To wish away these psychologic realities in pursuit of a utopian scheme of equality and autonomy is not only a politically driven mistake, but it misses the mark in terms of respect for the patient and good patient care. For those of us who strive to meet patient needs in a trusting and caring relationship, the roles of mechanistic sensitivity analysis and videodiscs will always be secondary.

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[The author responds:]

I suspect that Dr. Sargeant and I agree more than he thinks, and I regret that misunderstandings about the purpose and conclusions of my article have arisen. The articles in the series Physicians in Health Care Management were intended as reviews of relevant literature with commentary, rather than as scientific papers. Sargeant appears to project onto this article beliefs that I do not hold and had argued against; I must apologize for an evident lack of clarity. I will not attempt a point-by-point refutation, except to note that my article did not conclude that patients do not wish to participate; it was meant to clarify that the literature has not been clear about the definition of "participation" and, hence, may have understated patient wishes. A more complete review of this literature is found in the background papers for the Royal Commission on New Reproductive Technologies.[1]

There is some scientific evidence that the distinction I and my colleagues have made between problem-solving tasks (that have one correct answer and are not affected by the values affixed to particular outcomes) and decision-making tasks (for which the values placed on outcomes are important) does seem to describe patient preferences; the patients with cardiovascular illness we studied were not interested in being involved in problem solving, but most wished to share in decision making.[2,3] Far from calling for "some utopian scheme of equality and autonomy," I wished to endorse physicians' striving "to meet patient needs in a trusting and caring relationship." In my view — and that of a number of distinguished clinicians[4,5] — trust and caring are enhanced, not diminished, by provision of appropriate information and a genuine respect for patients' values.

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4. Kassirer JP: Adding insult to injury: usurping patients' prerogatives. *N Engl J Med* 1983; 308: 898–901
5. Katz J: *The Silent World of Doctor and Patient*, Free Press, New York, 1984

Death in a restraint jacket

I read with great interest "Death in a restraint jacket from mechanical asphyxia" (*Can Med Assoc J* 1994; 51: 985–987), by Dr. Harry Emson. I have been concerned about patient restraints and their possible sequelae over the years, and in 1991 I wrote a letter about a particular restraint (*Can Med Assoc J* 1991; 145: 12–13). In response, the manufacturer claimed that there had never been any reports of physical or mental harm to patients restrained with the use of its product. Emson's report puts the record straight. I hope that health care personnel will take note of the possible serious consequences of physical restraints.

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The medical hazards of television sports

An 82-year-old widow recently related that both her husband and his brother, on different occasions, had collapsed while watching exciting ice hockey games on television and had died, despite emergency surgery for ruptured aortic aneurysms.

This story brought back the vivid memory of a similar case involving an elderly man 22 years ago at Foothills Hospital, Calgary. He had been admitted a few days earlier for elective resection of an abdominal aortic aneurysm. While watching an exciting hockey game — the seventh and decisive match between Canada and the Soviet Union in the memorable 1972 series — he collapsed.

The patient had the good fortune to be in a four-bed room in which a general surgeon was visiting a roommate. As the patient descended into profound hemorrhagic shock the surgeon made a rapid and correct diagnosis of rupture of the aneurysm and pushed the bed of the dying patient across a hallway into the main operating room on the same floor. Luck continued to be with the patient; a vascular surgeon and an anesthesiologist (I) were immediately available to intervene. We were about to embark on

elective surgery, a case that was, of course, put on hold to make way for the emergency.

The "anesthesia" consisted of oxygen and rapid intravenous infusion of Ringer's lactate solution until blood became available. Although the patient initially had no pulse and was obviously near death, his cardiogram showed a normal sinus rhythm. After surgery and blood transfusion the patient recovered. To the amusement of the medical and nursing staff, who were aware of the story, on regaining consciousness in the recovery room the patient fervently asked, "Who won the game?" Readers may remember that Canada won the game and therefore the series.

I would be interested to hear if other practitioners have sports-hazard stories of this type. If an aortic aneurysm is going to rupture, an episode of arterial hypertension is likely to be the cause, and this might result from the excitement of a hockey game.

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Physicians and the pharmaceutical industry: Under the influence?

There has been a vigorous debate in *CMAJ* about the relationship between academic researchers and the pharmaceutical industry (*Can Med Assoc J* 1994; 150: 951–953, 955–956).

As a practising physician, I often wonder if I am affected by promotional activities. This was brought home to me recently at a sponsored continuing medical education (CME) evening in the restaurant of a very fine hotel. After two cardiologists had given excellent lectures, we adjourned for dinner, and I sat with three friends. Such an evening must cost as much as a wedding; the main difference is that the speaker, rather than the band, is the diversion. In conversation, my friends said they felt strongly that such events would not influence their prescribing habits.

These are my observations, based on one day in my life during which I take advantage of all the industry activities and paraphernalia freely available to me.

My mug for my morning coffee has a message on it. While I eat I read a medical journal, which I choose from one of the teetering obelisks of medical literature cluttering my house. While shaving I listen to a free medical audiotape. While showering I turn off the tape, and I later slip it into my automobile stereo.

At my office I pass through the waiting room, noting posters from the pharmaceutical industry on the walls and magazines "for waiting room use only." Pamphlets on many diseases are available.

My desk has a blotter from the drug industry on it. As I use free stationery, personalized prescription forms and a "Herman" calendar, I see drug ads. As teaching aids about various diseases, I hand my patients industry pamphlets, audiotapes and even videos. An industry clock times me.

My patients almost never need to pay for drugs, as most have drug coverage through the Ontario Drug Benefit Program. Introductory samples are usually available for those not covered.

My office policy on seeing representatives from pharmaceutical companies is generous. If I am not too busy, I discuss their products and compare products with competitors. The representatives are well educated and personable, but they cannot all be right. I see three today.

I lunch at my desk while reading my mail, which adds to my office journal obelisks. I receive several invitations to CME events. I could dine out at industry expense weekly if my energy and lipid levels permitted.

After my office hours, I go directly to the CME event at the hotel, mentioned earlier, and listen to my audiotape before and after the event. Back home, energized by the food, drink and collegial atmosphere, I slip an industry video into my videocassette recorder. I fall asleep reading journal ads, some of which are 12-page "info-mercials." I dream about juggling all those multicoloured tablets and capsules that compete for my attention.

Am I influenced? Yes.

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Payment options lacking

I read with interest the editorial "Family physicians and nurse practitioners: guidelines, not battlelines" (*Can Med Assoc J* 1994; 151: 19–21), by Dr. Carl Moore, especially his comments about alternative funding systems. I am a family physician currently working on a fee-for-service basis. Although I do not share Moore's repugnance for this system, I certainly would like to be able to explore others. I find it disturbing that I have no other options at a time when health care in Canada is in crisis and health care payers should be striving to provide innovative and cost-effective solutions.

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Deaths [correction]

Because of erroneous information received by *CMAJ*, an incorrect death notice for Dr. Stuart Carey appeared in a recent issue (151: 857). The notice should have read: **Carey**, Stuart L., Red Lake, Ont. (formerly of Thompson, Man.); University of London (England), 1943; chest and industrial medicine; senior member, CMA. Died Apr. 23 aged 75; survived by his wife Dorothy, children David, Diana, Paul, Michael, Murray, Patrick and Joanne, and stepchildren Sherry and Dr. Heather Rogan.

We apologize for this error. — Ed.