Related to this, the Cruesses ask how the medical common that I advocate[2] differs from the core curricula in use at present. The latter are preparatory to the uniform licensure that now is "required of all physicians entering medical practice in Canada."[3] Its underlying philosophy is that whereas "the human body appears to react to … insults in a finite number of ways," the examination is to cover "all of these ways" and, thereby, the "domain of medicine" in a comprehensive way.[4] Thus the aim still is to educate, and to license, only all-purpose — complete — physicians. By contrast, the medical common I advocate encompasses only that which truly is of common concern across all of the differentiated types of modern practitioner. This obviously involves only a very small fraction of all of the ways in which the human body reacts to insults. The concept is profoundly different, and so consequently are the curricular implications.

As for "what process might be utilized to actually identify 'the common,'" I'll just comment on pruning "the full clinical presentation list" of current concern in the licensing-oriented curricula.[5] One option is to convene representatives of the various types of specialized practice of modern medicine and to have them go down that list, each identifying the topics that truly would be relevant for professional self-cloning. I would expect that none of the 127 main types of clinical presentation on that list would turn out to be relevant to all types of practice.

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2. Miettinen OS. The modern scientific physician: 8. Educational preparation [editorial]. *CMAJ* 2001;165(11):1501-3.
3. Medical Council of Canada. *Objectives for the qualifying examination*. 2nd ed. Ottawa: The Council; 1999. p. ii.
4. Medical Council of Canada. *Objectives for the qualifying examination*. 2nd ed. Ottawa: The Council; 1999. p. iv.
5. Medical Council of Canada. *Objectives for the qualifying examination*. 2nd ed. Ottawa: The Council; 1999. p. 1-5.

Correction

In a recent *CMAJ* article on measles,[1] in the second column under the Prevention heading, the sentence that begins "The second dose should be given at least 3 months after the first" should instead begin "The second dose should be given at least 1 month (minimum 28 days) after the first."

Reference

1. Shapiro H, Weir E. Measles in your office. *CMAJ* 2001;164(11):1614.

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