

Correspondance

Sanmugasunderam and Romanchuk state that our program is "just a consensus model." We would argue that the consensus component of the model is an integral reason for its success. It was through consensus that we agreed upon the criteria to measure. We then selected the most objectively validated tools and agreed upon a relative scoring system. Another jurisdiction might go through the same process and come up with different criteria or a different scoring system. We feel that surgeons are more likely to accept the process if they have been involved in creating it.

Lorne Bellan

Misericordia Health Centre
Winnipeg, Man.

Mathen Mathen

Misericordia Health Centre
Winnipeg, Man.

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Burgeoning career opportunities in radiation oncology

Four years ago *CMAJ* reported that residents training in radiation oncology were experiencing difficulty securing career staff positions in Canada and were seeking employment elsewhere, while others were leaving the specialty before completing training.¹ Currently, approximately 60 funded staff positions in radiation oncology are vacant and specialists are being recruited actively outside Canada by a number of provinces.² The Royal College of Physicians and Surgeons of Canada has recently revised its regulations to once again allow physicians in this specialty to have postgraduate training obtained outside North America assessed to determine their eligibility to sit Royal College examinations and ultimately obtain Canadian certification.

There are approximately 275 funded radiation oncology staff positions at 33 cancer treatment centres across Canada. This represents an increase of more than 60 positions in the last 4 years, including 35 in Quebec alone.³ Attrition from the specialty is between 3% and 4% per year. Trends for the past 15 years show that the number of patients being treated by radiotherapy has increased by approximately 4% per year.⁴ This rate is unlikely to change in the next 10 years.

Once the shortfall of 60 radiation oncologists is eliminated, Canada will need approximately 25 of these specialists per year to account for attrition and increasing need. However, for the next 4 years an average of only 14 residents will complete training each year. It is unlikely that this shortfall can be made up simply by offshore recruiting because other countries are experiencing similar problems. It is quite clear that for the foreseeable future, Canadian trainees in radiation oncology will have employment opportunities across the country.

This letter is to affirm to medical school graduates that the specialty will

provide good career opportunities for trainees for many years to come.

Robert G. Pearcey

President
Canadian Association of Radiation
Oncology
Edmonton, Alta.

Donald B. Carlow

CEO
Canadian Association of Provincial
Cancer Agencies
Vancouver, BC

Andrew Padmos

Commissioner
Cancer Care Nova Scotia
Halifax, NS

Kenneth Shumak

President and CEO
Cancer Care Ontario
Toronto, Ont.

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National stroke surveillance program needed in Canada

The Canadian Stroke Systems Coalition is to be congratulated on developing recommendations for creating a systems approach to stroke care in Canada.¹ Implementation of the recommendations should considerably reduce Canada's stroke burden.

To better understand the national stroke demographics and to monitor the actual impact of programs and research will require emphasis not only on monitoring of stroke risk factors as proposed by the Canadian Stroke Systems Coalition, but also on surveillance of stroke care, stroke incidence and stroke mortality. National stroke surveillance would allow us to develop an overall picture of stroke in the Canadian population, do time trend analyses, better ex-

plore the geographic distribution of stroke and better understand stroke risk and care in important subpopulations.

Such a surveillance system would help to guide policy decisions concerning programs and research for specific populations, in ways that research targeted to the science of the disease generally cannot. We recommend that a national stroke care, incidence and mortality monitoring system be given a high priority as an integral part of a full systems approach to reducing the burden of stroke in Canada.

Kenneth C. Johnson

Surveillance and Risk Assessment
Division
Centre for Chronic Disease Prevention
and Control
Population and Public Health Branch
Health Canada
Ottawa, Ont.

Yang Mao

Surveillance and Risk Assessment
Division
Centre for Chronic Disease Prevention
and Control
Population and Public Health Branch
Health Canada
Ottawa, Ont.

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Update from the Canadian Stroke Consortium

In July 2000 *CMAJ* published a brief commentary by us on behalf of the Canadian Stroke Consortium concerning our current national study of stroke following cervical arterial dissection.¹ The goal of the study was, and still is, to determine the relationship of extreme head movements and other forms of head and neck trauma to dissection of the neck arteries and stroke. Therapeutic neck manipulation, performed usually for the relief of neck pain and mostly by chiropractors, is associated with only 20% of the cases of

dissection and stroke in our study.

We quickly received a large volume of email messages and faxes, mainly hostile and mainly from chiropractors. Trial by radio, television and print media was also swift, but the press coverage was generally favourable. However, “sides” were clearly declared. The study was vilified for not having “controls” and for being unscientific in general, and we were criticized for publishing results prematurely.

We have repeatedly protested that this is a collaborative national study (not a “Toronto study”) conducted to collect basic descriptive data on this underreported cause of stroke in young people. Data from the consortium and from centres in other countries consistently confirm dissection of neck arteries to be the major cause of stroke in young people.^{2,3} After our commentary was published, a case-control study showed that patients below 45 years of age with vertebrobasilar stroke were 5 times more likely than controls who had not had a stroke to have visited a chiropractor in the week before the event.⁴

Compared with a retrospective study design, the prospective nature of our study allows much more accurate evaluation of the role of trivial trauma in the occurrence of stroke and determination of the frequency of stroke recurrence in the acute phase, which may facilitate development of better therapies. We post data on our Web site as we accumulate it so that it is accessible to all.

Collaboration with our chiropractic colleagues is crucial to understanding and resolving the association between sudden neck movement and stroke. Blanket denial or distortion of our data from various quarters can only delay discovery of the necessary facts at the expense of the well-being of patients.

John W. Norris

Professor of Neurology
University of Toronto
Toronto, Ont.

Vadim Beletsky

Clinical Fellow
Division of Neurology
University of Toronto
Toronto, Ont.

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[Editor's note:]

Articles on arterial dissection following cervical manipulation appear on pages 905 and 907 in this issue.

If it looks like a cow and moos like a cow ...

Canadian medicare is really a medical care insurance plan, run by an arm of government acting as an insurance agency. The government charges the population to recover its costs, and calls this charge a “tax.” But is this really a tax?

Some would argue that it is an insurance premium — if the beast gives milk, chews its cud and moos, it is a cow, regardless of what name you give it. In this case, the premium is bundled in with your income tax. However, honesty and full disclosure require itemization of this “income tax.” (I am not referring to the direct, picayune medicare premiums charged in some provinces.)

The first item would read “income tax” and the second “medicare premium.” You would be required to sum the 2 and pay the total to the receiver general. Then, at least, you would know what medicare actually costs you.

Canadian governments are the equivalents of the private health insurance companies in the United States. In both countries there is a contract between insurer and insured. There is a slight difference in this contract but it is insignificant. In the United States it is explicit. In Canada it is implicit, but nonetheless exists because of our premium (“tax”) payments to government.

In the United States there is consid-