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Differences in abuse of female and male medical students

The article "Differences in abuse reported by female and male Canadian medical students" (*Can Med Assoc J* 1994; 150: 357-363), by Dr. Rebeka Moscarello and associates, provided startling data to which the authors paid little attention. They seemed more concerned that the self-worth and satisfaction of students, especially female students, were reduced than that students were abusing patients and others in the health care system. According to the data in the article 53% (183/347) of the students acknowledged abusing others (peers, junior medical students, nurses, patients or patients' families and support staff). But, more important, 14% (33/230) of the male students and 16% (19/117) of the female students admitted they had abused patients. Although more female than male medical students reported being abusive to their patients, the difference was not statistically significant.

There are two possible conclusions: the definition of abuse used was so broad and all-encompassing that the term was trivialized, or something is seriously wrong with our medical education that so much abuse of others, including patients, takes place in a teaching hospital. If

the first conclusion is correct, one wonders what motive lies behind efforts to sensitize students to abuse and to blame peers, faculty and clinicians (who, the report implies, are predominantly male). If the second conclusion is true, safeguards are needed to protect patients from abuse, and the issue of sex differences must not cloud the problem because, in this instance, women are as abusive as men.

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[One of the authors responds:]

Dr. Dineen's comment that "although more female than male medical students reported being abusive to their patients, the difference was not statistically significant" misrepresents the data. We compared male students who reported experiences of abuse during training with those who denied any such experiences, and then we examined the percentage of men in these two categories who reported that they had mistreated patients. A similar comparison was made for female medical students. Our data showed that there was a propensity for men to perpetuate their experience of abuse by abusing others, whereas men who had not been abused during training were not abusive. This propensity was not shown for women. In a separate article Margittai, Rossi and I¹ reported that all students who had experienced some form of abuse during training tended to perpetuate this mistreatment by abusing patients (20% [50/245]), whereas their peers who had not suffered abuse were much less likely to abuse patients (2% [2/102]; $\chi^2 = 19.24$, 1 df, $p < 0.001$). When similar comparisons were made for students who experienced abuse during medical training only (those who had experienced abuse before entering medical school were excluded) the results showed the same pattern. Of the male students 15% (14/95) perpetuated the abuse ($\chi^2 = 7.2$, 1 df, $p < 0.0007$), and of the female students

11% (4/35) had done so ($\chi^2 = 0.080$, 1 df, $p > 0.776$).

The conclusion that the definition of abuse used in our article is too broad and all-encompassing is a comment frequently made by those who deny the existence of violence against women and children in our society. Many academics and clinicians feel that such violence continues to be a major concern.² Our definitions of verbal, emotional and physical abuse were based on definitions used in previous studies published in reputable, peer-reviewed journals;^{3,4} the definition of sexual harassment was based on those used by the Ontario Human Rights Commission⁵ and the University of Toronto sexual harassment office.⁶ Many people agree with Dineen that the definitions used by these agencies are too broad.

Determination of whether "something is seriously wrong with our medical education" was the purpose of our survey. Medical-school faculty members are also members of society, subject to social, racial and cultural attitudes toward women, minorities and those of lesser power. However, the fiduciary relationship between teacher and medical student, in which the teacher accepts the trust and confidence of his or her student to act in the best interest of that student, must prevail. The teacher-student relationship is one model for the physician-patient relationship.

Safeguards and policies are in place, and attitudes are changing. On Mar. 18, 1994, Dr. Arnie Aberman, the Dean of the University of Toronto Faculty of Medicine, issued a statement that "our faculty provides a working and learning environment that allows all of our staff and students to realize their full potential unimpeded by harassment or discrimination."⁷

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Genetic testing and eugenics

The deterministic tone of Dr. Douglas Waugh's article "The human-genome project and Pandora's box" (*Can Med Assoc J* 1994; 151: 73) contrasted with that of *CMAJ's* recent 12-part series *Genetics Today*, by Alex Robinson. Waugh used Huntington's disease (HD) as a model to elaborate his thinking on several issues in medical genetics. I presume that the blood tests Waugh mentioned are direct gene probes to identify specific mutations that are prerequisites for many genetic diseases. By uncovering the pathophysiologic aspects of such diseases at their most basic level, these techniques hold the promise of future treatment or prevention, perhaps by somatic gene therapy.

The testing protocol for HD, implemented throughout Canada, is not "easy, convenient and cheap;" it involves a considerable commitment

of energy and time by various health care professionals. Testing is available through designated genetic centres. The test — for the number of cytosine-adenine-guanine trinucleotide repeats that characterize the HD gene — is not available to any physician who requests it. Furthermore, carrying a mutant gene is not the same as having a disease, "latent" or not. Eugenicists in the first half of this century failed to recognize this important difference, or refused to acknowledge it, for fear that it would interfere with the eugenic or political agenda of the powerful groups that had considerable influence on government policy, legislation and practice in Germany, the United States and Canada.

The prevalence of HD is about 1 in 10 000 people. However, for each patient with HD there are often 5 to 10 young or middle-aged relatives who are at significant risk of having the disease. The extent of familial illness in HD often engulfs and disrupts the nuclear and extended family; this degree of risk is matched by few, if any, of the other several thousand single-gene diseases. An understanding of when, and under what environmental and genetic conditions, a mutant gene contributes to a particular phenotype or disease is a fundamental objective of research in medical genetics. Only after this is understood can clinical trials, treatment, prevention and cure of genetic disease be achieved — such research is surely a worthy way to "distort already overloaded health care budgets," as Waugh expresses it. Health care budgets that do not allow an innovative and imaginative push into the unknown in order to ameliorate suffering and relieve those anxious about their genetic inheritance should be carefully scrutinized, particularly at a time when the catchphrase "evidence-based care" permeates the pages of *CMAJ*.

Prenatal identification of the HD allele, with selective abortion of a fetus carrying it, is a personal choice in Canada, but one that has been made very rarely. Fewer than

15 prenatal diagnoses have been made since the technique first became possible in the late 1980s; by contrast, more than 700 people at risk of having HD have obtained an accurate probability (usually 1% or 99%) of whether they have the HD allele through the predictive-testing protocol coordinated by genetic centres.

The main historical and cultural misinterpretation Waugh makes is that "there is the risk that the eugenicists, those apostles of engineered racial purity, might seize on genetic testing as a means of furthering their evil ends." These "eugenicists" need to be identified in the context of Canadian culture in the 1990s. They are mainly ourselves, in the collective sense — especially the well educated and affluent professionals who exercise personal power and control over their lifestyles. Members of this group sometimes demand a guarantee from the publicly funded health care system that their children (or embryos and fetuses) will not have particular genetic propensities.

The "brave new world" Waugh envisions is not around any corner that we can choose to turn or not to turn; the voluminous reports of the Royal Commission of New Reproductive Technologies make this apparent. Rather, the brave new world is largely within ourselves, created out of our narcissistic fantasies, our conditional acceptance of potential children or newborns, our addiction to technologic innovation and our deep-seated need for control in an area that, until very recently, was not susceptible to control: reproduction and the genetic quality of our children.

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[The author responds:]

I am afraid that Dr. Soltan has misunderstood my role in writing about the human-genome project. Although I have credentials as a scientist, I was writing in my more recently adopted role as a journalist and essayist. In