VITAL SIGNS

Fall 2012

Building a culture of Care, Compassion & Life….

Canadian Physicians for *Life*

Inside this issue:

The Preposterous Politics of Female Feticide

by Margaret Somerville

This article first appeared in The Globe and Mail on September 29, 2012 and is reprinted here with the author's permission.

Conservative MP Stephen Woodworth's motion to set up an all-party parliamentary committee to discuss when an unborn child becomes a human being was voted down 203-91 this week. But the fact that 30 per cent of the MPs who voted supported the private member's motion is a victory in defeat for Mr. Woodworth on two fronts.

First, most people had expected a far greater rate of rejection and never anticipated that, despite Prime Minister Stephen Harper's opposition to it, 10 cabinet members, including Status of Women Minister Rona Ambrose, would back the motion.

Second, the pro-choice mantra that "there is nothing to discuss" about abortion and that there's a consensus in Canada with respect to the current status quo of no legal restrictions on abortion at any point in gestation were both shown to be false by the heated discussion, both inside and outside Parliament, that Mr. Woodworth's motion generated.

So where do we go from here? The answer came almost immediately when B.C. Conservative MP Mark Warawa filed another motion: "That the House condemn discrimination against females occurring through sex-selective pregnancy termination."

Mr. Warawa is picking up on evidence concerning sex-selection abortion in Canada, documented

(Continued on page 2...Female Feticide)

Ontario Abortion Statistics No Longer Accessible

by Pat Maloney

In January 2012, the Ontario Government quietly shut down access to all information on abortion services. This was accomplished by an amendment to the *Freedom of Information and Protection of Privacy Act (FIPPA)*, as part of *Bill 122: An Act to increase the financial accountability of organizations in the broader public sector.* (1)

This is the clause that was added to the Act:

(5.7) This Act does not apply to records relating to the provision of abortion services. 2010, c. 25, s. 24 (17)

Why was this change made?

There are two background stories that will provide the answer to this question.

First. Officially, the Ministry of Health and Long Term-care (MOH) stated that the clause was added because *"Records relating to abortion services are highly sensitive and that is why a decision was made to exempt these records".* (2) This statement is disingenuous since, as numerous writers have already pointed out, all kinds of medical services are "highly sensitive", but are still subject to access to Freedom of Information rules. So why was this the only medical service singled out?

The more plausible reason for the change is that due to previous access to information requests made by this writer, we were discovering very high numbers of abortions being performed in Ontario, numbers much higher than being officially reported by the Canadian Institute for Health Information (CIHI). In fact, these FOI requests (based on OHIP billings and not hospital records like CIHI uses) were identifying abortion numbers a

(Continued on page 3...abortion statistics)

Vital Signs *is published by Canadian Physicians for Life, a registered charitable organization.*

Canadian Physicians for Life holds that reverence for every human life lies at the root of all medical tradition. Through the ages, this tradition has been expressed in the Oath of Hippocrates. It was rephrased in modern times in the Declaration of Geneva, which says in part, "I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity." We affirm this declaration.

Letters and submissions for publication are welcome. Membership is by donation. Tax receipts are issued for all donations.

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(Female Feticide...continued from page 1)

by a study in the Canadian Medical Association Journal and empirically confirmed in a CBC sting investigation of "recreational ultrasound" businesses. According to the CBC report, "of the 22 centres visited, 15 agreed to book an appointment for an ultrasound that would give a couple the gender of the fetus before 20 weeks of pregnancy. That's within the range of time when it's still possible for a woman to get an elective abortion."

Indeed, in Canada, an abortion on demand is legally possible throughout pregnancy.

In a press release, Mr. Warawa says "recent studies have shown that the practice of aborting females in favour of males is happening in Canada [and polls show that] 92 per cent of Canadians believe sex-selective pregnancy termination should be illegal. … As well, the Society of Obstetricians and Gynecologists of Canada have vehemently opposed sex-selection pregnancy termination."

So how will pro-choice activists or politicians who don't want to touch the topic of abortion (the "third rail of politics") react to Mr. Warawa's motion?

That unfettered access to abortion should be the litmus test of whether a society respects women and their rights is a long-standing claim of pro-choice advocates and at the heart of their rationale for supporting unrestricted access to abortion. They focus on women's rights to autonomy and self-determination and argue that such access is required to protect these rights and women's dignity.

But sex-selection abortion promotes the exact opposite values – it expresses a lack of respect for women in cultures in which sons are highly valued over daughters. It also differs from other abortions in that the woman wants a baby – just not a girl. In one study reported from India in which 8,000 consecutive abortions were followed, three were of unborn boys and 7,997 of unborn girls.

Until recently, most pro-choice advocates rejected sex-selection abortion, calling it "gendercide" and "female feticide." But that has changed, at least in Canada. Pro-choice activists, such as Joyce Arthur, now promote the view that no abortions should be prohibited. They're willing to selectively sacrifice unborn female babies, it seems, to keep the "purity" of their ideology, at least in terms of "choice."

The fact that sex-selection abortion in Canada is occurring also raises what should be unthinkable questions for our society. To what extent, for example, is female feticide associated with creating a culture in which other abuses of women – such as "honour killings" – are tolerated? And how consistent are we in our approach in criminal law when we prohibit female genital mutilation but not the killing of an unborn girl just because she's a girl?

It's very difficult to say how politicians, whose courage and conscience usually fail them when it comes to dealing with abortion in Parliament, will vote on Mr. Warawa's motion. At the heart of the issue, they'll have to choose between "choice" and "respect for female human beings," whatever their stage of development or age.

My prediction is, they might find they've jumped out of the frying pan of Mr. Woodworth's Motion 312 into the fire of Mr. Warawa's Motion 408.

Margaret Somerville is the founding director of the Centre for Medicine, Ethics and Law at McGill University.

New Board Members

We are honoured to announce the addition of four additions to the Canadian Physicians for Life board of Directors:

Dr. Mary Egan - Brandon, MB

Imane Belcaid - Medical Student, University of Ottawa

Natasha Fernandes - Medical Student, University of Ottawa

Jordyn Vanderveen - Medical Student, University of Calgary

Canadian Physicians for Life is a member organization of Life Canada (www.lifecanada.org); we are currently seeking a member to represent CPL on Life Canada's board. To put your name forward, contact us at info@physiciansforlife.ca.

(abortion statistics...continued from page 1)

full 53% higher than CIHI's numbers. (3)

(Note: CIHI statistics do not include abortions performed in private physician's offices. As well, it is voluntary for clinics to report data.)

CIHI reported 28,765 abortions in Ontario for 2010 (4), while my FOIs had hit 44,091 abortions and was about to climb again with my latest request for service code P001: *"Medical management of non-viable fetus or intra-uterine fetal demise between 14 and 20 weeks"*. However this FOI request was denied because of the exclusion clause added to FIPPA in January.

Second. The group Echo, which is funded by Ontario taxpayers, put together a so-called "Abortion Expert Panel" to study abortion access in Ontario (5). By their own admission, the panel was comprised of only pro-choice experts (6). This biased, tax-funded group advocates for more access to abortions, and for more access to second trimester abortions (7). Echo also lists these pro-abortion resources as sources of information:

National Abortion Federation
Canadians for Choice
Canadian Federation for Sexual Health
Abortion Rights Coalition of Canada
Medical Students for Choice
Gynuity Health Projects (medical abortion advocates)

If a government is paying abortion experts to advocate for increased access to abortions, then its agenda will be derailed if access to information requests divulge the inconvenient truth that Ontario is already performing far more abortions than officially reported.

Our best numbers to date are that 44,091 abortions were performed in 2010. With an average cost of $1,600 (8), that's $70,545,600 Ontario taxpayers spent destroying preborn children in 2010 alone. So in a time of fiscal restraint when expenditures are being slashed and doctors and teachers are being asked to reduce their salaries, it would become increasingly difficult to explain to the public why we need to pay more to an already lucrative abortion industry.

The solution to this dilemma was to ensure that all abortion information--the numbers of abortions being performed, the types of abortions, and their escalating costs--was hidden from public scrutiny.

If we don't know how many abortions are being performed we remain ignorant--and quiet--about the cost of those abortions.

Below are the numbers of procedures done for specific Service Codes/Diagnostic codes for 2010. This is the kind of information that we will be prevented from obtaining in the future because of this change to FIPPA.

Read more on access to abortion information on Patricia Maloney's blog: http://run-with-life.blogspot.ca.

Endnotes

(1) http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90f31_e.htm#BK83

(2) http://www.nationalpost.com/Ontario+cuts+access+abortion+data/7068507/story.html

(3) http://run-with-life.blogspot.ca/2011/12/ontario-abortion-doctors-very-busy-in.html

http://run-with-life.blogspot.ca/2012/05/revised-2010-ontario-abortions-tell-sad.html

(4) http://www.cihi.ca/CIHI-ext-portal/pdf/internet/TA_10_ALLDATATABLES20120417_EN

(5) *Abortion Expert Panel Report: Recommendations to Improve Abortion Services in Ontario*

http://www.echo-ontario.ca/sites/default/files/Abortion%20Expert%20panel%20report%20final%20format_0.pdf

(6) http://run-with-life.blogspot.ca/2011/12/pro-life-experts-need-not-apply.html

(7) *INDUCED ABORTION IN ONTARIO: CASE SCENARIOS1*

http://www.echo-ontario.ca/sites/default/files/saas%20scenarios%20april%202011%20final.pdf

(8) http://www2.canada.com/edmontonjournal/news/archives/story.html?id=57816457-0bde-439e-97f2-195e979fbf0d&p=2

(9) http://run-with-life.blogspot.ca/2012/06/dont-let-numbers-fool-you.html

(10) *Improving Access to Abortion Services in Ontario, Information for Women and Proposed System Changes* http://www.ontla.on.ca/library/repository/mon/25006/310401.pdf

Improving Access to Abortion Services in Ontario, Recommendations for the Ministry of Health and Long-Term Care http://www.ontla.on.ca/library/repository/mon/25006/310394.pdf

A couple of additional notes on the Echo reports:

1) There is a contradiction in Echo's literature regarding short-term abortion complication rates. In three (5)(10) of the four Echo reports it states that *"Abortion is a safe procedure with less than a 1% complication rate"*.

Yet in the Case Scenario report (7)(9), the percentages for short term complication rates are actually much higher at 6.95% to 8.05%.

2) Echo also recommends that: "Sexual and reproductive health topics, abortion counselling, and abortion procedures are part of the core content of medical and nursing schools' curricula and supported by core education in medical ethics. Practical training is provided to medical students and primary care practitioners".)

2010 Ontario abortion statistics

Fee Schedule Codes	Clinics	Private Physicians Offices	Hospitals	Total procedures
S752 (< 14 weeks)	15,066	17,985	8,761	41,812
S785 (> 14 weeks)	989	345	774	2,108
P054			77	77
A920, Code 635		72	22	94
Totals	16,055	18,402	9,634	44,091
Possible abortions?				
S770		2	7	9
S783			1	1
A920, Code 895	58	193	10	261
A920, Code NA		30	72	102
A920, Code 650		473	53	526
Totals	58	698	143	899

P054 - selective fetal reduction of one or more fetuses by intracardiac potassium chloride injection

S752 - induced - by any surgical technique up to and including 14 weeks gestation

S785 - induced - by any surgical technique after 14 weeks of Gestation

S770 - hysterotomy (may be claimed for purposes other than Therapeutic abortion)

S783 - hysterotomy with tubal interruption (may be claimed for purposes other than Therapeutic abortion)

Following diagnostic codes are for: Medical management of early pregnancy

A920, Code 635 (Therapeutic abortion)

A920, Code 895 (Family Planning, Contraceptive advice, advice on sterilization or abortion)

A920, Code NA (Non-specific diagnostic code)

A920, Code 650 (Normal delivery, uncomplicated pregnancy, what is this? Appears redundant under A920)

Procedure descriptions source:

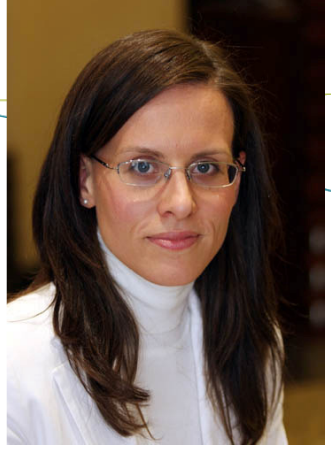
http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/k_obstet.pdf

http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/v_female.pdf

Date source: Freedom of Information requests to the Ministry of Health and Long-Term Care

How Pro-lifers Won M-312

by Andrea Mrozek



M-312. Stephen Woodworth's motion in Parliament to strike a bi-partisan committee examining when life begins was not exactly a success.

It may have even appeared to be a failure, with 91 Members of Parliament in favour and 203 against. The Prime Minister declared early on he'd vote against it (he did) and Conservative Whip Gordon O'Connor gave nothing short of a pro-abortion speech in expressing his disdain for the motion. Those on the other side were pleased it was defeated.

Yet, in reality, it was a tremendous victory for the pro-life side.

How so?

Fighting abortion in Canada is a long game if there ever was one. A marathon, not a sprint. An uphill battle. It's a tough struggle, made tougher by a media and cultural elites (judges, professors, authors, lawyers, doctors and even Prime Ministers and their caucus whips) who are aligned against the pro-life view, demeaning and belittling at every possible turn.

> "...doctors have a unique position from which to speak to the life issues, be it abortion or euthanasia."

Winning this largely cultural battle will involve many different avenues. Political activity is not the only way in which to promote life, but it is indeed one way.

M-312 was no exception. The mere fact that there was a motion on the table addressing when life begins forced many to face the issue head on.

For starters, take Member of Parliament Stephen Woodworth's diplomatic defence of his motion. He presented his case fairly, logically and clearly at every press conference. He has conducted himself with integrity, and certainly had some opportunity to talk with journalists, colleagues and constituents on the topic of M-312. A win.

Other Members of Parliament were then forced to respond to the mail of constituents, expressing their views on M-312, both for and against. Another win.

Journalists reported on the motion and the backlash and had to seek interviews from both sides. Yet another win.

All along, throughout the process, it was obvious that pro-choice groups were running Scared with a capital "S." Rightly so. Their case is built as tightly as a house of cards. And if one card falls, the whole house comes crashing down.

M-312 represented a tremendous threat to them, simply for the freedom of speech it encouraged. If it had passed, politicians would call witnesses, and journalists would report on the proceedings. Even more Canadians would have pondered the issue of when life begins and what that means.

Political initiatives, like M-312 and others start the process of breaking the current pro-abortion status quo down. Each initiative helps.

And each person who contributes helps as well. Politicians actually do count the mail that reaches them. Sending a letter or an email goes into their folders, counted and most of them actually care what their constituents are thinking.

When doctors speak up, write a letter to the editor, sign a petition, or contact their Member of Parliament, it has greater impact because of the magical "MD" letters. Take Ron Paul, the American member of the U.S. House of Representatives, who has run for President. An obstetrician gynecologist, he is pro-life, and states openly that in his medical career he's never seen a case where abortion was necessary to save the life of the mother.

This is not to say that doctors must run for office, but rather that doctors have a unique position from which to speak to the life issues, be it abortion or euthanasia.

When MDs speak out, both for and against life, it has an impact. Currently, more MDs do so against than for.

In general, Members of Parliament didn't feel a pro-life presence beating down their door over M-312. Today, a new push is on: To write letters to the Prime Minister (pm@pm.gca.ca) in support of Status of Women Minister Rona Ambrose, since she voted for the motion. The very same evening as the M-312 vote, the Abortion Rights Coalition of Canada was calling for her resignation.

So pro-lifers get the opportunity to write the Prime Minister again, this time in support of Rona Ambrose. This lengthens the media attention to the matter, providing more opportunity for pro-lifers to speak.

It may be counter-intuitive to view M-312 as a success. But it was. When and how we bring abortion to an end in Canada is up for grabs. But that we are indeed walking toward that goal right now, and every moment counts. Engaged citizens, doctors especially, are a critical part of the process.

Andrea Mrozek is Manager of Research and Communications at the Institute of Marriage and Family Canada (www.imfcanada.org) and founder of ProWomanProLife.org.

Assisted suicide – a dangerous illusion of control

by Will Johnston, MD

The daughters are beside themselves. One sat in my office recently, telling me about her father's trips to the bank which are draining his savings. He gets angry when his daughters challenge him. The money – thousands of dollars, slowly saved from a meagre pension, and needed for his care – seems to be going to a recently acquired girlfriend some years younger than himself. He speaks almost no English. The situation was detected by chance when a daughter gave him a ride to the bank and saw his bank book.

Some time ago I performed a competency assessment on a socially isolated older person who had been placed in a nursing home. An unrelated neighbour had listed the person's home for sale and was receiving enquiries before a relative became aware.

On another occasion an older woman had adequate resources to stay in her attractive home and employ a live-in caregiver. A family member, an heir and beneficiary, arranged to have her met at her door by an ambulance crew with a gurney. She was told that if she did not cooperate, the police would be called. She submitted and was transported to a dingy nursing home which she described as "a prison." Her home was sold.

A colleague recalls being on duty in an Emergency Room several years ago when an older bachelor came in desperately ill and confused, accompanied by his niece and nephew. "He's had a good life. He wouldn't want any treatment," his only relatives (and presumably heirs) attested. With ordinary care and rehydration the older man *walked* out of hospital a week later.

Each of these scenarios is different, and none of them grace a research paper, but all of them are the real face of elder abuse. I could list 10 more from my own experience. Government of Canada policy recognizes the epidemic of elder abuse and the unusual difficulty of detecting it, often because the victim resists the revelation of abuse. I routinely see people induced to do things and accept arrangements which are contrary to their own interests. People can be surprisingly naive.

High profile assisted suicide cases might at first seem to be about another kind of person, a sophisticated and clear-minded sort, immune to undue influence. I suggest that this presumption is also naive.

We all take our cues from those around us. It only takes a few words to promote suicide. If the law is changed, an obligation to mention the legal fact of assisted suicide will be created. Some patients will experience even the most perfunctory acknowledgement of assisted suicide as an inducement to it.

If state-sanctioned suicide becomes part of the atmosphere in our hospitals, a presumption in that direction will be created. I predict the same erosion of medical diligence which many of us on the front lines have already watched happen when caregivers choose to see a patient as having finished all useful life. How much more will this be the case when the patient's present fear and loss of hope feed smoothly into an official assisted suicide regime?

Some people would throw away months or years of life, and some would miss good medical care or medical advances they would have wanted to enjoy. Consider the case of Jeanette Hall, who wanted to use Oregon's assisted suicide law and is grateful, 12 years later, that her doctor directed her toward treatment rather than suicide. One of Dr. Ken Stevens' Oregonian patients was not so lucky – part way into his cancer treatment he became despondent and was given suicide pills by another doctor. I know someone, happy to be alive, who had alarming symptoms and a clear diagnosis of ALS (Lou Gehrig's disease) more than a decade ago. The symptoms inexplicably resolved. Huntington's disease, a factor in a recent high-profile suicide in Toronto, moved closer to a treatment recently in a stem cell experiment.

If a legal assisted suicide offer is always dangling, variations in the competence and diligence of doctors create arbitrary forces which move choice and control to others, not the patient.

When you or your loved one goes to the hospital you need to be able to trust that an assisted-suicide-minded doctor or nurse will not be steering you or them toward death. People can be offered the illusion of control and autonomy when the choices are really being shaped by others.

When empowered medical personnel – and right-to-die activists - choose their own opinions about your quality of life, and have been given constitutional protection to counsel, facilitate and steer you toward suicide, you and your loved ones will not be safe. The choices created by legal assisted suicide may end up being someone else's, not yours. The speculative legal changes being offered are dangerous and irresponsible. Parliament rejected them firmly two years ago. We will all be safer if our courts do the same.

Will Johnston MD is the Chair of the Euthanasia Prevention Coalition of BC
www.epcbc.ca

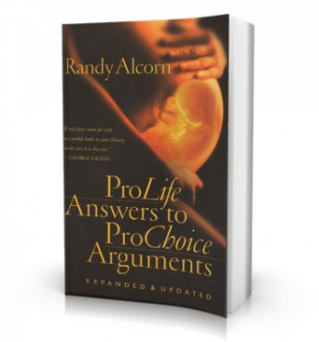
2012 MEDICAL STUDENTS FORUM

November 9 - 11, 2012
Delta Hotel Winnipeg, MB

Feedback!

The 2012 Medical Student Forum was a great success! On behalf of the Board of Directors, and the 52 students that attended this year, thank you for your very generous support. In addition to the appreciation and thanks we heard throughout the weekend, we continue to receive emails from students wishing to express their deep thanks to you.

Our aim has always been to offer to pro-life medical students a broad range of seminars and workshops designed to not only inform them with regards to sensitive and emerging issues, but to equip them with the confidence to 'make their case' when interacting with colleagues and the public who may question their stance on life issues. One student got the chance to practice as early as the plane ride back to British Columbia, when her seat-mate asked where all the students were coming from. Many students have expressed their increased confidence in addressing abortion and end-of-life topics with colleagues at medical school.



A highlight of the forum was having some CPL member physicians in attendance. The students enjoyed the informal conversations and gleaning from the experiences of more senior colleagues. Thanks for taking the time to meet with us!

A special thank you to CPL members Drs. Koke and Brickell for donating a copy of Randy Alcorn's "ProLife Answers to ProChoice Arguments" to every student. This is a great resource for every pro-life person, and an important reference tool for our students.

Before the snow storm hit, the Forum opened with a wine and cheese networking evening hosted by Dr. and Mrs. Larry Reynolds.

A brief welcome from Member of Parliament Rod Bruinooge kicked off the weekend. It was nice to see local members visiting for the evening, and serving guests.

> "The CPL conference each year reinvigorates my passion for pro-life issues. **Each time I go, I am taught new and practical lessons on how to advocate for the most vulnerable sectors of our society.** Meeting likeminded colleagues is both fun and motivating, and hearing from leaders like Dr. Johnston is truly an inspiration that I will never forget. **I am deeply grateful for those who have contributed to allow me to have this exceptional experience in medical school.** Indeed, the conferences I have attended have been a highlight of my medical training. Please accept my sincerest thanks for your generous donations."
>
> **McMaster Student, Class of 2013**

Dr. Mike Harlos opened the Saturday sessions with a talk on Perinatal Palliative Care, describing palliative care approaches that focus on providing comfort to newborn patients and support for families.

> "I found Dr. Harlos's talk especially informative, as it opened my eyes to a region of care that I have never considered before...**The measures he spoke of were so logical but so thoughtful at the same time, showing how very powerful small acts of care and consideration can be.**"
>
> **University of Calgary student, Class of 2014**

Save the date!

The 2013 Medical Student Forum will be hosted in Toronto, ON, November 8 - 10.

Pat Murphy and Dr. George Webster (both pictured left) examined Moral Resilience and what is necessary to navigate uncertainty, dilemmas and distress in the everyday world of a medical student. They also tackled the topic of Difficult Conversations in an interactive workshop.

CPL's own Dr. Will Johnston discussed the 2011 "Carter Case" and current legal appeal that has put it on hold. This was a provincial case ruling that purported to legalize assisted suicide and euthanasia for all of Canada.

> **"Dr. Johnston's lessons were incredibly useful! The comments he made about how to legally combat PAS in Canada and the very practical facts he gave about the recent court ruling in BC were exactly what I was hoping to get out of this conference."**
>
> University of Calgary student, Class of 2014

In a brief personal address, Dr. Ronald Allan spoke about Integrity during a lunch to honour one of CPL`s founding members, Dr. Paul Adams (pictured below). Dr. Will Johnston and Dr. Larry Reynolds presented Dr. Adams an award, recognizing his lifetime dedication to building a culture of life.

Stephanie Gray, founder of the Canadian Centre for Bio-ethical Reform, presented her talk, The Abortion Debate: Equipped to Engage. This session is a staple of the Medical Student Forum each year. Students appreciated receiving her recent publication, *A Physicians Guide to Abortion*.

Margaret Dore, a lawyer from Washington State, held a session called Legal Assisted Suicide: Whose Choice? She discussed how assisted suicide laws in Oregon and Washington work and how those laws compare to pending lawsuits in BC and Quebec seeking to legalize assisted suicide and euthanasia in Canada. In a joint workshop with Dr. Johnston, Ms. Dore also examined Arguing Smart: Defeating Assisted Suicide and Euthanasia in the Court of Public Opinion.

Other workshops included Dr. Larry Reynolds` session on Spirituality in Healthcare, and Dr. Sheila Harding`s session: The Ethical Practice of Pro-Life Medicine: Making the Case to the Deanery.

Dr. Stephen Genuis rounded out the forum with his session Is it Time to Rethink the Way we do Healthcare? And several workshops: Hormonal Contraception & The Sexual Revolution: Past, Present & Future; Infertility and Assisted Reproductive Technologies; and Discrimination on the Basis of Ethical Orientation.

> **"This conference is one that I would recommend to any pro-life medical professional.** A wide variety of topics were covered, despite our limited time. **Speakers used methodologically sound studies to support their viewpoint**, which is an essential tool in our evidence-based medical culture. The conference was also a great opportunity to network and identify other individuals with similar values."
>
> **University of Ottawa student, Class of 2016**

Vital Signs is running a series of cases for reflection on a relevant topic related to medical ethics or challenging scenarios with colleagues in order to spark discussion among our readers and members.

Pro-Life Case File #3: "I am crying all day..."

Alarming ultrasounds and parental anguish

Case *[Names and details have been altered]*

Five months ago Jason and Stephanie went for an ultrasound at the 19 week point in their second pregnancy. Their healthy 2-year-old stayed with a friend. The ultrasound tech was cool and professional. Halfway through the procedure, she left the room and returned with someone else, presumably a radiologist although this was not explained, and much muttering ensued. A day later I received the report which mentioned bilateral choroid plexus cysts and echogenic bowel and a circumvallate placenta. Hand written on the report was the sentence "Consultation with Medical Genetics is advised." I shared this information with the couple.

Stephanie remembers all too well those days and weeks after the "soft markers" were found. She and Jason had no intention of terminating her pregnancy. "It was really hard on me," she recalls. "We should have had the option to refuse an ultrasound search for anything that wasn't life threatening." Stephanie googled "soft markers" and "baby" and found chat rooms full of women reporting things like "I am crying all day long" and "I felt so disconnected from the pregnancy these past two weeks, and the stress is killing me."

Yesterday at 4:20 in the morning, I attended the rapid spontaneous term delivery of their vigorous and normal 8 pound son. Stephanie's conclusion? "Sometimes not knowing every detail is better."

Another patient, Rachel, was angry that her very explicit request to be told only whether her baby was growing normally, and had no life threatening malformations, was ignored and her ultrasound report described two soft markers. When the radiologist was questioned, he speculated that the College would not tolerate his compliance with a patient's request for limited information. He saw it as his medical duty to report every soft marker regardless of the patient's wishes. His attitude seemed to be "While it is unfortunate if she can't handle the truth, my job is just to report everything I see." He described a vivid concern about his own medicolegal liability which in his analysis trumped Rachel's claim that she had suffered unnecessary anguish.

Response

So how do we balance our duty to inform the mother and father about relevant medical facts concerning their unborn child with our duty to "first do no harm"? It would help if there was extensive research about the effect of prenatal bad news on the whole health of parents and children, but what we know now is rather limited – if the bad news is Down syndrome, over 90% of the children die by abortion. What we don't know is whether prenatal ultrasound false positives – or true positives for that matter – have a bad effect on parent-child bonding, pregnancy health, mood disorders, divorce rates, or much else of consequence. Some large studies suggest that routine prenatal ultrasound, as opposed to ultrasound for specific indications, is not associated with improved perinatal mortality or morbidity. (1, 2) At least one radiologist has wondered in print if he is doing more harm than good by reporting all soft markers. (3)

As a friend put it, after choroid plexus cysts were reported at 18 weeks in a daughter she wouldn't have dreamed of terminating, "It hangs over you for the whole pregnancy." It is past time to have a lively public conversation about the context in which ultrasound soft markers are sought and reported to parents.

Notes

1. Bucher HC, Schmidt J G. Does routine ultrasound scanning improve outcome in pregnancy? Meta-analysis of various outcome measures. BMJ 1993; 307: 13-7.

2. Ewigman BG, Crane JP, Frigoletto FD, LeFevre ML, Bain RP, McNellis D, and the RADIUS Study Group. N Engl J Med 1993; 329:821-827.

3. Filly RA. The best way to terrify a pregnant woman. J Ultrasound Med 2000; 19:1-5.

Will Johnston, MD, practices the full spectrum of family medicine, including obstetrics, in Vancouver. He is President of Canadian Physicians for Life.