xenophobic overtones as its use was linked to Mexican farm workers in the United States.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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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\textbf{Anticoagulation therapy for patients with atrial fibrillation}\n
S\textit{tuart Connolly} posed the following question in a \textit{CMAJ} commentary: \textit{Why are so many patients with atrial fibrillation not receiving anticoagulation therapy?} I offer a different perspective from his on this issue: \textit{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\textsuperscript{7} 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.\textsuperscript{8} Patients over

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age 75 with atrial fibrillation are more likely to be at high risk but less likely to receive anticoagulation.4,5 Ironically, younger patients with fewer comorbidities are more attractive candidates for anticoagulation, yet, on average, accrue less benefit when the absolute risk reduction is considered.

Those decrying underuse of warfarin often imply that anticoagulation therapy is underused because physicians lack the knowledge or commitment to prevent stroke, yet it is often the patients themselves who choose not to receive anticoagulation.6 Patient-perceived thresholds of benefit for choosing anticoagulation vary widely; often those with stroke risks in the moderate range elect not to receive anticoagulation after the benefits and risks are explained to them.7 Further study of the preferences of informed patients and of the influence of different educational methods is sorely needed.8

I contend that the 50% frequency of coagulation use among patients with atrial fibrillation reported in recent studies does not represent gross underuse for many populations of patients with atrial fibrillation9 (I acknowledge that patients at high risk may make up a larger proportion of the patients in clinical practice than of the participants in clinical trials10). Rather, anticoagulation is too often given to those who benefit least rather than most. Additional studies of the the reliability of risk stratification schemes when applied in clinical practice11 and of patient perceptions of minimal thresholds of benefit are needed to foster the optimal use of this highly efficacious therapy to prevent stroke.

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References

Corrections

Because of an editing error, a recent article contained an incorrect name for the organization responsible for amateur hockey in Canada.1 The correct name is the Canadian Amateur Hockey Association.

Reference