

Manitoba workshop provides insight into sexual abuse by physicians

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Today, many Canadian jurisdictions are addressing the issue of sexual abuse of patients by physicians. The final report of the Ontario Task Force on Sexual Abuse of Patients, which was released in 1991, proved to be the catalyst for many of these responses.

More recently, the Manitoba Medical Association (MMA) sponsored a 1-day workshop on the physician-patient relationship that paid particular attention to the sexual abuse issue. The October workshop was conducted by Gary Schoener, executive director of the Walk-In Counselling Center in Minneapolis, and a licensed psychologist who has consulted on more than 3000 cases of sexual abuse involving professionals and their patients or clients.

Using tools that ranged from videotaped segments concerning actual sexual abuse cases to lecture-style presentations on the latest literature, Schoener provided a historical overview of sexual exploitation by professionals, a typology of situations and offenders, and a model for the assessment of practitioners charged with sexual abuse. He also discussed rehabilitation and re-entry to practice, assessment issues and complaint investigation, the evolving disciplinary framework, and safeguards that can reduce the risk of complaints by patients.

Of the many topics covered by Schoener, the typology of ther-

apists who sexually exploit clients was perhaps the most provocative (see Gonsiorek J, Schoener G: Assessment and evaluation of therapists who sexually exploit clients. *Prof Pract Psych* 1987; 8 (2): 79-93). Although not based on empirical research, the model provides a description of some of the major clusters of abusers that have been observed, along with a prognosis for rehabilitation. Schoener divided them into six groups:

Gary Schoener divided abusers into six groups.

- **Uninformed:** These are physicians or therapists who have little concept of professional boundaries. They operate in a grey area between professional and lay services and exhibit a general lack of professionalism. They require more professional training.

- **Healthy or mildly neurotic:** They account for one of the largest categories of sexual exploiters. The exploitation is limited or involves an isolated circumstance and is often related to situ-

ational stresses in the practitioner's personal life. There is good prognosis for treatment.

- **Severely neurotic or socially isolated:** These abusers have significant emotional problems, especially social isolation and ongoing problems with depression and feelings of inferiority and inadequacy. They look to certain patients or clients to meet their own emotional and social needs. They will exhibit a great deal of denial about the inappropriateness of their relationship. Although rehabilitation is feasible, prognosis is guarded because of long-standing difficulties.

- **Impulse character disorders:** These practitioners will have long-standing problems with behaviour and impulse control and rarely if ever have a true comprehension of the impact of their behaviour on others. This group will include numerous repeat sex offenders; generally, practitioners in this group are not capable of being rehabilitated.

- **Sociopathic or narcissistic character disorder:** These practitioners tend to be deliberate and cunning in their sexual exploitation of clients. They often claim multiple victims over many years, often for their entire careers. They are adept at manipulating colleagues, other clients and professional organizations to help them avoid the consequences of their behaviour. Typically they are not capable of being rehabilitated, although on occasion, as part of their manipulation, they may attempt to look as if they are undergoing rehabilitation.

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• Psychotic or borderline personalities: These abusers are characterized by extremely poor social judgement and disordered thinking. They are often psychotic on an ongoing or acute basis and vary considerably in terms of remorse, guilt and ability to understand the impact their actions have on others. They have a poor prognosis for treatment.

Schoener said several rehabilitation alternatives are available in the United States. These include traditional psychotherapy, sex offender treatment programs, sexual addiction treatment programs, impaired practitioner programs aimed at professionals, and individualized programs offered at the Minneapolis Walk-In Counselling Center.

The Winnipeg workshop attracted officers and councillors from the College of Physicians and Surgeons of Manitoba, and

members of the MMA Board of Directors and Council on Health Care and Promotion. This type of workshop may help physicians achieve a greater understanding of the complexity of the physician-patient relationship, and help them use this new knowledge to develop solutions to the problem.

Initiatives have already been taken by many organizations, including the CMA, its divisions and affiliated and associated societies, provincial and territorial licensing authorities, and Canadian medical schools. The CMA recently formed a physician-patient working group to develop relevant policies and educational and prevention strategies.

To fully appreciate the complexity of the problem and consequently to be able to address it in practice, doctors must learn as much as they can about the issue from as many sources as possible. It is also important to consider

the experience of professionals working in other disciplines, such as the clergy, teachers and psychologists, in terms of how they have managed sexual abuse issues. Multiple and interdisciplinary approaches will provide a rich and valid means of understanding the problem and exploring innovative solutions that will help the medical profession.

Dr. Ivan Kowalchuk, who chairs the MMA Committee on Sexual Abuse by Physicians (he also chairs the CMA Working Group on the Physician-Patient Relationship), and his committee deserve praise for organizing the Winnipeg workshop. Those who attended learned a great deal from it.

Further information about the workshop and the work of the CMA physician-patient relationship working group is available from Margo George, 1-800-267-9703, ext. 2014. ■



THERAPEUTIC CLASSIFICATION Mucosal Protective Agent

INDICATIONS CYTOTEC (misoprostol) is indicated for the prevention of NSAID-induced gastric ulcers. Patients at high risk of developing NSAID-induced complications and who may require protection include: • Patients with a previous history of ulcer disease or a significant gastrointestinal event. • Patients over 60 years of age. • Patients judged to be at risk because of general poor health, severe concomitant medical disease, or patients who are poor surgical risks. • Patients disabled by joint symptoms (e.g., HAQ Disability Index Score >1.5) or those with severe systemic manifestations of arthritis. • Patients taking other drugs known to damage or exacerbate damage to the gastrointestinal tract such as corticosteroids or anticoagulants. • Patients taking a high dosage or multiple NSAIDs, including those available Over-The-Counter. The risk of NSAID-induced complications may be highest in the first three months of NSAID therapy. CYTOTEC is also indicated for the treatment of NSAID-induced gastric ulcers (defined as ≥ 0.3 cm in diameter) and for the treatment of duodenal ulcers.

CONTRAINDICATIONS Known sensitivity to prostaglandins, prostaglandin analogues, or excipients (microcrystalline and hydroxypropyl methylcellulose, sodium starch glycolate and hydrogenated castor oil). Contraindicated in pregnancy. (See CLINICAL PHARMACOLOGY.) Women should be advised not to become pregnant while taking CYTOTEC (misoprostol). If pregnancy is suspected, use of the product should be discontinued.

WARNINGS Women of childbearing potential should employ adequate contraception (i.e., oral contraceptives or intrauterine devices) while receiving CYTOTEC (misoprostol). (See CONTRAINDICATIONS.) **Nursing Mothers:** It is unlikely that CYTOTEC is excreted in human milk since it is rapidly metabolized throughout the body. However, it is not known if the active metabolite (misoprostol acid) is excreted in human milk. Therefore, CYTOTEC should not be administered to nursing mothers because the potential excretion of misoprostol acid could cause significant diarrhea in nursing infants. **Pediatric Use:** Safety and effectiveness in patients below the age of 18 have not been established.

PRECAUTIONS **Selection of Patients:** Caution should be used when using symptomatology as the sole diagnostic and follow-up procedure, since CYTOTEC (misoprostol) has not been shown to have an effect on gastrointestinal pain or discomfort. Before treatment is undertaken, a positive diagnosis of duodenal ulcer or NSAID-induced gastric ulcer should be made. The general health of the patient should be considered. Misoprostol is rapidly metabolized by most body tissues to inactive metabolites. Nevertheless, caution should be exercised when patients have impairment of renal or hepatic function. (See CLINICAL PHARMACOLOGY.) **Diarrhea:** Rare instances of profound diarrhea leading to severe dehydration have been reported. Patients with an underlying condition such as irritable bowel disease, or those in whom dehydration were it to occur, would be dangerous, should be monitored carefully if CYTOTEC is prescribed. **Use in Elderly or Renally Impaired:** Considerations for Dosage Adjustment: In subjects over 64 years of age or those who are renally impaired the pharmacokinetics may be affected, but not to a clinically significant degree. (See DOSAGE AND ADMINISTRATION.) No routine dosage adjustment is recommended in older patients or those patients with renal impairment. Dosage may need to be reduced if the usual dose is not tolerated. In patients with renal failure, a starting dose in the low range (100 mcg QID) is recommended. **Drug Interactions:** The serum protein binding of misoprostol acid (the active metabolite of misoprostol) was not affected by: indomethacin, ranitidine, digoxin, phenylbutazone, warfarin, diazepam, methyldopa, propranolol, triamterene, cimetidine, acetaminophen, ibuprofen, chlorpromazine, and hydrochlorothiazide. Salicylic acid (300 mcg/mL) lowered the protein binding of misoprostol from 84% to 52%; this is not considered clinically significant since the binding of misoprostol acid is not extensive and its elimination half-life is very short. In laboratory studies, misoprostol has shown no significant effect on the cytochrome P450-linked hepatic mixed function oxidase system, and therefore should not affect the metabolism of theophylline, phenytoin, benzodiazepines or other drugs normally metabolized by this system. No drug interactions attributable to misoprostol have been observed to date. (See CLINICAL PHARMACOLOGY.) Some prostaglandins and prostaglandin analogues have the capacity to produce hypotension through peripheral vasodilation. The results of clinical trials to date indicate that CYTOTEC has not produced hypotension at dosages effective in promoting the healing of ulcers. Nevertheless, CYTOTEC should be used with caution in the presence of disease states where hypotension might precipitate severe complications, e.g., cerebral vascular disease or coronary artery disease. Epileptic seizures have been reported with prostaglandins and prostaglandin analogues administered by routes other than oral. Therefore, misoprostol tablets should be used in known epileptics only when their epilepsy is adequately controlled and then only when expected benefits outweigh potential risks. Symptomatic responses to CYTOTEC do not preclude the presence of gastric malignancy.

ADVERSE REACTIONS **Gastrointestinal:** In subjects receiving CYTOTEC (misoprostol) 400 or 800 mcg daily in clinical trials, the most frequent gastrointestinal adverse events were diarrhea, abdominal pain and flatulence. The average incidences of these events were 11.4%, 6.8% and 2.9%, respectively. In clinical trials using a dosage regimen of 400 mcg bid, the incidence of diarrhea was 12.6%. The events were usually transient and mild to moderate in severity. Diarrhea, when it occurred, usually developed early in the course of therapy, was self limiting and required discontinuation of CYTOTEC in less than 2% of the patients. The incidence of diarrhea can be minimized by adjusting the dose of CYTOTEC, by administering after food, and by avoiding co-administration of CYTOTEC with magnesium-containing antacids. **Gynecological:** Women who received CYTOTEC during clinical trials reported the following gynecological disorders: spotting (0.7%), cramps (0.6%), hypermenorrhea (0.5%), menstrual disorder (0.3%) and dysmenorrhea (0.1%). **Elderly:** There were no significant differences in the safety profile of CYTOTEC in approximately 500 ulcer patients who were 65 years of age or older, compared with younger patients. Confusion has been reported in a small number of patients in our post marketing surveillance of CYTOTEC. **Incidence greater than 1%:** In clinical trials, the following adverse reactions were reported by more than 1% of the subjects receiving CYTOTEC and may be causally related to the drug: nausea (3.2%), headache (2.4%), dyspepsia (2.0%), vomiting (1.3%) and constipation (1.1%). However, there were no clinically significant differences between the incidences of these events for CYTOTEC and placebo.

DOSAGE AND ADMINISTRATION **Treatment and Prevention of NSAID-Induced Gastric Ulcers:** The recommended adult oral dosage of CYTOTEC (misoprostol) for the prevention and treatment of NSAID-induced gastric ulcer is 400 to 800 mcg a day in divided doses. NSAIDs should be taken according to the schedule prescribed by the physician. When appropriate, CYTOTEC and NSAIDs are to be taken simultaneously. CYTOTEC should be taken after food. **Duodenal Ulcer:** The recommended adult oral dosage of CYTOTEC (misoprostol) for duodenal ulcer is 800 mcg per day for 4 weeks in two or four equally divided doses (i.e., 200 mcg qid or 400 mcg bid). The last dose should be taken at bedtime with food. Antacids (aluminum based) may be used as needed for relief of pain. Treatment should be continued for a total of 4 weeks unless healing in less time has been documented by endoscopic examination. In the small number of patients who may not have fully healed after 4 weeks, therapy with CYTOTEC may be continued for a further 4 weeks. **Use in Elderly and Renally Impaired:** Consideration for Dosage Adjustment: Pharmacokinetic studies in patients with varying degrees of renal impairment showed an approximate doubling of $T_{1/2}$, C_{max} and AUC compared to normals. There was no clear correlation between degree of impairment and AUC. In subjects over 64 years of age the pharmacokinetics may be affected. In both patient groups the pharmacokinetic changes are not clinically significant. No routine dosage adjustment is recommended in older patients or those patients with renal impairment. Dosage may need to be reduced if the usual dose is not tolerated. In patients with renal failure, a starting dose in the low range (100 mcg QID) is recommended.

AVAILABILITY CYTOTEC (misoprostol) 200 mcg tablets are white to off-white, scored, hexagonal with SEARLE 1461 engraved on one side available in bottles of 120 and 500 tablets. CYTOTEC 100 mcg tablets are white to off-white, round tablets with SEARLE engraved on one side and CYTOTEC on the other available in bottles of 100 tablets.

Store below 30°C (86°F).
Pharmacist: Dispense with Patient Insert.

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References: 1. Adapted from Langman, MJS. Peptic Ulcer Complications and the use of Non-Aspirin, Non-Steroidal, Anti-inflammatory Drugs. Adverse Drug Reaction Bulletin 1986;120:488-451. 2. Cytotec Product Monograph May 1991. 3. Graham DY, Agrawal NM, Roth SH et al. Prevention of NSAID-induced gastric ulcer with misoprostol. Lancet 1988;2:1277-1280. 4. Elliot SL, Yeomans ND, Buchanan RR, et al. Long term epidemiology of gastropathy associated with nonsteroidal antiinflammatory drugs (NSAID) (abstr). Clin Exp Rheumatol 1990; (suppl 4) 8:58. 5. Fries JF, Miller SR, Spitz PW, et al. Toward an epidemiology of gastropathy associated with nonsteroidal antiinflammatory drug use. Gastroenterology 1989;96:647-655. 6. Gabriel S, Jaakkimainen L, Bombardier C. Risk of serious gastrointestinal complications related to use of nonsteroidal antiinflammatory drugs A meta-analysis. Annals of Internal Medicine. 1991; 115:787-796. PAAB