In cases in which patient care and management are driven by interpretive pathological reports, be they related to biopsy, cytology, cytogenetics or hematology, it is inappropriate for the pathologist to be left out of the patient-contact loop. The most appropriate person to explain, and even show, the pathologic features is the pathologist, whose training involves not only the pattern recognition of tissue diagnosis but also the natural history of the disorder and its basic biology.

Many patients must find it difficult to accept a diagnosis when only a slip of paper is given as proof of their illness. In my experience with prenatal diagnosis I often face questions. "Was a mistake made? Could there be a mix-up in the specimens?" When I see families, I have the karyotype with me and can demonstrate the changes and explain the laboratory's quality control. How much more difficult must it be for a man faced with therapeutic decisions about prostate cancer or a woman with malignant melanoma not to be offered the opportunity to see and discuss the biopsy results with the person who interpreted them.

I believe that every pathology report should include a statement that the pathologist would be pleased to discuss the diagnosis with the patient. Such contact will allow patients to satisfy themselves about the validity of the diagnosis and would also give the pathologist a deservedly higher profile in patient management.

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## Practice patterns in hypertension

In the article "Contemporary practice patterns in the management of newly diagnosed hypertension" (*Can Med Assoc J* 1997;157[1]:23-30), Dr. Finlay A. McAlister and associates suggest that research must be done to "determine the reasons underlying physicians' noncompliance with the evidence-based guidelines established by the Canadian Hypertension Society."

I think that I may have the answer, without undertaking any great research effort, other than talking with drug reps. The drug companies have not been giving out samples of β-blockers or diuretics for years now. They are all promoting the angiotensin-converting-enzyme (ACE) inhibitors and calcium channel blockers. So, when a patient with newly diagnosed hypertension walks into your office, what are you likely to do — write a prescription or give the patient a sample? And if all you have are samples of the new drugs, that is what the patient gets. And if the drug controls the hypertension, that is what the patient will continue to receive, providing there are no side effects.

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**[One of the authors responds:]**

I appreciate Dr. Hardin's interest in our article but do not share his view that the discrepancies between actual practice and the hypertension guidelines are due solely to the marketing efforts of the pharmaceutical industry.

Much has been written about how physicians learn and which educational interventions are effective in altering practice.[1] However, little is known about the impact on prescribing habits of "detailing" by pharmaceutical company representatives (including the provision of free samples). A recent study[2] of general practitioners in England provides some insight into the factors that influence physician practice. The most important factor appeared to be "the general practitioner's personal experience of a drug," and only 1 of the 19 respondents reported being "influenced by drug company representatives."

In an attempt to verify and expand on the findings of our practice audit, we recently surveyed physicians in central and northern Alberta to determine their approach to treating hypertension.[3] A total of 155 family physicians and 58 internists, approximately 67% of the eligible target audience, responded. We found that the pattern of laboratory utilization and medication prescribing closely mirrored that documented in our chart review. As part of this survey, we asked the physicians to rank the various factors that influenced their prescribing practice. Although the majority of both groups ranked personal clinical experience (79%) and the opinion of colleagues and local experts (66%) as moderate or strong influences, only 4% placed as much emphasis on "the pharmaceutical industry" (which was defined to include educational materials and free drug samples). Granted, physicians may be reluctant to admit to what extent their prescribing practices are influenced by industry representatives or advertising, but I think we should be cautious in attributing departures from recommended guidelines to the effects of advertising. As pointed out by Dr. Nuala Kenny, "clinical practice is both science and art"[4] and there are many factors that may legitimately prevent the application of the guidelines to every patient. The challenge for clinicians, researchers and policy-makers is to determine whether divergence from evidence-based guidelines is systematic or random and whether the observed dis-

crepancies are justified by the specifics of each case.

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## Gender-neutral language: only a first step

In the recent discussion concerning gender neutralization of the English language, I found it amusing that Dr. Guyatt and associates effectively invalidated the views of Dr. Berger by simply pointing out that he is not a woman ("Brave new world of gender-inclusive language," by Emile Berger, with response from Gordon Guyatt and associates, *Can Med Assoc J* 1997;157[6]:641-2). However, Guyatt is also a man (although his co-authors are all women). If the discussion is to be reduced to that level, what makes Guyatt's views more valid than those of Berger or of any man?

Glibness aside, let me address what I think is the important issue. Language is important because it provides a historical perspective on the relationship between men and women. English originated in a culture dominated by males, so terms such as "chairman" emerged from boardrooms full of men. Language is important because it reminds us of the male-dominant attitudes that can pervade a workplace. However, to focus on language alone risks skirting the real issue: the way women are often treated by men in certain work environments. This attitudinal problem has the same origins as the language, but language is only a symptom. This is where I would agree with Dr. Lawrence Clein ("Gender sensitivity a sensitive issue," *Can Med Assoc J* 1997;157[6]:640), who is also a man but whose opinion I hereby validate.

Language has nothing to do with women's tendency to shy away from surgical specialties. Every specialty attracts certain personality traits, and very traditional male attitudes toward women tend to pervade surgery. From experience, I know that in no other specialty is the relationship between men and women sexualized as much as it is in surgery. No words are needed to make a woman feel that it is her breasts and not her techniques that are being observed, because a look is all it takes. The banter and commentary heard in the OR only add to this atmosphere. Many men view such banter as an innocent and charming expression of a man's appreciation of women, but inappropriate sexualization of a relationship tells women they are nothing but objects of sexual interest. Objectification is a dangerous process, one that makes it easier for a man to think he has a right to transgress interpersonal and professional boundaries. The traditional power hierarchy is invoked, and women can feel powerless and threatened because of it.

Sexualization of a professional relationship is the most unpleasant and effective way to invoke that power relationship, and language is merely a reflection of the attitudes underlying it. If changing language will also change attitudes, then I'm all for change, but we risk ignoring more delicate and more significant issues. Chairman, chair and chairperson are all the same to me. The way the words are said and the look or gestures that accompany them are more indicative of the degree to which I am being regarded with respect, equality and professional legitimacy.

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## A role for the sick role

In "A role for the sick role: patient preferences regarding information and participation in clinical decision-making" (*Can Med Assoc J* 1997;157[4]:383-9), by Drs. Anne M. Stiggelbout and Gwendoline M. Kiebert, we learn that "the mere fact of being a patient leads to a shift in preference away from participation." This leads to some interesting speculation about patients' preferences compared with those of physicians and administrators in medical decision-making.

Drs. Stiggelbout and Kiebert suggest that cultural expectation might account for this. In her accompanying editorial, "Should physicians discourage patients from playing the sick role?" (*Can Med Assoc J* 1997;157[4]:393-4), Dr. Christine Laine suggests that physicians may have no choice in the matter but they might be prudent to warn patients that playing the sick role may prevent them from obtaining optimal health.

I suggest that the nature of the doctor–patient relationship is at the heart of this issue. When ill, patients tend to regress emotionally. Part of the physician's role is to assess the amount of regression and demoralization and to instil hope and improve morale by providing information and explanations. It may be bordering on insult to suggest the