approved by several staff physicians, and history-taking and physical examination also helped to rule out contraindications to massage therapy as well as the presence of exclusion criteria. Ancillary tests are appropriate when indicated and should not be routine.[3]

Sedergreen was also concerned about the potential influence of the nonblinded providers of sham laser treatment. This was not reported as a double-blinded study, nor was double blinding feasible. One finding not in the published report was that at post-test, 8% of the subjects in the sham laser group indicated that they had no pain as compared with 5% in the exercise and education group. Both providers of the exercise and education believed exercise to be an effective remedy for subacute low back pain. In this study there is no clear link between the nonblinded treatment provider and subjects' self-reported outcomes.

It is true that medication use was not considered during randomization; however, only 6 subjects indicated analgesic use and they were fairly evenly dispersed among the 4 groups. Each of these 6 subjects scored within the 95% confidence interval of their group mean at each time.

In terms of secondary gain, the case histories revealed that no patients were receiving disability payments or compensation for their low-back pain, and this issue was thus not mentioned.

Regarding interaction, this study revealed that some part of the interaction between massage therapist and patient is beneficial within a specified treatment protocol. It was not within the scope of this study to determine the mechanism of remediation.

This study provided some evidence of the effectiveness of massage therapy for some patients with subacute low-back pain. One randomized controlled trial cannot provide conclusive evidence for treatment effectiveness; more research is clearly needed.

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Legalization of drugs not the answer

We disagree with a recent *CMAJ* article calling for "decriminalization of possession of small amounts

of drugs for personal use."[1] It is pure fantasy to believe that all problems would magically disappear if we just legalized narcotics.

Almost daily in our practices we see the consequences of misusing a drug that is legal, readily available, often socially acceptable and relatively cheap: alcohol. Its costs are well documented in an article in the same issue.[2] How would society be well served by the addition of yet another legal intoxicating drug?

As always, the devil is in the details. What is meant by "small amounts"? By "personal use"? How would this be verified? Which "drugs"? Marijuana? Morphine? Cocaine? Heroin? Where would clients obtain these "drugs"? Pharmacies? Government-run stores with the same ambience and level of customer-friendly service as government-run liquor outlets? Corner grocery stores? Internet shopping? How would costs be set? What about driving after marijuana use? Is there a Breathalyzer test for marijuana?

It is a lot easier to write commmentaries for *CMAJ* than it is to achieve the undescribed and unreferenced "risk-reduction strategies," "pragmatic prevention" and "rehabilitation" for substance abusers outlined in this article.[1]

Catherine Hankins should reconsider before she advocates providing society with easier access to yet another intoxicating drug. Drugs are not bad because they are illegal. Drugs are illegal because they are bad.

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[The author responds:]

In arguing that drugs are illegal because they are bad, Gordon Brock and Vydas Gurekas seem to assume that drug laws are based on thoughtful consideration of relative harms. In fact, the history of drug law development in Canada more reflects racist views of drug consumption than concern with public protection. Opium, which was favoured in Canada by the middle and upper classes and available in a variety of over-the-counter medications, was made illegal by the 1908 Opium Act, which was directed at Chinese immigrant workers.[1] Much of the impetus to make marijuana illegal in 1923 had

xenophobic overtones as its use was linked to Mexican farm workers in the United States.[2] Use of currently legal drugs such as alcohol and tobacco clearly has more devastating public health consequences in Canada than use of all illegal drugs combined.

Just as prohibition of alcohol saw prices and crime rates driven up by criminalization, so do current drug policies encourage profiteering and other criminal activity. In 1988 it was estimated that laundered drug money amounted to tax-free sums of over $100 billion per year, more than the gross national products of 150 of the 170 nations of the world.[3] The United Nations reported that by 1993, $500 billion or 13% of all international trade was in illegal drugs, compared with $360 billion in petroleum products.[4]

One approach to this problem at the national level is exemplified by the Dutch policy of normalization, which places a low priority on possession of drugs for personal use and includes low-threshold methadone programs in all cities with 100 or more heroin users.[5] These social policies are reflected in rough estimates that 20% of heroin users in the Netherlands are injectors, compared with 50% in the United States.[6] In Canada, pragmatic application of drug laws has meant a decreased emphasis in many jurisdictions on prosecuting users in the interest of devoting law enforcement and judicial resources to the pursuit of drug traffickers. Some police departments have defined the quantities of each illicit drug that they consider to constitute evidence of trafficking. Understandably, these departments advocate national consensus on this issue to avoid movement of drugs and migration of drug users.

Brock and Gurekas appear to confuse drug decriminalization with legalization. Although there is a diversity of opinion about the merits of each approach, there is general consensus that, in either case, constraints similar to those for alcohol and tobacco should apply to other drugs. These include bans on advertising, channelling of revenues from taxes or the proceeds of crime toward primary prevention, prosecution of those selling or giving drugs to minors, conspicuous warnings about health consequences, and sanctions for driving a car or operating heavy machinery under the influence of drugs.

Increasing recognition of the harms associated with current drug laws and their application has led to public debate about how best to reform them. It is high time that in addressing drug law reform we consider all mind-altering drugs used in Canada, both currently legal and currently illegal, rather than accepting that alcohol and tobacco should retain their legal status whereas other drugs should remain prohibited and their users marginalized as pariahs.

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Anticoagulation therapy for patients with atrial fibrillation

Stuart Connolly posed the following question in a *CMAJ* commentary: Why are so many patients with atrial fibrillation not receiving anticoagulation therapy?[1] I offer a different perspective from his on this issue: Warfarin is not so much underused as poorly used. It is often given to patients who benefit minimally, while those patients who would benefit most are not treated.

Anticoagulation reduces stroke for all patients with atrial fibrillation,[2] but the magnitude of benefit (that is, the absolute risk reduction) is small for many patients with atrial fibrillation who have relatively low inherent risks of stroke. Many younger patients with atrial fibrillation have low (less than 2% per year) or moderate (3–5% per year) rates of stroke, and the number-needed-to-treat with warfarin for 1 year to prevent 1 stroke is between 30 and 100 for such patients; the number-needed-to-treat figures are doubled for prevention of strokes leaving even minimal residual disability.[3] Patients over

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