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 Act[2] 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.

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[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.

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Neuroradiologists and stroke

Stephen Phillips and colleagues[1] 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 colleagues[1] 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.

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[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-