two national certifying bodies all physicians who are licensed to practise medicine in Canada should possess and demonstrate those general medical competencies deemed essential for the independent practice of medicine, and (b) these competencies should be objectively evaluated at the time of application for licensure or as near as possible to that event.

The FMLAC accepted the premise that this body of general medical competencies might be acquired through residency programs accredited by either the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada (RCPSC) and, therefore, that no other preregistration program need be completed. However, the FMLAC has never supported the view that these competencies are adequately developed by the conclusion of undergraduate medical education. Indeed, I know of no credible medical organization that would support that premise. It hardly seems logical that an examination designed to assess an applicant's fitness for entry to medical practice should be applied at the conclusion of undergraduate medical education.

Whether all the general competencies essential to independent medical practice are adequately covered in the final examinations of the CFPC and the RCPSC or whether the new MCC examination will evaluate competencies distinct from these will probably not be known for some years. However, if there is evidence of examination overlap between Part II and the national certifying examinations the CFPC and the RCPSC could logically discontinue any efforts to examine those areas of overlap.

The FMLAC had originally proposed that Part II be conducted in the spring, so that applicants for primary care practice could take it with the certification examinations of the CFPC. This would have reduced examinee travel costs and minimized disruption of the educational process. The federation eventually agreed that Part II should be set back to the fall, so that unsuccessful candidates would have an opportunity to retake the examination the following spring.

The medical licensing authorities (except in Quebec) have offered full assurance of national portability to applicants who acquire the enhanced licence of the MCC and certification from either the CFPC or the RCPSC; they will maintain an option for applicants to acquire some form of medical licensure if they obtain the enhanced licence but not certification. That point is critically important, because it clarifies that medical licensure is not inextricably linked to certification, whereas national portability of licensure is.

It is also important to remember that the medical licensing authorities and the public do not have any input into or control over the certification examinations offered by the CFPC and the RCPSC. Because of the governance structure of the MCC both these interest groups do have input into and control over MCC examinations.

As the chief executive officer of a medical licensing authority directly accountable to the public for the competence of licensed physicians, I believe it is critically important that all licensees demonstrate a common standard of clinical competence before licensure for independent practice. A clinical skills examination applied at the end of undergraduate medical education would necessarily be structured to measure skill levels that could reasonably be expected of a student near the conclusion of the clinical clerkship. Such a skill level is quite different from that expected of a physician seeking licensure for independent medical practice. For that reason the Part II examination offered at the conclusion of undergraduate medical education would not meet the needs and expectations of the medical licensing authorities in Canada.

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Dr. Maudsley should perhaps be applauded for his recent editorial, in which he suggests that the Part II examination should be given along with Part I, at the end of the 4th year of medical school. From the perspective and reasoning that he presents it seems easy to see that Parts I and II should be administered together.

However, the MCC had initially suggested that the purpose of the examinations was to evaluate the competence of all physicians for general medical health care in Canada.[1] Maudsley comments that Part II is redundant and ill-advised in its currently proposed timing, but he goes on to conclude that it should be given instead with Part I, at the end of the clerkship. I challenge that conclusion.

The general clinical competence of physicians-to-be should logically be of great concern to all Canadians. Nevertheless, does a pathologist need to be able to communicate and establish rapport with a patient? Does a psychiatrist need to know how to perform a pelvic examination and address the concerns of the woman about to be examined? If Maudsley rejects the notion that an examination given 15 months into residency training serves a serious purpose (except, perhaps, that of pump-priming the economy), then why should it serve any purpose at the end of the clerkship? The CFPC and the RCPSC are more than capable of assessing the academic adequacy of their

potential graduates. It is more appropriate (rationally, economically and logistically) to expand their role to encompass the assessment of their graduates' clinical competence as it relates to their chosen field. In fact, I would be surprised to discover that a clinically incompetent resident would ever be allowed to achieve licensure, even in the absence of Part II. For the almost extinct species of physician who will expect to achieve licensure through a third pathway, a comprehensive examination including components of Part II should obviously be passed.

If these recommendations were followed there would be no need for a separate — and, at over $1200 per examinee, costly — Part II examination.

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Reference

1. Des Marchais JE: Education and licensure: the Medical Council of Canada at the crossroads. *ACMC Forum* 1989; 22 (5): 9–12

[The author responds:]

I agree that physicians should possess general medical competence as well as more specific knowledge and skills in their chosen field. However, the time when these should be acquired and evaluated is at question. Much of the basic knowledge, skills and attitudes that define general medical competence can be acquired during undergraduate medical education and should be assessed at the end of that period. If this general competence should be assessed as close to the start of independent practice as possible, it does not make sense for specialty residents to take Part II 33 to 45 months before completion of training and certification. Also, for family medicine residents Part II, whether taken after 15 or 24 months of training, is probably redundant.

The FMLAC withdrew from specifically prescribing prelicensure training and accepted accredited training and certification by the national colleges. To place Part II at 15 months would influence specialty programs to incorporate specific clinical experiences aimed primarily at preparing residents to pass the examination. I agree that some broad-based experience in the earlier years of specialty training is desirable in many, if not all, RCPSC programs. Efforts are under way by the RCPSC to better define and broaden the core training in medicine and surgery. However, such experience should be integrated into the program curriculum as relevant to the discipline and be assessed by in-training evaluation and certification examinations.

Dr. Kendel suggests that the CFPC and the RCPSC not examine in areas that might be covered by Part II. Another option is to eliminate redundancy by concentrating on competencies to be achieved by the end of the undergraduate program. Postgraduate trainees practise medicine under supervision and are licensed to do so. Shouldn't trainees have their basic clinical skills assessed before embarking on this important part of their experience, in which they provide substantial direct patient care?

Provincial licensing bodies should retain the authority to license physicians whom they deem suitable but who have not achieved Canadian certification. However, to hold the Part II examination at a time that is inappropriate and redundant for the great majority of trainees who will be certified is unsound.

The argument that the training and certification processes of the CFPC and the RCPSC lack public input and therefore the licensing bodies must maintain their autonomy by preserving an examination independent of certification is specious. Provincial licensing bodies for many years have accepted CFPC and RCPSC certification as a qualification for licensure. Recently the FMLAC and the MCC, acting in the public interest, have chosen these qualifications as *the* standards for licensure in Canada.

Part II is an important and positive step in the assessment of our medical graduates and is complementary to Part I. It is the timing and the role of Part II that I question.

Dr. Alibhai contends that we should not assess basic clinical competence using a national standard at the time of graduation of the undifferentiated physician but, rather, rely on the national colleges to assess the academic adequacy of their certificants.

I believe that all graduating physicians should possess competencies such as communication skills and the ability to perform a pelvic examination. The knowledge base common to all graduating physicians has been assessed for many years by the written examinations of the MCC. What is needed is a complementary and coincident assesssment, against a national standard, of basic clinical skills and attitudes. I agree that the assessment of discipline-specific knowledge, skills and attitudes is best left to the national colleges.

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Abortion debate continues

Having read "Canadians' access to abortion still limited, activists argue," by Michel Martin (*Can Med Assoc J* 1992; 147: 497–499), I am concerned that a medical journal