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