

ing. The platelet count is  $20\,000 \times 10^9/L$ ; the leukocyte count and hemoglobin level are within normal limits. She has purpuric patches on her forearm, but there is no evidence of petechial hemorrhage in the mouth, on the fundus of the eye or on the legs. I imagine that this would be a very uncommon presentation of idiopathic thrombocytopenic purpura.

A third case is of a 22-year-old man who has fallen 20 m off a scaffold and presents with abdominal pain and severe shortness of breath. His blood pressure is 90/60 mm Hg and pulse rate 120 beats/min. The candidate must examine the patient and tell the nurse at the bedside how to manage him. The patient, who looks healthy, has a neck collar, is lying on a stretcher and has bruises painted on his abdomen. The pulse rate is 60 beats/min, the respiratory rate is 14 breaths/min, and, although the blood pressure is reported to be 90/60 mm Hg and decreasing, the patient is warm and seems to have normal circulation. The patient winces during attempts to examine his abdomen, whereas the chest examination reveals nothing abnormal. This case had me mystified.

A final example is a young man with HIV infection who presents with a bilateral infiltrate in the pulmonary region. The patient is well built, muscular, with no evidence of debilitating illness. His respiratory rate is 12 breaths/min, and chest auscultation gives normal results.

I question the value of such an examination in assessing the clinical competence of medical graduates. Furthermore, I believe that this examination makes a mockery of the art of clinical examination. The subtleties and nuances of the clinical examination can only be demonstrated with the use of genuine patients with real diseases. Surely there is no lack of clinical material and patients willing to participate in a well-structured clinical examination, an approach demonstrated to be valuable in assessing the clinical skills of undergraduate and postgraduate students

in Canada and in leading medical schools and colleges throughout the world.

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I am a frustrated postgraduate first-year intern in internal medicine at McMaster University, Hamilton, Ont. My anger is directed at the MCC. The council requires that I participate in the MCCQE Part II, an examination that has no bearing on my future practice of medicine.

Because I graduated from a Canadian medical school after 1992 I can no longer obtain a general licence to practise in Canada after 1 year of postgraduate clinical training. I must now complete at least 4 years of specialty training before I can become a fellow of the RCPSC, and I will be licensed in only my specialty. I will not be permitted to deliver babies, treat children or perform basic surgery.

The MCCQE Part II tests clinical skills in medicine, pediatrics, obstetrics, gynecology, psychiatry and surgery. The absurdity is that I have had no exposure, clinical or otherwise, to obstetric, gynecologic, psychiatric or surgical cases; my internship training does not give me these "basic" and "fundamental" experiences. How, then, can the MCC test these areas, in which I have had no experience and in which I will not be able to practise? I am growing cynical all too early in my finite career.

**Joel Ray, MD**  
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## Blood donation and HIV

**T**his letter (*Can Med Assoc J* 1994; 150: 12), by Dr. Milan A. Radivoyevitch, was interesting. He and I were colleagues in Cleveland and treated some of the same hemophiliac patients.

I and other physicians were the first to use  $\epsilon$ -aminocaproic acid

(EACA) for tooth extraction at the Cardeza Foundation, Jefferson Medical College, in Philadelphia,<sup>1</sup> to carry out a long-term prophylactic study of EACA in Cleveland<sup>2</sup> and to use it in minor<sup>3</sup> and major<sup>4</sup> surgery at St. Joseph Mercy Hospital, in Pontiac, Mich., and Wayne State University School of Medicine, in Detroit.

Over 22 years we treated 50 people with hemophilia, using EACA as an alternative not an adjunct to blood products. Because EACA cannot transmit HIV infection or hepatitis or induce inhibitors, which are common with the use of blood products, these problems never arose. Furthermore, we were always able to maintain satisfactory hemostasis.

Would the advocates of the use of blood products for hemophilia explain why they never use EACA as an alternative treatment?

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## References

1. Reid WO, Lucas ON, Francisco DMD et al: The use of epsilon-aminocaproic acid in the management of dental extractions in the hemophiliac. *Am J Med Sci* 1964; 248: 184-188
2. Reid WO, Hodge SM, Cerutti ER: The use of EACA in preventing or reducing hemorrhages in the hemophiliac. *Thromb Diath Haemorrh* 1967; 18: 179-189
3. MacPherson BH, Drayton NE, Reid WO: Surgical hemostasis in a hemophiliac using blockade of the inhibitor system. *Am J Surg* 1974; 40: 224-228
4. Reid WO, Henry RL, MacPherson BH et al: Hemostasis: the balance concept of procoagulant and inhibitor systems and use of the serial thrombin time (STT). *Med Hypotheses* 1948; 15: 169-183

## Male circumcision in Canada

**I** am astounded at Dr. Eike-Henner Kluge's article "Female circumcision: When medical ethics confronts cultural values" (*Can Med Assoc J* 1993; 148: 288-289) and

Dr. Mary E. Lynch's letter "Male and female circumcision in Canada" (*Can Med Assoc J* 1993; 149: 16). Kluge falsely equates male circumcision with clitoridectomy and then dismisses the former as having little medical value, and Lynch ridicules parents who think male circumcision will prevent phimosis or urinary tract infections (UTIs).

Wiswell and Hachey's<sup>1</sup> report of nine studies indicated that uncircumcised male infants are on average 12 times more likely to have a UTI. They found no contrary studies.<sup>1</sup> Some UTIs scar the kidneys and may result in end-stage renal disease.<sup>2</sup> As well, older uncircumcised males are at increased risk for UTIs.<sup>3</sup>

Penile cancer occurs almost exclusively in uncircumcised men. Meanwhile, the female sexual partners of men with penile cancer are at increased risk for cervical cancer.<sup>4,5</sup>

Fink<sup>6</sup> reviewed more than 50 studies showing that uncircumcised men are at increased risk for sexually transmitted diseases. Important African studies — some by Canadians — have demonstrated that uncircumcised heterosexual men have a fivefold to eightfold increased risk for HIV infection.<sup>7</sup> Moreover, a new US study has shown that uncircumcised homosexual men have a twofold increased risk for HIV infection.<sup>8</sup>

It is unfortunate that some provincial health insurance plans no longer cover prophylactic circumcision in male newborns and even more unfortunate that some doctors appear to be giving false information on the subject. Medical ethics dictates that new parents receive informed counselling about consent for and refusal of the procedure.

**Michael Jones**  
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## References

1. Wiswell TE, Hachey WE: Urinary tract infections and the uncircumcised state: an update. *Clin Pediatr (Phila)* 1993; 32: 130–134
2. Roberts JA: Does circumcision prevent urinary tract infections? *J Urol* 1986;

135: 991–992

3. Spach DH, Stapleton AE, Stamm WE: Lack of circumcision increases the risk of urinary tract infection in young men. *JAMA* 1992; 267: 679–681
4. Schoen EJ: The status of circumcision of newborns. *N Engl J Med* 1990; 322: 1308–1312
5. Rotolo JE, Lynch JH: Penile cancer: curable with early detection. *Hosp Pract* 1991; 26: 131–138
6. Fink AJ: *Circumcision: a Parent's Decision for Life*, Kavanah, Mountain View, Calif, 1988
7. Marx JL: Circumcision may protect against the AIDS virus. *Science* 1989; 245: 470–471
8. Kreiss JK, Hopkins SG: The association between circumcision status and human immunodeficiency virus infection among homosexual men. *J Infect Dis* 1993; 168: 1404–1408

[Dr. Kluge responds:]

Mr. Jones presents a one-sided picture of research into the medical appropriateness of male circumcision. To get another picture one should read Dr. Keith Morgan's letter (*Can Med Assoc J* 1993; 149: 1382–1383) and research cited by Poland.<sup>1</sup>

However, to continue citing opposing research results would merely be to engage in a battle of references without coming to grips with the central issue, as outlined by Morgan in his discussion of penile cancer, among other issues: Is it ethically appropriate to perform circumcisions because there is some statistical evidence that a potentially curable disease with a low incidence rate may be prevented by surgery, even though the disease also occurs in people who have undergone the surgery<sup>2</sup> and the incidence rate of the disease in countries where the surgery is not routinely performed is similar to that in countries where it is?<sup>3</sup>

If the answer to this question is Yes then the same underlying principle should be applied to all similar cases: whenever there is statistical evidence that a potentially curable disease or condition with a low incidence rate could be prevented by surgery, but the evidence also indicates that the incidence rate is the same in other countries where the

surgery is not routinely performed, we should still perform the surgery in every person in whom the disease or condition might develop. All sorts of medical conditions would be implicated. I suspect that we would be operating nonstop on just about every part of the human body if we took this stance. I shudder to think of the cost — and the implications for public health. The more appropriate action would be to investigate why the incidence rate of the disease or condition differs between countries.

Even if further investigation corroborated the results of studies Jones cites on the risk of HIV infection among uncircumcised men, the very mention of this issue in this context is disturbing. Because condoms are good protection against HIV infection the transmission rates among circumcised and uncircumcised men using condoms should be the same. Therefore, Jones must be talking about transmission rates among men who do not use condoms. It is universally agreed that unprotected sexual intercourse is inappropriate. The sexual transmission of HIV will be retarded or stopped not by circumcising males but, rather, by appropriate sexual behaviour. To suggest that all men be circumcised so that some who engage in irresponsible sexual behaviour will have a lower rate of HIV transmission runs the risk of encouraging such behaviour among circumcised men. Is that appropriate?

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## References

1. Poland RL: The question of routine neonatal circumcision. *N Engl J Med* 1990; 322: 1312–1315
2. Boczek S, Freed S: Penile carcinoma among circumcised men. *N Y State J Med* 1979; 79: 1903–1904
3. Waterhouse J, Shanmugaratnam K, Muir C et al: Cancer incidence in five continents. *IARC Sci Publ* 1982; 4: 750–751