7 | 6.3 | 6.0 | 6.0 |
| Infant mortality excluding infants weighing < 500 g at birth | 6.8 | 6.7 | 6.7 | 6.2 | 5.6 | 5.6 | 5.4 | 5.7 |

*Data from Newfoundland were not included because they were incomplete for 1987 to 1990.
†Infant mortality = deaths under 1 year.
‡Neonatal mortality = deaths under 28 days.
§Postneonatal mortality = deaths between 28 days and 1 year.

ity rate for 1994 does not necessarily imply a deterioration in perinatal or infant health; it could be the result of random variation. However, the concomitant increase in the proportion of live births of infants weighing 500 g to 2500 g in 1994 adds to the seriousness of the increase in infant mortality. We are examining regional patterns in the change observed in 1994 and attempting to exclude possible errors in the data. Future trends in low birth weight and infant death require close attention.

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1. Health Statistics Division. *Births and deaths, 1994*. Ottawa: Statistics Canada, 1996. Cat no 84-210-XMB.
2. Armitage P, Berry G. *Statistical methods in medical research*. Boston: Blackwell Scientific Publications, 1994.

## Beware the curriculum-reform troops

The CMA needs to rethink its endorsement of a gay curriculum for medical schools, as described in the article "Gay, lesbian and bisexual health care issues and medical curricula" (*Can Med Assoc J* 1996;155:709-11), by Drs. Gregory Robinson and May Cohen.

This program looks like a design not to influence competency but to mandate a prescribed moral belief about homosexuality. Human sexuality is inherently a moral discussion. Will this proposal give full expression to differing views and model the tolerance it purports to teach? Without penalty? Moral convictions at odds with this curriculum could be risky for student or faculty. A closet might be a safe place.

Then again, maybe the authors have in mind the original idea of the university — unimpeded inquiry, free expression of ideas, search for truth — and I just missed it. We have here a curriculum enthusiastically promoted but without evidence. AIDS aside, questions of prevalence, genesis, dynamics, associated morbidities and medical justice relating to homosexuality are largely unstudied but are typically decided in the well-rehearsed court of febrile opinion.

This proposal appears to offer no departure. Surely medical research is not satisfied by reference to a few surveys of the gay population. The sad irony is that because the answers are "known" before the questions are posed and because acceptance of homosexual behaviour is sacrosanct, it is unlikely that tough issues will be faced, that rigorous research will be conducted and, ultimately, that anything will be learned.

Finally, and most offensively, is what the authors propose the good physician to be. Rather than simply showing compassion, integrity and respect for all, it is conformity that matters. Acquiescence to a particular moral view becomes the proper aspiration of all physicians. Dr. Michael Myers urges people in medicine who belong to quite conservative religions that consider homosexuality a sin to refer their gay patients to other physicians (*Can Med Assoc J* 1996; 155:770). In this brave new curriculum, when we cannot change people's beliefs, they keep them to themselves,

**Table 2: Rates of live births by weight category***

| | Year; rate per 1000 live births† | | | | | | | | 1987 to 1993 | | 1987 to 1994 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Birth weight, g | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | $\chi^2$‡ | *p* value | $\chi^2$‡ | *p* value |
| < 500 | 4.7 | 4.2 | 3.9 | 5.8 | 8.2 | 5.1 | 8.5 | 5.8 | 71.26 | < 0.01 | 47.65 | < 0.01 |
| 500–749 | 1.4 | 1.3 | 1.6 | 1.3 | 1.4 | 1.4 | 1.6 | 1.5 | 3.34 | 0.07 | 5.73 | 0.02 |
| 750–999 | 1.7 | 1.8 | 1.8 | 1.7 | 1.7 | 1.7 | 1.8 | 2.0 | 0.00 | 0.96 | 5.32 | 0.02 |
| 1000–1249 | 2.2 | 2.1 | 2.0 | 2.2 | 2.2 | 2.2 | 2.3 | 2.2 | 2.12 | 0.15 | 1.44 | 0.23 |
| 1250–1499 | 2.8 | 2.7 | 2.6 | 2.8 | 2.8 | 2.6 | 2.9 | 2.8 | 0.18 | 0.67 | 0.57 | 0.45 |
| 1500–1749 | 4.1 | 4.3 | 4.1 | 4.1 | 4.1 | 4.1 | 4.0 | 4.2 | 0.98 | 0.32 | 0.15 | 0.70 |
| 1750–1999 | 6.6 | 6.6 | 6.5 | 6.3 | 6.4 | 6.5 | 6.8 | 7.5 | 0.04 | 0.84 | 16.13 | < 0.01 |
| 2000–2249 | 12.2 | 12.9 | 12.1 | 12.4 | 12.3 | 12.3 | 12.0 | 12.0 | 3.19§ | 0.07 | 5.11§ | 0.02 |
| 2250–2499 | 23.8 | 24.6 | 24.5 | 24.0 | 24.2 | 23.6 | 25.5 | 27.1 | 4.49 | 0.03 | 59.81 | < 0.01 |
| Not stated | 2.0 | 3.7 | 3.7 | 2.9 | 8.7 | 3.6 | 3.0 | 1.6 | 208.18 | < 0.01 | 0.12 | 0.73 |
| 500–2499 | 54.9 | 56.1 | 55.2 | 54.8 | 55.1 | 54.4 | 56.8 | 59.3 | 1.14 | 0.28 | 44.74 | < 0.01 |

*Data from Newfoundland not included.
†In the category of birth weight < 500 g, the rate is per 10 000 live births.
‡1 degree of freedom.
§A decreasing trend.