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.

Joel G. Ray, MD
Department of Medicine
McMaster University
Hamilton, Ont.

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.

Stephen Workman, MD
Toronto, Ont.

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

← For prescribing information see page 287