

## Armoured brain

In describing a 10-month-old boy with bilateral calcified subdural hematomas, Mohammed Al Wohaibi and associates<sup>1</sup> report that the hematomas, which occurred after replacement shunting at 4 months of age, calcified intensely within a period of 6 months. They discuss trauma, as well as infection and overshunting, as a possible cause of subdural hemorrhages in general, but state that the mechanism for the underlying calcifications remains unclear.

The possibility of shaken baby syndrome should be considered in this case. A baby with special needs, such as this infant, might well be an increased burden and source of stress for caregivers. Two recent reports attest to a lack of recognition by physicians of occult head injury.<sup>2,3</sup> The babies may present with nonspecific symptoms, and the results of general and neurological examinations at the time of presentation may be normal. However, consideration of this diagnosis might prevent possible further injury or death.

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## [The authors respond:]

We appreciate the interest of Susan Bennett and her colleagues, and agree that child abuse must be considered as a cause of subdural hematoma in the patient we described. However, in this *Clinical Vistas* article,<sup>1</sup> it was not

our intention to review the case (or the topic of subdural hematoma) in detail. Rather, our purpose was to illustrate the unusual phenomenon of dense calcification within the membranes of a chronic subdural hematoma.

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## Pilot study of the Defining Issues Test

We have performed a preliminary study<sup>1</sup> to examine whether the moral reasoning skills of medical students and residents change over the course of their training. We provide here some data for comparison with the results of Johane Patenaude and associates<sup>2</sup> and the reports cited in their paper. Our group used the Defining Issues Test, version 2 (DIT-

2),<sup>3,4</sup> a short, validated, self-administered test for measuring such skills. The instrument was administered in 2001 to all first- and fourth-year medical students at the University of Manitoba, as well as to a random sample of first- and final-year medical residents. Confidentiality was assured by the use of unique identification numbers. Comparisons between groups and the data analysis were conducted by the Center for the Study of Ethical Development at the University of Minnesota, Minneapolis, which developed the DIT-2. The centre has shown that higher scores are linked to positive valuing of democratic ideals and to community and civic responsibility.<sup>5</sup> In addition, orthopedic surgeons with higher scores had a significantly lower risk of malpractice claims.<sup>6</sup>

As was the case in the study by Patenaude and associates,<sup>2</sup> there appeared to be little difference in moral reasoning skills between our first- and fourth-year medical students and those in the postgraduate years (Table 1), despite a generally well-rated ethics education program presented in the first 2 years of both the undergraduate and the postgraduate curricula. The DIT scores of the medical students and the residents

**Table 1: Mean scores on Defining Issues Test, version 2, for University of Manitoba medical students and residents (with reference scores)**

Subject group	No. of respondents	Mean score (and SD)*
<b>University of Manitoba Faculty of Medicine</b>		
First-year students	75	39.4 NA
Fourth-year students	57	40.8 NA
First-year residents	27	45.6 NA
Final-year residents	6	44.9 NA
<b>Reference groups†</b>		
Ninth-grade students	47	20.5 (9.7)
Freshman college students	35	30.6 (14.4)
Senior college students	65	40.4 (13.6)
Graduate students and students in professional streams	53	53.3 (11.5)

Note: SD = standard deviation, NA = not available.

\*Further analysis of the data, to be performed by the Center for the Study of Ethical Development, Minneapolis, is not yet available.

†Reference values (for US subjects) are from the Center for the Study of Ethical Development.<sup>5</sup>

were consistent with those of college level students (Table 1).

We intend to continue this study over the next few years to track our current first-year undergraduate cohort, to see if these preliminary data are replicated in the future. If so, we as medical educators will need to consider how to promote the development of moral reasoning skills within the medical profession and other health care professions, to keep pace with growing demands for sophistication in this area.

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## MCC evaluating examination and the international medical graduate

The information pamphlet on the Medical Council of Canada

(MCC) evaluating examination states that "Without exception, for eligibility to sit the MCC Qualifying Examination Part I, an IMG [international medical graduate] must have a valid pass on the MCC Evaluating Examination."<sup>1</sup>

Given that the qualifying examination is designed and promoted as representing a minimal standard of the knowledge and problem-solving skills needed for general practice in Canada,<sup>2</sup> I do not understand the need for the evaluating examination. The IMGs who must take the evaluating examination include physicians who have completed residencies and fellowships in the United States with specialty and subspecialty certifications. Having these fellowship-trained and board-certified physicians go through the evaluating examination as a prerequisite for the qualifying examination seems redundant and unnecessary.

I am one such IMG. Originally from Pakistan, I have a total of 7 years of postgraduate training (including a US residency and a 2-year fellowship at Yale University). After earning neurology and clinical neurophysiology certifications in the United States, I worked as an assistant professor at the University of Manitoba for over 2 years. I successfully wrote my Royal College of Physicians and Surgeons of Canada examination in neurology in 2001 and was granted an unrestricted licence in Manitoba. However, when I filed a written request to write the MCC qualifying examination part I with a waiver of the evaluating examination, my request was turned down. I eventually wrote all of the required MCC examinations for the sake of obtaining a permanent Canadian licence, but at the cost of having to cancel clinics and make some patients wait even longer for care.

What is the MCC's objective in having such physicians complete the evaluating examination? Is this really a way of standardizing the delivery of health care, or is it a way of deterring qualified medical practitioners from entering into practice in Canada?

I suggest that the MCC seriously reconsider the objectives of the evaluating

examination and define circumstances in which qualified physicians would be exempted.

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#### References

1. *Information pamphlet on the Medical Council of Canada evaluating examination (MCCEE) 2003*. Ottawa: Medical Council of Canada; 2003. Available: [www.mcc.ca/pdf/PamphletENG.pdf](http://www.mcc.ca/pdf/PamphletENG.pdf) (accessed 2003 Oct 7).
2. Dauphinee WD. Role of examinations of the Medical Council of Canada in improving medical standards. *CMAJ* 1981;124(11):1425-7.

#### [The MCC's Executive Director responds:]

Nizam Ahmed raises an important question: Why doesn't the MCC exempt IMGs who have received specialty training and been certified in a general clinical specialty in the United States from its initial evaluating examination and allow them to proceed directly to the 2 steps of the MCC qualifying examination?

The current requirement is that all candidates who have graduated from a medical school not accredited by the US Liaison Committee on Medical Education or the Committee on Accreditation of Canadian Medical Schools must pass the evaluating examination before undertaking the qualifying examinations.<sup>1</sup> This has been part of the MCC bylaws for over 25 years. Thus, it is not possible for the executive director or any other officer of the MCC to exercise discretion and "excuse" a candidate from the exam. Any change in admission eligibility would require a change in the bylaws. The policies and procedures that affect recruitment and licensure of IMGs are currently being reviewed by a national task force, which is due to report to the deputy ministers of health in December 2003.

Through the task force, issues such as those raised by Ahmed will be identified for all organizations concerned, including the appropriate ministries and the several bodies involved in the recruitment, hiring and licensure of IMGs. More specifically, Ahmed's concern has been noted by MCC staff and