service programme for graduating physicians. However there is room for imaginative incentive programmes to retain physicians in rural areas such as the one adopted in Ontario, Canada (**http://www.oma.org/cme/**)

In targeting the vital registration system, the statistical organisation should activate and formalise the dormant medical assessor and querying systems. The automatic selection of underlying cause of death does not work for all cases. Some cases are rejected by the system. Such cases could be queried with physicians and/or referred to the medical assessor. In Australia, the Australian Bureau of Statistics (ABS) has an in-built query subsystem in their cause-of-death processing system. In that subsystem, information from rejected forms is automatically outputted onto a standard form and posted to the relevant physician for querying.

The statistical organisation should be encouraged to conduct periodic evaluation of internal consistency among medical coders and undertake occasional external review of all steps of the coding process.

Further, the statistical organisation should be encouraged to continue strengthening in-house and external training of nosologists and place value on long service. Good-quality nosologists are very hard to get and the available ones should be valued and used to train new recruits.

Lastly, the statistical organisation should be encouraged to make full cause-of-death data available to researchers as done elsewhere. Limited demographic information on cause-of-death data can only lead to limited analyses. Researchers need to get all the non-confidential information (everything else beside name, ID number and physical address) in order to pinpoint the problem areas in data quality and do further analysis on the data.

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## Myths, magic and medicine

**To the Editor:** I found your editorial with the above title[1] extremely interesting and thought-provoking. Indeed, patients in virtually every health care discipline consult such providers

with an element of belief. Without belief in the ability of the doctor to aid in a time of health crisis, the task of caring for such patients would often be more difficult. As such we need to accept and respect this aspect of health care.

I agree with you that many practices are based entirely on a so-called 'belief system', but I must question your inference that chiropractic is another one of these belief systems. Today there is so much evidence in support of chiropractic and the value of such care – here I refer to our 'Open letter to the medical profession' in the May issue of the *SAMJ* (p. 293).

In the interests of professional bridge-building, and ultimately the welfare of the patients we serve, I sincerely trust that you will take a fresh look at our profession. I believe we can progress towards a point where we can interrelate and respect each other with greater understanding, and without the bias and misrepresentations of the past. Perhaps we could even discuss some of these developments soon over a cup of coffee.

**Reg Engelbrecht**

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1. Van Niekerk JP. Myths, magic and medicine (editorial). *S Afr Med J* 2005; **95:** 447-448.