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Medical Council of Canada MCCQE

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Exam**



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Question: 1

A 33-year-old man with severe bacterial meningitis is intubated and unresponsive in the Intensive Care Unit. If he receives immediate treatment, his prognosis is excellent. If he does not, he will likely die. Three years ago, the patient had Huntington disease diagnosed, but he has been asymptomatic since then. His advance directive, which was made before this hospitalization, states that he should be allowed to die if he contracts a life-threatening illness. His parents demand that he be treated for the meningitis. Which one of the following is the best next step?

- A. Ask for a current mental capacity assessment
- B. Initiate treatment, using the parents as substitute decision-makers
- C. Consult a second physician for an opinion on emergent treatment
- D. Order an electroencephalography
- E. Do not provide any treatment other than comfort measures

Answer: E

Explanation:

Comprehensive and Detailed Explanation:

An advance directive is a legally binding document that outlines a competent person's preferences regarding future medical care. If the patient clearly stated a refusal of treatment in the event of a life-threatening condition, this directive must be followed, even if the patient is currently incapacitated and family disagrees.

Toronto Notes 2023 – Ethics and Law:

“Advance directives must be respected when valid, clear, and applicable. Substitute decision-makers cannot override them.”

MCCQE1 Objectives (ELOM > 90-4: Informed Consent and Advance Directives):

“Candidates must apply valid advance directives to guide care for incapacitated patients.”

B (parents as SDMs) is incorrect if an advance directive exists. A and D are irrelevant—capacity has already been documented. C is unnecessary when an advance directive is clear.

Question: 2

A 63-year-old man is brought to the Emergency Department by ambulance after he injured his abdomen. While working on a house, he fell 1 m from a scaffold and landed on a metal pipe. He is clinically stable but reports localized abdominal pain. On examination, he has a 17-cm laceration to his abdomen in the left hypochondrium. The laceration is 4 cm deep, but there is no fascial laceration. Which one of the following is the best next step?

- A. Primary repair of the laceration.
- B. Abdominal computed tomography.
- C. Surgical debridement and delayed closure.

- D. Antibiotic irrigation of the wound.
- E. Exploratory laparotomy.

Answer: A

Explanation:

This patient has a traumatic abdominal wall laceration but is hemodynamically stable, and importantly, there is no fascial violation. MCCQE objectives emphasize that the key determinant in abdominal trauma is whether the peritoneum/fascia has been breached, as this determines the risk of intra-abdominal injury. In the absence of fascial penetration and with stable vital signs, the injury is limited to the soft tissues of the abdominal wall.

Therefore, the appropriate management is local wound care and primary repair after adequate irrigation and assessment. Abdominal CT or exploratory laparotomy is not indicated because there is no evidence of peritoneal violation or intra-abdominal injury. Surgical debridement with delayed closure is typically reserved for grossly contaminated wounds or high infection risk. Antibiotic irrigation alone is insufficient without proper closure.

Thus, for a stable patient with a superficial abdominal wall laceration that does not penetrate fascia, primary repair is the correct next step.

Question: 3

A physician attending a sporting event with his family provides emergency treatment to a 65-year-old man who suffers a seizure followed by a cardiac arrest. The patient is successfully resuscitated by the physician on the scene and transported to a hospital, where he is found to have critically low blood sugar and subsequently suffers irreversible brain damage. Which one of the following statements is most accurate?

- A. The physician's medical licence requires him to treat anyone in need.
- B. The physician had a legal duty to accompany the patient in the ambulance.
- C. The physician will be found negligent by the regulatory body.
- D. Professional ethics require physicians to render reasonable assistance to anyone in need.
- E. The Good Samaritan laws require physicians to provide care to anyone in need.

Answer: D

Explanation:

MCCQE objectives emphasize the distinction between ethical obligations and legal duties in emergency "Good Samaritan" situations. Physicians generally do not have a legal obligation to provide care outside of a formal physician-patient relationship, nor are they legally required to accompany a patient to hospital. Good Samaritan laws are designed primarily to protect healthcare providers from liability when they voluntarily provide emergency assistance in good faith and within the scope of their competence; they do not compel physicians to act.

Professional ethical standards, however, state that physicians should render reasonable assistance in emergencies, considering their own safety, competence, and available resources. This reflects the profession's commitment to beneficence and social responsibility. In this case, the physician appropriately provided emergency resuscitation. Subsequent poor outcome (irreversible brain injury

due to hypoglycemia) does not imply negligence if care was reasonable and provided in good faith. Therefore, the most accurate statement is that professional ethics require physicians to render reasonable

Question: 4

A 16-year-old girl presents to the clinic with concerns about her toenails. The lesions, as shown in the attached image, have been present for 2 to 3 months. She is otherwise healthy and is in training for a triathlon. Which one of the following is the best next step?

- A. Recommend that the patient's running shoes provide adequate toe space.
- B. Advise the patient to carefully wash and dry feet after all activity.
- C. Arrange for biopsy of the lesions.
- D. Suggest that the patient avoid swimming pools and hot tubs.
- E. Prescribe daily antifungal cream application.

Answer: A

Explanation:

In a healthy adolescent training for a triathlon, the most likely cause of subacute toenail changes is repetitive microtrauma from running—often due to shoes with inadequate toe box space or downhill running—leading to nail plate injury (e.g., subungual hemorrhage/onycholysis and dystrophic discoloration). MCCQE objectives emphasize choosing the most probable diagnosis based on context and initiating the least invasive, most appropriate first-line management. The key intervention is correcting the mechanical cause: ensuring adequate toe space, proper shoe fit, and appropriate nail trimming, which typically prevents progression and allows gradual regrowth over months. Topical antifungal creams are unlikely to help if the primary issue is trauma and, even in onychomycosis, topical creams generally do not penetrate the nail plate effectively. Hygiene advice and avoiding pools/hot tubs may reduce superficial fungal exposure but does not address the principal driver in this scenario. Biopsy is unnecessary for typical trauma-related nail changes in a low-risk patient without concerning features (rapid growth, pigment extending onto adjacent skin, or mass).

Question: 5

A 26-year-old woman, gravida 1, para 0, aborta 0, consults you at 36 weeks' gestation regarding newborn care. She has HIV. Which one of the following is the best advice regarding reducing the risk for transmission of HIV to her newborn?

- A. Bottle-feed her newborn boiled expressed breast milk.
- B. Avoid kissing her newborn.
- C. Formula-feed her newborn.
- D. Bottle-feed her newborn expressed breast milk.
- E. Breastfeed her newborn during the colostrum period only.

Answer: C

Explanation:

In Canada and other high-resource settings where safe alternatives are readily available, women living with HIV are advised to exclusively formula-feed their infants to eliminate the risk of postnatal HIV transmission through breast milk. HIV can be transmitted during pregnancy, delivery, and breastfeeding. While effective maternal combination antiretroviral therapy and neonatal prophylaxis significantly reduce perinatal transmission risk, breastfeeding still carries a residual risk because HIV is present in breast milk. Boiling expressed breast milk is not recommended as a standard preventive strategy in high-resource settings. Avoiding kissing is unnecessary, as casual contact does not transmit HIV. Breastfeeding only during the colostrum period does not eliminate transmission risk. According to MCCQE objectives, physicians must provide evidence-based counseling regarding prevention of vertical transmission, including maternal antiretroviral therapy, appropriate mode of delivery when indicated, neonatal prophylaxis, and avoidance of breastfeeding when safe formula feeding is accessible. Clear counseling supports informed decision-making and optimal neonatal outcomes.

Question: 6

You are caring for a 17-year-old girl who has end-stage renal disease. She is receiving dialysis at the hospital 3 times a week. She requests medical assistance in dying (MAID). Which of the following is the best next step?

- A. Inform the patient that she will need parental consent to be assessed for MAID.
- B. Explain to the patient that she is not terminally ill.
- C. Refer the patient to a psychiatrist.
- D. Suggest a trial of home dialysis.
- E. Explore the reasons for the patient's request for MAID.

Answer: E

Explanation:

The first step in any MAID request is to explore the patient's motivations, psychosocial concerns, and mental health status. The request should be taken seriously and approached with compassion. Exploring the reasons is essential to determine eligibility and to distinguish suffering from other potentially treatable issues (e.g., depression, loss of hope).

Toronto Notes 2023 – ELOM, " Medical Assistance in Dying " :

"Upon receiving a request for MAID, the physician must first explore the patient's motivations, ensure understanding of their condition, and assess for coercion, depression, or other treatable factors."

MCCQE1 Objectives (ELOM > Ethical Dilemmas > End-of-Life Care):

"Candidates must demonstrate understanding of the ethical and legal framework surrounding MAID and respond appropriately to requests by exploring reasons and providing necessary support and referrals."

MAID is available to mature minors in some jurisdictions but not uniformly. Assuming the patient is ineligible or redirecting to other treatments without discussion is inappropriate.

Question: 7

A 59-year-old woman is referred to you because of a 2-month history of left nipple discharge. She is otherwise healthy and is not on any medication. There are no palpable lesions on breast examination.

She is able to express a small amount of blood-tinged liquid from her breast. Which one of the following would be the best next step?

- A. Biopsy of nipple complex.
- B. Mammography.
- C. Serum prolactin.
- D. Galactography.
- E. Magnetic resonance imaging of breast.

Answer: B

Explanation:

Spontaneous, unilateral, blood-tinged nipple discharge in a postmenopausal woman is considered pathologic and warrants imaging to rule out intraductal pathology including malignancy. The best initial test is diagnostic mammography, often with ultrasound if indicated.

Toronto Notes 2023 – Breast Disorders:

“Unilateral, spontaneous, bloody nipple discharge should be evaluated with mammography and targeted ultrasound. Further tests such as MRI or duct excision are based on findings.”

MCCQE1 Objectives (Gynecology > 81-1: Breast Conditions):

“Candidates must recognize red flags for breast malignancy and apply appropriate initial diagnostic imaging.”

Serum prolactin (C) is indicated in galactorrhea. Galactography (D) and MRI (E) are second-line. Biopsy (A) is premature without imaging.

Question: 8

A 29-year-old woman presents with vaginal spotting after 6 weeks of amenorrhea. She is asymptomatic otherwise. Serum β -hCG is 2150 IU/L, and pelvic ultrasound shows an empty uterus. She has been trying to conceive for 7 months. Which one of the following is the best next step?

- A. Repeat pelvic ultrasonography in 10 days.
- B. Perform dilatation and curettage for chorionic villi.
- C. Administer intramuscular methotrexate.
- D. Arrange exploratory laparoscopy.
- E. Repeat serum β -hCG test in 48 hours.

Answer: E

Explanation:

An empty uterus with β -hCG > 1500–2000 IU/L raises concern for a pregnancy of unknown location (PUL), including the possibility of ectopic pregnancy. However, the patient is hemodynamically stable and asymptomatic. In such cases, the best initial step is to repeat serum β -hCG in 48 hours to assess the rise or fall of hCG levels.

Toronto Notes 2023 – Obstetrics, " First Trimester Bleeding " :

“If β -hCG > 1500 IU/L and no intrauterine pregnancy is visualized on ultrasound, repeat β -hCG in 48 hours to determine rise or decline. A suboptimal rise (less than 66%) suggests ectopic pregnancy.”

MCCQE1 Objectives (Obstetrics > 79-1: Early Pregnancy Complications):

“In a patient with early pregnancy bleeding, the candidate must interpret quantitative β -hCG trends to distinguish ectopic pregnancy, miscarriage, or viable intrauterine pregnancy.”

Immediate administration of methotrexate or invasive procedures such as D & C or laparoscopy are not appropriate until further diagnostic clarification is obtained.

Question: 9

A mother brings her 4-week-old daughter to your office because she is concerned about the lesion shown in the attached image. Which one of the following is the most appropriate advice to give the mother?

- A. You have a duty to report her to child protective services.
- B. The lesion will likely fade away with time.
- C. The child likely has a bleeding disorder.
- D. The child is at increased risk of malignant melanoma.
- E. The child should be referred to a dermatologist.

Answer: B

Explanation:

In a 4-week-old infant, a common vascular lesion such as a nevus simplex (“salmon patch”) or a superficial infantile hemangioma is a frequent benign finding. Nevus simplex lesions are flat, pink-red patches commonly located on the eyelids, glabella, or nape of the neck and typically fade spontaneously over the first 1–2 years of life. Superficial infantile hemangiomas may initially enlarge but later undergo spontaneous involution during early childhood. In the absence of concerning features (rapid ulceration, functional impairment, large segmental distribution, or associated anomalies), reassurance and observation are appropriate.

There is no indication of trauma requiring child protective services, nor signs of a bleeding disorder. These common neonatal vascular lesions are not associated with increased melanoma risk. Routine dermatology referral is unnecessary unless the lesion is atypical or complicated.

MCCQE objectives emphasize distinguishing benign neonatal skin findings from pathology, providing parental reassurance, and avoiding unnecessary investigations or referrals while recognizing features that would warrant further evaluation.

Question: 10

A 45-year-old woman presents to the emergency department after being involved in a motor vehicle collision. She reports severe right hip pain. On examination, the right hip is flexed and adducted. A radiograph shows a posterior dislocation. Which one of the following is the most appropriate management?

- A. Closed reduction under sedation.
- B. Open reduction under general anesthetic.
- C. Gradual reduction with skeletal traction.
- D. Total hip arthroplasty.

Answer: A

Explanation:

A posterior hip dislocation is an orthopedic emergency . The classic position is a shortened limb held in flexion, adduction, and internal rotation after high-energy trauma. MCCQE objectives emphasize immediate recognition and urgent management to prevent complications, especially avascular necrosis (AVN) of the femoral head and sciatic nerve injury . The key treatment is prompt closed reduction (ideally within hours) under procedural sedation or anesthesia, after appropriate analgesia and neurovascular assessment. Post-reduction priorities include confirming concentric reduction with imaging, repeating a neurovascular exam (particularly sciatic nerve function), and evaluating for associated fractures (acetabular or femoral head/neck) that may require CT and possible operative management.

Open reduction is reserved for irreducible dislocations, incarcerated fragments, or associated fractures preventing stable closed reduction. Skeletal traction is not definitive acute management. Total hip arthroplasty is not indicated as first-line in an acute traumatic dislocation in this context. Urgent closed reduction best aligns with time-sensitive limb- and joint-preserving care.

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