

provincial evidence acts. The tone of this and similar articles suggests that the entire Canadian medical community experiences medical incidents and errors and that none of these problems is reported or analyzed because of fear of litigation.

This implication is incomplete and perhaps untrue. I cannot speak for other provinces, but in British Columbia the Evidence Act² protects from disclosure any reports and investigations of committees such as hospital morbidity and mortality committees.

Similarly protected by designation under the Act is the British Columbia Anesthesiologists' Society Critical Incident Reporting Service.³ This service is a patient safety and quality assurance program offered by BC anesthesiologists, the existence of which seems to have been overlooked by the authors of the original report.

I do not see fear of litigation as a barrier to establishing specific patient safety programs. Rather, there is a need to establish a supportive environment in which overly busy clinicians can reflect upon and analyze the quality and results of the care they provide. Such support will necessarily involve not only education on the value of self-analysis but also appropriate support facilities, with funding, staff, and access to tools and information. Such an undertaking will not be inexpensive.

Richard N. Merchant

Chairman, Patient Safety Committee
British Columbia Anesthesiologists'
Society
Vancouver, BC

References

1. Sibbald B. Reducing medical error: "People doing their best is not enough." *CMAJ* 2002;167(9):1047.
2. Evidence Act. R.S.B.C. 1996, c. 124. Available: www.qp.gov.bc.ca/statreg/stat/E/96124_01.htm (accessed 2002 Dec 2).
3. Patient safety: BCAS Critical Incident Reporting Service [online]. Burnaby, BC: British Columbia Anesthesiologists' Society; [no date]. Available: www.bcanesthesiologists.ca (accessed 2002 Dec 2).

[The author responds:]

I agree that it is incomplete and, indeed, untrue, to suggest that none

of Canada's incidents and errors is reported or analyzed because of fear of litigation. However, the fact remains that medical error is underreported in Canada.¹ The question is why. There are myriad reasons: the lack of a supportive environment is one, fear of legal reprisal is another. The Canadian Medical Protective Association has stated that people reveal medical errors at their legal peril because "there is no privilege [exemption from legal action] following disclosure."² Evidence acts come under provincial and territorial jurisdiction and therefore differ substantially. Changing this legislation would be an easier — and less expensive — approach to alleviating this problem, at least when compared with instituting supportive environments. Let's hope it's only the first of many steps.

Barbara Sibbald

Associate News Editor
CMAJ

References

1. Sibbald B. Reducing medical error: "People doing their best is not enough." *CMAJ* 2002;167(9):1047.
2. Sibbald B. Ending the blame game key to overcoming medical error. *CMAJ* 2001;165(8):1083.

Neuroradiologists and stroke

Stephen Phillips and colleagues¹ are to be congratulated for organizing and developing an acute stroke unit in Halifax and for describing the contributions that such units can make to the care of stroke patients. Halifax is well served by its unit, which is an example for Canada and the world.

However, the article omitted mention of one important group of medical specialists. Neuroradiologists have participated in stroke management in Canada for decades, and skilled neuroradiologists and the neuroimaging they perform are integral to the management of stroke, both acute and chronic. Up-to-date diagnostic and interventional neuroradiology procedures and well-trained neuroradiologists are needed for stroke care as we now know

it, including the care of patients in acute stroke units.

Phillips and colleagues¹ list the important contributions of 13 professional groups to their model stroke unit. This list mentions food and nutrition services, research assistants and spiritual care, but not neuroradiology. Perhaps neuroradiologists have come to be appreciated in the same way as an institution's walls and its plumbing — absolutely necessary, always available, excellent and reliable.

Allan J. Fox

Department of Neuroradiology
Sunnybrook and Women's College
Health Sciences Centre
Toronto, Ont.

Reference

1. Phillips SJ, Eskes GA, Gubitz GJ, on behalf of the Queen Elizabeth II Health Sciences Centre Acute Stroke Team. Description and evaluation of an acute stroke unit. *CMAJ* 2002;167(6):655-60.

[Two of the authors respond:]

We regret that some radiologists may feel slighted because their specialty was not explicitly listed among the members of our acute stroke team.¹ We agree that radiologists, and neuroradiologists in particular, play an important and expanding role in the diagnosis and treatment of stroke.

We are pleased to have a close working relationship with the radiologists in our department of diagnostic imaging. Radiologists have been helpful in improving our ability to deliver care in a timely manner. Although waiting for a scan may be a rate-limiting step in the administration of tissue plasminogen activator, our protocol specifies that any candidate for such treatment is next in line for CT. We also have a rapid carotid Doppler ultrasonography service, so patients can be scanned immediately if they present to the emergency department during the day (the next day, including weekends, if they present after hours).

Our interventional neuroradiologists, in collaboration with neurosurgery and neurology specialists, treat aneurysms and arteriovenous malfor-

mations. We seldom use intra-arterial thrombolysis for acute ischemic stroke and do not perform angioplasty and stenting for carotid or vertebral basilar occlusive disease, because of persisting uncertainty about the efficacy of these interventions.

We hope that this letter helps to clarify the role that our radiologists play in the management of stroke patients.

Gordon J. Gubitz
Stephen J. Phillips

Division of Neurology
Department of Medicine
Dalhousie University and Queen
Elizabeth II Health Sciences Centre
Halifax, NS

Reference

1. Phillips SJ, Eskes GA, Gubitz GJ, on behalf of the Queen Elizabeth II Health Sciences Centre Acute Stroke Team. Description and evaluation of an acute stroke unit. *CMAJ* 2002;167(6):655-60.

Pharmacists helping physicians

The report by Catherine Lemièrè and colleagues¹ raising concerns about Health Canada's approval of a new indication for Advair (a combination of fluticasone propionate and salmeterol) contains the following important sentence: "In a health care system that is already struggling with the increasing cost of medication, it is our responsibility to avoid prescribing expensive drugs without evidence of their superiority over the standard treatment." If every physician hung that sentence on his or her wall and looked at it before pulling out a prescription pad, would prescribing behaviour necessarily change?

I believe that doctors in practice should not be getting all or most of their information from drug manufacturers and their representatives. There is an opportunity for community pharmacists to take a much greater role in training groups of physicians about the appropriate use of new drugs and in discussing issues such as determining when old drugs should be "retired."

Most physicians have poor knowledge of the costs of the drugs they prescribe, and pharmacists could be a valuable resource for more information in this area as well. This enhanced role for community pharmacists has already been suggested in some models of primary care reform.²

Denise Bowes

Family Physician (Retired)
Athens, Ont.

References

1. Lemièrè C, Becker A, Boulet LP, Bowie D, Cartier A, Cockcroft D, et al, for the Asthma Committee of the Canadian Thoracic Society. Should combination therapy with inhaled corticosteroids and long-acting β_2 -agonists be prescribed as initial maintenance treatment for asthma? [editorial] *CMAJ* 2002;167(9):1008-9.
2. Rachlis M, Kushner C. *Strong medicine: how to save Canada's health care system*. Toronto: Harper Collins Canada; 1995.

Dr. Farmer deserved better

I read your recent death notice for Dr. Alfred Farmer¹ with dismay and incredulity. There are no inaccuracies in your report, only regrettable omissions.

"Farm," who graduated from the University of Toronto in 1927, was a

founder of plastic surgery in both Canada and the US and a member of the American Association of Plastic Surgery, the oldest organized body of its type in the world. He was also a founding member of the Canadian Society of Plastic Surgeons and is considered the father of Canadian hand surgery — now a sophisticated subspecialty.

As surgeon-in-chief at the Hospital for Sick Children for 10 years, he reorganized the department into the 7 divisions we are familiar with today. In World War II he was chief surgical consultant with the Royal Canadian Air Force. His work was recognized by his appointment to the Order of Canada and as an honorary surgeon to the Queen. He was also awarded Member of the Order of the British Empire.

As must be evident, your brief paragraph concerning this great man was regrettably inadequate, and I cannot allow it to pass without comment.

Barry Shandling

Professor of Surgery (Emeritus)
University of Toronto
Toronto, Ont.

Reference

1. Deaths. *CMAJ* 2002;167(11):1312.

Pour écrire à la rédaction

On peut envoyer une lettre à la rédaction par notre site web, par la poste, par messenger, par courriel (pubs@cma.ca) ou par télécopieur. Les lettres doivent compter au plus 250 mots et être signées par tous les auteurs. Les lettres se rapportant à un article publié dans le *JAMC* doivent nous parvenir dans les 2 mois de la publication de l'article en question. Le *JAMC* ne correspond qu'avec les auteurs des lettres acceptées pour publication. Les lettres acceptées seront révisées et pourront être raccourcies.

Cyberlettres

Nous encourageons les lecteurs à écrire à la rédaction par le service Cyberlettres de notre site web (www.jamc.ca). Nous visons à publier au plus tard le jour ouvrable suivant les lettres qui apportent une contribution importante à la discussion. Les lettres électroniques seront annexées à l'article pertinent du *JAMCél* et on pourra les publier dans la version imprimée du *JAMC*. Pour envoyer une lettre électronique (cyberlettre), cliquez sur «Lettres électroniques : répondre à cet article» à la droite du texte HTML de tout article du *JAMCél*.