pickup truck in which one girl died.[1] Paragraph 4 of the article,[1] as well as the table of contents of the *CMAJ* issue in which it appears (page 891), use the word "accident" to refer to the collision. This terminology is misleading.

An accident is unpredictable and unpreventable. However, almost all motor vehicle collisions are due to driver error, often compounded by fatigue, alcohol or excess speed. Motor vehicle collisions are a major source of injury, disability and death. If this carnage were due to an infectious agent, the outcry would be deafening — witness the continuing furor concerning SARS.

Vehicular incidents are predictable and preventable. The *CMAJ* could help to improve public attitudes toward the causes of these events by using the proper words to describe them.

Robert Shepherd
Gatineau, Que.

Reference
1. Sibbald B. MDs call for new safety features after death in school bus crash. *CMAJ* 2003;169(9):951.

[The associate news editor responds:]

Robert Shepherd's point is well taken, and the CMAJ editors agree that the word "accident" should not have been used in my article[1] or in the table of contents for the issue.

We intend to follow the example of *BMJ*[2] and will in future avoid use of this term with reference to motor vehicle collisions and other predictable and preventable incidents causing injury and death.

Barbara Sibbald
CMAJ

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1. Sibbald B. MDs call for new safety features after death in school bus crash. *CMAJ* 2003;169(9):951.
2. Davis RM, Pless B. *BMJ* bans "accidents". Accidents are not unpredictable [editorial]. *BMJ* 2001;322:1320-1.

Mercenary hypocrisy at *CMAJ*

The CMA[1] and the Royal College of Physicians and Surgeons of Canada[2] both have guidelines restricting relationships between physicians and industry. These include specific admonitions against receiving gifts.

In its Sept. 30, 2003, issue, *CMAJ* published a news article containing criticisms of oxycodone (OxyContin) because of its highly addictive nature and describing legal actions being taken against the manufacturer. In the same issue, and in a much more prominent space, *CMAJ* sold a full-page colour ad promoting OxyContin for the treatment of chronic pain.

The usual tired caveats in the journal's defence will be invoked: that the prescribing physician is ultimately responsible for obtaining, synthesizing and interpreting the medical literature related to a treatment decision. It seems to me, though, that *CMAJ* has gone beyond mere hypocrisy to a new level of mercenary greed. While the CMA admonishes physicians against having truck with nefarious pharmaceutical types, *CMAJ* is lining its pockets with money from a company selling a drug that has introduced a new level of misery — addiction — into the lives of patients with chronic pain.

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2. *Physicians and industry — conflicts of interest*. Ottawa: Royal College of Physicians and Surgeons of Canada; updated 2003 Aug 25. Available: rcpsc.medical.org/english/publications/ (accessed 2003 Oct 29).
3. OxyContin class-action suit to proceed. *CMAJ* 2003;169(7):699.

Competing interests: None declared.

[The editor responds:]

Michael Jacka criticizes *CMAJ* for accepting an OxyContin advertisement directed at physicians while publishing a news story[1] describing a US class action lawsuit against Purdue Pharma for aggessively marketing OxyContin.

Drug advertisements in Canada, unlike those in the United States, are regulated by the Pharmaceutical Advertising Advisory Board, an autonomous organization endorsed by Health Canada.[2] This process provides assurance that Canadian advertisements are appropriate for the intended audience. Undoubtedly narcotics can lead to addiction, but they are also useful in certain clinical situations.[3]

John Hoey
CMAJ

References
1. OxyContin class-action suit to proceed. *CMAJ* 2003;169(7):699.
2. Chepesiuk R. Supported by an unrestricted educational grant [editorial]. *CMAJ* 2003;169(5):421-2.
3. Gardner-Nix J. Principles of opioid use in chronic noncancer pain. *CMAJ* 2003;169(1):38-43.

Eliminate trade barriers

The collapse of the WTO meeting in Cancun[1] in September has exposed the gross disadvantage that African, Caribbean and Asian countries have endured for decades. The promise of the benefits of so-called free trade, and the absolute certainty of the trickle-down theory, so enthusiastically proclaimed by economics gurus, have been frustrated by new protectionist barriers erected to replace the more blatant ones of the colonial period.

Under these conditions, the socioeconomic determinants of health, so obvious to even the most casual observer, remain intractable impediments to good health for millions of people. The suicide of South Korean farmer Lee Kyung-Hae should convince us that unfair trade practices kill and maim people just as effectively as bombs, land mines and other conventional methods of warfare.

Nonreciprocal free access to the markets of the advanced countries of

the north would be a useful first step toward the accumulation of capital, so vital for poor countries to achieve their economic take-off.

Poor countries in 2004 need to nurture their economies just as rich countries needed to do in the past when they were at a corresponding level of economic development. In fact, the QUAD (the United States, European Union, Japan and Canada) have protected their agricultural sectors enormously in the past 50 years, and still continue to do so.

Canada as an influential member of the QUAD can do much in the WTO to promote the phased elimination of tariff and nontariff barriers to exports from developing countries. To add to our credibility, we can initiate this measure within Canada. Fortunately our economy is strong enough to withstand a structural adjustment program of the type that has often been imposed on those countries, but without the devastating effects seen in them.

Health For All remains the elusive goal declared at Alma Ata. We can contribute something concrete toward its realization. Healthy, productive human beings with adequate incomes create trading partners that safeguard our security and our own economic well-being.

J.M. Dubé
Physician
Nanaimo, BC

Reference

1. Talk failures: food and fair trade [editorial]. *CMAJ* 2003;169(9):893.

Who was S. Weir Mitchell?

A recent commentary by Paul W. Armstrong and Robert C. Welsh opens with a quotation attributed to S. Weir Mitchell, who is identified as an American novelist.[1]

Mitchell was also one of the most prominent physicians of the late 19th and early 20th centuries and is recognized as one of the most important neurologists in American medicine. In the 1850s, Mitchell completed extensive experimentation in medical physiology, publishing 25 papers in the *Proceedings of the Academy of Natural Sciences of Philadelphia*. During the Civil War years 1862 to 1864, Mitchell worked as a contract surgeon in the Union Army. Of the many publications resulting from his Civil War work, the 2 most important were *Gunshot Wounds and Other Injuries of Nerves*, published in 1864 with coauthors G.R. Morehouse and W.W. Keen, and *Injuries of Nerves and Their Consequences*, a comprehensive work published in 1872. *Gunshot Wounds* immediately became the authoritative work on nerve injuries; it featured the first descriptions of phantom limb, ascending neuritis and causalgia (the