and thus to deviate again from the recommendation that patients should select their physician on the basis of merit rather than sex, race, religion or sexual orientation.

I certainly hope that women will not develop and maintain for long the prejudices we men harboured for centuries.

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I would like to comment on a statement by Ms. Thorne about a finding of the 1991 study of the Sexual Assault Assessment Service (SAAS) in Vancouver: "77% of patients presenting to this emergency service indicated a preference for a female examiner. The authors concluded that emergency services for women who have been sexually assaulted should aim to have female physicians available whenever possible."

In fact the official policy of the SAAS in Vancouver has been to restrict male physicians from being on the service altogether. This formal, blatantly sexist policy, which I am attempting to rectify, implies to the victim that a male physician cannot provide the same quality of care as a female physician, while at the same time conveying the message to the male physician that he should avoid assessing a female victim of sexual assault. This ultimately undermines, albeit unintentionally, the delivery of health care to victims of sexual assault.

Another potential pitfall of a policy that formally restricts men from serving on the SAAS roster is a question of legality: although the policy has yet to be challenged in court, it is difficult to imagine a ruling in its favour.

Perhaps a more accurate method of determining patients' satisfaction with the quality of care is to examine satisfaction with other sexual assault assessment services that have accepted or been formed by male physicians. Our colleagues in San Luis Obispo, Calif., who assess more than 1000 victims per year, have not found that victims of sexual assault relate differently to the physician solely on the basis of the physician's sex. A similar experience has been reported by our colleagues in Victoria.

It is my sincere hope that ongoing efforts to change this policy will succeed and that male physicians who have expressed an interest in serving on the SAAS roster currently at the Vancouver Hospital and Health Sciences Centre (Vancouver General) will be welcomed.

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Methotrexate and misoprostol used in abortions

Contrary to the claims of Dr. Ellen R. Wiebe in her letter (*Can Med Assoc J* 1994; 150: 1381–1382) the *Compendium of Pharmaceuticals and Specialties*[1] clearly indicates that methotrexate is contraindicated during pregnancy. If Wiebe and the University of British Columbia Ethics Committee have information on the safety of this drug during pregnancy perhaps they could share it with readers.

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Reference

1. *Compendium of Pharmaceuticals and Specialties*, Canadian Pharmaceutical Association, Ottawa, 1994: 772

[The author responds:]

Of course methotrexate is contraindicated for a wanted pregnancy: it causes abortion in approximately 95% of pregnancies of less than 7 weeks' gestation. This is why we are using it as an abortifacient. Single-dose methotrexate has been found to be safe for ectopic or unwanted pregnancy.[1–3] However, if abortion failed in a women given methotrexate and she refused to undergo surgical abortion, there would be a risk to the fetus.[4,5] From the experience with RU 486 in Europe we know that women rarely change their minds about abortion in such cases.

In my study the risks of methotrexate are clearly stated in the consent form each woman must sign.

Ellen R. Wiebe, MD, FCFP
Vancouver, BC

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4. Ross GT: Congenital anomalies among children born of mothers receiving chemotherapy for gestational trophoblastic neoplasms. *Cancer* 1976; 37: 1043–1047
5. Kozlowski RD, Steinbrunner JV, MacKenzie AH et al: Outcome of first-trimester exposure to low-dose methotrexate in eight patients with rheumatic disease. *Am J Med* 1990; 88: 589–592

Cutting costs by targeting prescribing practices [correction]

This letter (*Can Med Assoc J* 1994; 151: 13–14), by Dr. David Rapoport, should have referred to "Diltiazem SR, 90 mg, a newer drug for hypertension," in the third paragraph. As well, in the seventh paragraph the third sentence should have read as follows: "One common, dangerous and expensive example of this is the use of NSAIDs [nonsteroidal anti-inflammatory drugs] *and* peptic acid suppressors," with the corrected word in italics. We apologize for any confusion our editing may have caused readers. — Ed.