to reduce the resources for such services over time. This situation has major implications for the spread of HIV in IDUs in the future, as well as concomitant spread into the heterosexual population.

It may be time to seriously consider harm reduction by the controlled distribution of narcotics to IDUs. This seems to be a valuable part of the HIV-reduction strategy in places such as Liverpool, Glasgow and Zurich. Could it be considered here, initially on a pilot basis in a major city?

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[The author responds:]

I agree with Dr. Johnstone that it is time to consider alternative opioid-substitution programs. Among 90 recommendations in the national action plan drawn up by the National Task Force on HIV and Injection Drug Use and published this year[1] are recommendations for the investigation of alternative drug therapies beyond methadone, such as buprenorphine, naltrexone and levomethadyl, and for the conduct of clinical trials of prescription morphine, heroin and cocaine.

More than 1200 heroin users in Switzerland are participating in a prescription program through which they inject up to 3 times a day under medical supervision at 1 of 18 participating treatment centres. The program, which commenced in 1994, recruits IDUs who have been dependent on heroin for more than 2 years, have failed several treatment attempts, and have impaired health status or social functioning. Results so far demonstrate declines in illegal drug use, improvements in physical and mental health, decreased criminality and income from illegal sources, fewer overdoses, and positive changes in social functioning.[2] Public support for the program's continuation was evident in a referendum held in Switzerland in late September. In the face of the increasing epidemic of blood-borne viral infections among Canadian IDUs, it is time for bold, creative thinking and action on opioid substitution in Canada.

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Eliminate stirrup, improve compliance?

The prosaic picture of a stirrup on the cover of *CMAJ* (Sept. 1, 1997) makes this retired GP wonder why the many women who might be offended by the slightest sexual slur have not forced physicians to relegate this antiquated contraption to the scrap heap. Might not distaste for a procedure that requires undignified subjection to such unnecessary restraint contribute to the noncompliance in cervical cancer screening that concerned your contributors?

When I was practising, I used the platform that pulls out from most examining tables, including those in the case room, where an appropriate "flat drape" is available for most pelvic procedures. It is puzzling that female patients and the increasing number of female physicians have not championed this more comfortable alternative.

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The changing role of the pathologist

The title for this letter was also used in a poster presented by Drs. N.S. Gill and Sandip SenGupta at the recent 60th annual meeting of the Ontario Association of Pathologists. They told of a 16-year-old with an above-the-knee limb amputation for Ewing's sarcoma. "Postoperatively, this patient made the unusual request to review the surgical specimen with the pathologist. We were presented with a unique opportunity to discuss the disease with her and educate her about the role of the pathologist in the diagnosis and treatment process."

A recent issue of *Harper's* magazine included an article by Dr. Spencer Nadler, a surgical pathologist from southern California.[1] In the article he described conversations with a patient who had asked him to review with her the histology of her malignant breast lesion, discovered at biopsy.

A recent study concerning abnormal cervical smears[2] concluded that "most women did not receive the information they required. We also found that women's accounts of their abnormality often conflicted with their clinician's approach."

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.

Barry Hardin, MD
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Received via email

[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-