pert witness" who purportedly represents the collective wisdom of today's political policy-makers. The witness' arguments are neatly demolished by the fictitious commissioner, and the witness and his position are made to look foolish and weak.

In doing this the authors have set up a "straw-man" argument, so called because it is easier to knock down a man of straw than a real opponent. Another explanation is that, in the 19th century, witnesses-for-hire would hang about law courts, willing to say whatever was requested. These untrustworthy characters were identified by a straw in their shoe.[2]

Schechter and O'Shaughnessy create the impression that their opponents' point of view has been properly represented and justly defeated, but in fact no debate has taken place. An opponent of needle-exchange programs could easily write a similar script that would have a very different and equally unsubstantiated verdict. The authors may or may not be correct in their conclusions, but we won't know until a full and proper deliberation has occurred and each side has advanced its own arguments instead of relying on partisan interpretation of each other's views.

Robert Patterson, MD
Leamington, Ont.

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2. Brewer EC. *The dictionary of phrase and fable*. New York: Harpercollins; 1995.

[The authors respond:]

We did not write a technical article but rather a dramatic piece whose purpose was to raise the following point: If questions of civil and criminal negligence can be raised with regard to bureaucrats and politicians who knowingly did not provide the means to protect the blood supply, then cannot the same questions be raised about those who knowingly did not provide the means for injection drug users to protect themselves from lethal harm? We do not know the answer, but the question is legitimate.

As to whether the opinions of our decision-makers were properly represented, if only this were not so. Since 1986 both of us have sat on a number of national and provincial ministerial advisory panels, where we have discussed this subject with a host of federal and provincial bureaucrats and ministers of health. Sadly, the statements of our "witness" are virtual quotations from those discussions. If our witness was made to look foolish and weak, then we are better playwrights than we thought, for this is precisely how we believe decision-makers have acted.

Robert Patterson quite rightly asks for a full and proper deliberation. We invite him to read the report of the National Task Force on HIV, AIDS and Injection Drug Use,[1] which brought together national and international experts and evidence in 1997. He might also read the Le Dain Royal Commission report,[2] which was written more than 25 years ago. Unfortunately, these reports have been neglected, not discussed.

Patterson correctly notes that opponents of harm reduction could write a similar script to ours but with a different verdict. We would look forward to reading the testimony of their "witness" about his or her accomplishments over the last 30 years, including the overwhelming success of the war on drugs, the wonderful state of affairs in our inner cities and the tens of thousands of cases of hepatitis C and HIV infection that could have been prevented.

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2. Commission of Inquiry into the Non-Medical Use of Drugs. Final Report. Ottawa: Queen's Printer; 1973.

Smoking out the economics of tobacco use

I read with interest the editor's preface on global tobacco use in a recent issue of *CMAJ*.[1] Whenever I see figures like these I can't help wondering what would happen if all smokers miraculously quit overnight. Presumably they would live longer, healthier lives. But what would be the cost of their health care as they fade into senility? Greater, less than or the same as the $14.5 billion you quoted as the maximum amount to look after smoking-related illnesses?

Finally, where did you get the statistics you quoted? Are there comparable figures for ordinary age-related morbidity?

W.R. Harris, MD
Toronto, Ont.

Reference
1. Editor's preface. *CMAJ* 1999;160(11):1537.

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[The Editor-in-Chief responds:]

Most smokers we know would like to quit and live longer lives. We know how to help people quit smoking and it doesn't cost much. The funds saved could be applied to preventing other illnesses or perhaps to improving health care for conditions that we don't know how to prevent, such as degenerative hip disease, to mention something of interest to Dr. Harris.

As for the figures, they are widely available. We found them at www.who.org/toh/worldnotobacco99/teaser.htm (last accessed 1999 July 6).

John Hoey, MD

Whiplash cultures

The recent *CMAJ* piece on the increase in the cost of seat-belt-related injuries[1] reveals the seriousness of the whiplash problem in the United Kingdom. It is a medicolegal and social problem in many other countries as well.

There is a stark contrast, however, between the experience of whiplash in areas such as the United Kingdom and North America and that in Lithuania, Greece and Germany. In the latter countries, acute whiplash injury does occur frequently, but despite the use of seat belts, whiplash patients do not appear to have an increased risk of chronic pain compared with the uninjured population.[2] The acute whiplash injury is not even associated, in most cases, with short-term disability; time off work (if any) is usually 2 weeks or less. This is despite the fact that in both Greece and Germany, for example, accident victims have full insurance and disability coverage and are fully entitled to and do (especially in Germany) engage in litigation if they so desire. Yet in these same countries, recovery routinely occurs in 6 weeks or less, and treatment costs are usually less than Can$100-200. It has been shown that this profoundly different outcome is not due to a failure to report symptoms or cultural stoicism.[2]

The reasons for these cross-cultural differences are many and complex, but their elucidation is the basis for new paradigms for the management of this problem in "whiplash cultures."[3] The problem may not be, as Charles Galasko suggests, a lack of attention to whiplash in countries where it is epidemic,[1] but rather our lack of attention to whiplash in countries in which it is not.

Robert Ferrari, MD
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