



VITAL SIGNALS

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Bill to protect pregnant women from coerced abortions fails in Parliament – Where do we go from here?

By Barb McAdorey

On December 15, 2010, a bill to protect pregnant women from being coerced into having unwanted abortions was defeated in our House of Commons by a vote of 178 to 97.

The UN has recognized coerced abortion as a “violation of basic human rights and principles.”

Canada’s Immigration and Refugee Board has called forced/coerced abortion “a crime against humanity.”

And yet, only one out of three of Canada’s elected Members of Parliament voted in favour of MP Rod Bruinooge’s Private Members Bill C-510 (“Roxanne’s Law”), which would have protected pregnant women from being coerced into having abortions against their will.

Bruinooge named the bill after a young woman from his home town of Winnipeg, Roxanne Fernando, who was beaten to death by the father of her unborn child in 2007 after she refused to comply with his repeated attempts to coerce her into having an abortion.

This bill should have passed. It would have given additional protection to pregnant women who want to continue their pregnancies, without in any way affecting the choice of a woman who wants an abortion. It was solely aimed at putting an end to *unwanted* abortions. This was a bill that all people of goodwill—wherever they fall along the pro-life/ pro-choice spectrum—could support.

During the debate, there was some predictable ranting about “turning back the clock on

(Continued on page 6...Roxanne’s Law)

Clarifying the Clarification: College of Physicians & Surgeons of Saskatchewan Guideline on Unplanned Pregnancy

By Sean Murphy

Reports in the *Toronto Sun* and *Edmonton Sun* in February, 2011, stated that the College of Physicians and Surgeons of Saskatchewan would henceforth require physicians who refuse to perform abortions to refer patients to other physicians to obtain the procedure.¹ These reports were false. The *National Post* highlighted the story with a headline to the same effect. Its story was more accurate, but still misleading.² The Protection of Conscience Project began receiving e-mails from concerned physicians and others as soon as the stories appeared.

The source of the problem was a revision to the College *Guideline for Unplanned Pregnancy* that incorporated a requirement for “referral” in certain circumstances. It was this new requirement that the big dailies appear to have misunderstood and used as the basis for their inaccurate headlines and stories.

To be fair to reporters and editors, the wording of the revised *Guideline* lends itself to such misunderstanding.

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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.

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(Clarifying...continued from page 1)

The story begins in January of 2010, when the College Registrar identified the 1991 *Guideline* in a 185 page document listing College policies that might be in need of updating.³ The Registrar listed policies in six categories, from those recommended for affirmation (Category 1) to those recommended for deletion (Category 6). The *Guideline for Unplanned Pregnancy* was placed in Category 5, the Registrar seeking the Council's direction about whether or not it should be retained.

During discussion, the Registrar commented that physicians response to patients with unplanned pregnancy may be governed by the physician's "values and beliefs." It is not clear from the minutes whether or not the comment was directed only at physicians who object to abortion; physicians who do not object to abortion are equally guided by "values and beliefs." In any case, a subcommittee consisting of three College Councilors was formed to review the *Guideline*. Reverend J. Fryters, a public representative, joined two physicians, Dr. A. Danilkewich and Dr. P. Hanekom, to undertake the review.⁴ In June, 2010 the Council designated Dr. Hanekom chair of the subcommittee.⁵

Reporting to the Council in September, Dr. Hanekom requested clarification of the Council's opinion about maturity and consent capacity with respect to pregnant minors and the meaning of 'policy' and 'guideline.' He was advised that a 'policy' sends a stronger message to the profession than a guideline.⁶

On 19 November the subcommittee, now including Dr. Karen Shaw, provided a draft *Guideline* to Council that included two references to referral.

5 (c) With reference to the option of termination of the pregnancy, the physician should appraise the patient of the availability of abortion services in the province, or elsewhere, in accordance with any current law or regulation governing such services, *and arrange for the necessary referral*. Ideally the patient should be provided the information regarding the nature of termination options, to the best of the physician's ability. (emphasis added)

11) Any physician who is unable to be involved in the further care and management when termination of the pregnancy is considered, should reveal this to the patient *and make an expeditious referral* to another available physician.⁷ (emphasis added)

The references to referral were challenged during discussion, and the guideline was returned to the subcommittee with instructions to provide a written discussion and submit a report to the Council at its February, 2011 meeting.⁸

A revised draft *Guideline* dated 12 January, 2011 was brought to the Council in February, but the subcommittee failed to deliver the expected written discussion or report. It was approved after further revisions, after which it made the news. For the most part, the 2011 *Guideline* replicates its 1991 predecessor and the changes are not substantive. This is consistent with a published comment by the Deputy Registrar that the College did not mean to change the policy, but to clarify it⁹

It was the following new addition to the *Guideline* that triggered the inaccurate news stories and set off alarms among health care workers and others who find abortion morally objectionable:

(Preamble) Any physician who is unable to be involved *in the further care and management of any patient* when termination of the pregnancy *might be contemplated* should inform the patient and *make an expeditious referral* to another available physician. (emphasis added)

The Preamble appears to be directed at physicians who refuse to continue a relationship with a patient who 'might contemplate' abortion. Physicians who take this approach must be extremely rare - if any can be found at all - so it is doubtful that the situation considered here would ever arise.

(Continued on page 3...Clarifying)

And while one can arrive at more than one interpretation of this passage, there is no requirement that the “available physician” be an abortion provider. Thus, it would seem that the Preamble cannot be understood to imply a duty to refer for abortion. Section 5 of the guideline can also be interpreted in different ways.

- 5) Will fully apprise the patient of the *options she may pursue* and provide her with *accurate information relating to* community agencies and services that may be of assistance to her in pursuing each option. (emphasis added)
- 5(c) With reference to the option of termination of the pregnancy, the physician should apprise the patient of the *availability of abortion services in the province, or elsewhere, in accordance with any current law or regulation governing such services*, and should ensure that the patient has the *information needed to access such services or make the necessary referral*. . . . (emphasis added)

In the Project’s experience, objecting physicians are usually willing to indicate that abortion may be obtained from other physicians without the need for referral, and to suggest that the patient consult a phone book or seek assistance from the College of Physicians. However, some physicians are unwilling to provide contact information for an abortion provider, on the grounds that doing so would make them complicit in the abortion that followed.¹⁰ The term “necessary referral” is confusing, since a referral is not necessary for abortion and is not required by the Canadian Medical Association.¹¹ Thus, whether or not this part of the *Guideline* is problematic hinges upon the meaning of “information needed to access.”

The College policy *Performance of Abortion* is also relevant here because it specifies that a physician “who is unwilling to carry out the procedure in this instance, should advise the patient where the service may be obtained and, if requested to do so, assist the patient in establishing contact with such a physician or facility.”¹² Since this passage contemplates refusal to perform an abortion in a particular instance, and not a global refusal to do so, it appears that this is directed at physicians whose refusal is grounded upon clinical competence, or upon clinical rather than moral judgment.

Nonetheless, it could be interpreted to apply to physicians who, while generally willing to provide abortions, have moral objections to doing so in particular cases. Dr. Henry Morgentaler, for example, who has been awarded the Order of Canada for the dedicated delivery of abortion service for decades, is unwilling to perform abortions after about 24 weeks gestation because he does not want to abort fetuses after they have become babies.¹³ Other physicians may set lower gestational limits, and some may not be willing to provide abortions for sex selection or other social reasons. Of these, some may be unwilling to facilitate such abortions by assisting the patient in the manner indicated in the *Guideline*.

Happily, *Performance of Abortion* is one of the policies slated for review by the Council, with a recommendation that it be deleted.¹⁴ Since much of it has been incorporated into the new *Guideline on Unplanned Pregnancy*, the deletion should have no adverse

effects and will relieve the profession of an ambiguous and therefore potentially troublesome directive.

The fact that the Guideline on Unplanned Pregnancy was under review was not formally announced, nor was the draft published for comment from the profession and the public before it was approved. However, the review process can be described as reasonably transparent because the subject was discussed at Council meetings open to the public, and the College promptly responded to Project requests for copies of relevant documents after the story broke. The failure to consult the profession and the public before approving the Guideline seems to reflect a lack of awareness by College Councilors that referral for morally controversial procedures is a highly contentious issue.

It is unfortunate that an effort to clarify the Guideline on Unplanned Pregnancy has generated such confusion and that the Guideline itself is, on key points, less than clear. The Protection of Conscience Project suggests that concerned physicians and medical students contact the College directly and obtain a written explanation of the Guideline. In the meantime, they may take comfort in the fact that physicians who object to abortion for reasons of conscience - whether globally or, like Dr. Morgentaler, selectively - can hardly be disciplined for failing to adhere to ambiguous directives or guidelines.

Notes

1. “Saskatchewan Updates Abortion Policy.” *Edmonton Sun*, 9 February, 2011 (<http://www.edmontonsun.com/lifehealthandfitness/2011/02/09/17209346.html>). *Toronto Sun*, 9 February, 2011 (<http://www.torontosun.com/lifehealthandfitness/2011/02/09/17209251.html>) Accessed 2011-02-09
2. Scissons, Hannah, and Boesveld, Sarah, “Anti-abortion Docs Must Provide Referrals.” *National Post*, 9 February, 2011. (<http://www.nationalpost.com/todays-paper/Anti-abortion+doctors+must+provide+referrals/4247767story.html#ixzz1DUMkmyb0>) Accessed 2011-02-09
3. Registrar to Council, 2010-01-20, No. 20-10. *Registrar’s Review of All Current Council Policies*.
4. Extract of minutes of Council meeting of 29 January, 2010, in e-mail dated 28 February, 2011, from the Associate Registrar, College of Physicians and Surgeons of Saskatchewan to the Project Administrator.
5. Extract of minutes of Council meeting of 25 June, 2010, in e-mail dated 28 February, 2011, from the Associate Registrar, College of Physicians and Surgeons of Saskatchewan to the Project Administrator.
6. Extract of minutes of Council meeting of 17 September, 2010, in e-mail dated 28 February, 2011, from Associate Registrar, College of Physicians and Surgeons of Saskatchewan to the Project Administrator.
7. To Council from Registrar, 15 November, 2011. *Guideline: Unplanned Pregnancy*. No. 256-10
8. Extract of minutes of Council meeting of 19 November, 2010, in e-mail dated 28 February, 2011, from Associate Registrar, College of Physicians and Surgeons of Saskatchewan to the Project Administrator.
9. Scissons, Hannah, “Abortion Guidelines Updated: Rules clarify protocol for doctors unwilling to terminate pregnancy.” *Star Phoenix*, 9 February, 2011 (<http://www.thestarphoenix.com/news/Abortion+guidelines+updated/4248285/story.html#ixzz1DUM1ust7>) Accessed 2011-02-09
10. Murphy, Sean, “The Problem of Complicity.” *Protection of Conscience Project*, (<http://www.consciencelaws.org/issues-ethical/ethical082.htm>)
11. Canadian Medical Association, *Induced Abortion*. (15 December, 1988) (http://www.cma.ca/index.php/ci_id/3218/la_id/1.htm) Accessed 2011-03-02. Blackmer, Jeff, *Clarification of CMA’s position concerning induced abortion*. CMAJ • April 24, 2007; 176 (9). (<http://www.cmaj.ca/cgi/content/full/176/9/1310>) Accessed 2011-03-02
12. Registrar to Council, 2010-01-20, No. 20-10. *Registrar’s Review of All Current Council Policies*, p. 181.
13. Henry Morgentaler initially advocated unrestricted abortion during the first 12 weeks of pregnancy. In 1989 he was performing abortions on women 16 weeks pregnant, moving to 18 weeks by 1996. He noted in 2004 that he had “ethical problems” doing abortions from about 24 weeks, explaining, that he did not want to abort fetuses after they had become babies. [Canadian Press, “Quebec hopes to offer late term abortions.” (http://www.ctv.ca/CTVNews/Canada/20040912/quebec_abortion_040911/) Accessed 2010-09-20; Dunphy, Catherine, *Morgentaler: A Difficult Hero*. Random House: Toronto, 1996, p. 62-64, 339.
14. “[T]he College does not attempt to ‘micro manage clinical practice’ in respect to other services so this policy would seem to be inconsistent with our usual approach to guiding clinical care.” Registrar to Council, 2010-01-20, No. 20-10. *Registrar’s Review of All Current Council Policies*, p. 181.

2010 Medical Students Forum - Vancouver, B.C. Nov. 12 - Nov. 14



Canadian medical students from across Canada gathered in Vancouver November 12-14 for CPL's 2010 Medical Students Forum. **Keynote speaker, Dr. Nuala Kenny** of Halifax (pictured left) opened the event with her talk on Euthanasia and Palliative Care, followed by her Saturday presentation, "Challenges to Life in a Commercialized World."

Other topics included:

- "Dismembering the Ethical Physician" - Dr. Stephen Genuis
- "Post-Abortion Recovery/Informed Consent" - Vicky Green
- "The Abortion Debate: Equipped to Engage" - Stephanie Gray
- "Technology and the Depersonalization of the Patient" - Dr. John Patrick
- "Pimatisiwin: Life is Sacred - An Aboriginal Perspective" - Maureen Brown
- "How to Talk about Abortion without Starting a Riot" - Dr. John Patrick

"Hormonal Contraception and the Sexual Revolution: Past, Present, and Future" - Dr. Stephen Genuis

"Moral Courage" - Dr. Larry Reynolds



Students also attended breakout sessions on Freedom of Conscience and on Student Initiatives, and participated in a Q&A session with a panel of speakers.

The CPL Board of Directors extends a special thanks to everyone who so generously donated towards the 2010 Medical Students Forum. Each year we are reminded of the importance of this educational event. We are also impressed with the students who, in addition to studying so diligently, work to bring pro-life perspectives to their campuses –both in the classrooms, and to the medical student pro-life and bioethics clubs they maintain.

Every year new clubs are being formed and are expanding the scope of their activities. The annual Forum provides a place for club administrators to exchange ideas and encourage one another. The Forum also gives students valuable access to physicians and researchers who share their pro-life views. Every year, students tell us that informal conversations over meals with speakers and physicians are some of the most valuable moments of the event.



Our deep gratitude goes to Drs. Robin and Margaret Cottle for all of their practical efforts and generosity of time to make sure we had flawless audio. We encourage other CPL physicians to attend the AGM and Medical Students Forum and to get involved in the organization of the event. We hope to see you in Ottawa November 11-13, 2011.

“Thank you SO much for sponsorship to attend the 2010 forum in Vancouver. It was AMAZING!! The speakers were dynamic, engaging and highly educational. I learned a lot and am excited to share what I learned. ”

McMaster student, class of 2011



U of Alberta Students Launch New Pro-Life Medical Student Club

David Beking, CPL's Student Liaison in 2010, interviewed Tiara Malina about the launch of a new pro-life medical student club on the University of Alberta campus this year. CPL supports several pro-life medical student groups at universities across Canada.

Background of Leader: *Tiara Malina is currently in her second year of medical school at the University of Alberta. She was born and raised in Edmonton, Alberta. Tiara graduated from the University of Alberta in 2009 with a BSc specializing in Chemistry.*

"The reason I started this club is largely due to attending the Canadian Physicians for Life Student Forum in Calgary last year. During the conference, I realized the importance for all medical students to be more aware of the pro-life side of bioethical issues

such as abortion and euthanasia and the power they hold in helping patients make these decisions. As a medical student who is pro-life, I wanted to have a way to share with other medical students reliable information about pro-life beliefs and therefore help students to think about their own beliefs and make informed decisions. I was aware that there was not a pro-life medical students group at my University and decided to start one for the upcoming year.

"The objectives for this club are to introduce and educate medical students about the different beliefs and ideals that individuals identified as "pro-life" hold. This will benefit medical students by providing them with:

(Continued on page 5...Student Club)

(Student Club...continued from page 4)

1. A basic understanding of what it is to be pro-life and the spectrum of beliefs pro-Life individuals hold.
2. An explanation of why individuals are pro-life and use this understanding to relate to future patients who many be pro-life. This includes understanding why individuals from different faith backgrounds, (Muslim, Christian, etc.) have pro-life beliefs.
3. Exposure to different ethical biomedical issues such as abortion and euthanasia with a holistic look at these issues (ie: weighing the pros and cons of each).

“The goal of this club is not to make medical students pro-life, nor is it to be a club exclusively for those who identify themselves as pro-life. This club is open and intended for all medical students regardless of their beliefs and backgrounds and its purpose is to educate them about what pro-life beliefs are and why individuals hold to these beliefs in order to stimulate thought and look at topics such as abortion and euthanasia from a different perspective than is



(above) Tiara Malina stands with Pro-Life Medical Students Club display during the Fall 2010 semester.

often presented. Although these topics can be quite controversial, they will be presented in a respectful way that does not attack the beliefs of other groups but rather serves to stimulate thought, discussion and promotes learning.”

Providing Hospice in the Womb

by Roger Collier

This article appeared in the Canadian Medical Association Journal on March 22, 2011, and is reprinted here with permission.

Amy Kuebelbeck was 25 weeks into her pregnancy when she received the terrible news. Her fetus had been diagnosed with an incurable heart defect. If she carried through with her pregnancy, her baby’s life would be a brief one.

Kuebelbeck did continue her pregnancy and gave birth to a boy. Her new son, Gabriel, was even sicker than anticipated. He died a few hours after his birth.

“He lived for nine months before he was born,” says Kuebelbeck, “and for two and a half peaceful hours afterward.”

That was in 1999, a time when perinatal palliative care — support for families expecting babies with life-limiting illnesses — was still very much in the concept stage. There was no formal support program at the hospital where Kuebelbeck, a freelance writer from Saint Paul, Minnesota, received care during her pregnancy with Gabriel. There was, however, one person on staff who helped her family through the entire process.

“One person validated for us that we still had a profound opportunity to parent and love this baby,” says Kuebelbeck.

Her experience led to a 2003 memoir, *Waiting with Gabriel: A Story of Cherishing a Baby’s Brief Life*. It also led to the creation of the website perinatalhospice.org, which lists hospitals, mostly in the United States and Canada, that have perinatal hospice programs. When she started the website, in 2006, there were only 10 programs on that list. Now there are 90.

“My long-term goal is to take the website down because every hospital has a perinatal hospice program, just as every hospital has an emergency room,” says Kuebelbeck.

Perinatal hospice, or “hospice in the womb,” begins at the time of prenatal diagnosis, consisting at first of birth planning and preliminary medical decision-making. The goal is to ensure terminally ill babies are comfortable during their short lives, and to provide support to the families of those children — before, during and after pregnancy. Perinatal palliative care teams can consist of obstetricians, perinatologists, nurses, neonatologists, social workers, clergy, genetic counsellors, midwives and therapists.

The need for perinatal palliative care arose from the incredible growth of prenatal diagnostic technology. “The testing got ahead of the ability to care for families when the news is bad,” says Kuebelbeck.

There hasn’t yet been much written on the topic of perinatal hospice, though Kuebelbeck has again contributed to the subject’s literature, coauthoring a new book called *A Gift of Time: Continuing Your Pregnancy When Your Baby’s Life Is Expected to Be Brief*.

For the book, she and her coauthor, a developmental psychologist named Deborah Davis, interviewed 120 families — from the United States, Canada, Europe and Australia — who have experienced the loss of a baby with a life-limiting illness.

Some of those families reported positive experiences, having received support from their medical caretakers. Others, however, say they felt abandoned, or, even worse, were made to feel they were making a mistake by continuing their pregnancies, considering the inevitable outcomes.

(Continued on page 8...Hospice in the Womb)



Barbara McAdorey is the former Administrator for Canadian Physicians for Life (above).

“Enacting Bill C-510 into law would have communicated a strong message that, as a society, we strongly condemn any coercive behaviour that takes away a woman’s freedom to say “no” to abortion.”

(Roxanne’s Law...continued from page 1)

women’s rights” and “backdoor attempt to criminalize abortion.” (Note that those who use this language do not explain how such things will result from a bill that prohibits only abortion coercion and does not affect access to freely chosen abortions.) However, the argument which seemed to hold most sway in the end was the claim that abortion coercion is already illegal, making Bill C-510 “wholly redundant.”

Was Bill C-510 “wholly redundant”?

Although many types of coercion, such as harassment, uttering threats and intimidation, are already illegal, there is still value in creating a new offence specifically for abortion coercion. Criminal law scholars say we use the criminal law as “a way of indicating a serious condemnation of an activity or action”; “not only to punish people, but also to state our most important social values”; and “to send a clear message expressing society’s rejection of, and intolerance for a specific act.”

Enacting Bill C-510 into law would have communicated a strong message that, as a society, we strongly condemn any coercive behaviour that takes away a woman’s freedom to say “no” to abortion.

Creating a specific offence when a more general one already exists is nothing new. During the parliamentary debate, Bruinooge cited three bills currently before Parliament that have passed at least one parliamentary vote. For example, Bill S-9 which has received royal assent, creates a specific offence for stealing a motor vehicle, even though theft is already a crime.

Legal counsel for the EFC Faye Sonier has given another example: although we have the general crime of assault, legislators have enacted specific offences for aggravated assault, assault with a weapon, sexual assault and assault causing bodily harm because these offences were deemed unambiguously worthy of special condemnation.

Finally, C-510’s definition of coercion was so broad as to include some behaviour not obviously condemned by the Code in its present form.

“Already illegal” – a convenient excuse to oppose the bill

Claiming C-510 was “wholly redundant” allowed MPs to oppose the bill without coming across as though they support forced abortion. But it is not difficult to see that the real reason they wanted to oppose it was that an explicit prohibition for abortion coercion in the Criminal Code would too clearly send the message that something important is at stake during an abortion. After all, why single out abortion coercion and not coercion to submit to other “medical procedures” unless abortion is, somehow, different?

Indeed. The Law Reform Commission of Canada, speaking from a pro-choice perspective, recognized that abortion is not just another “medical procedure” and wrote in its 1989 report, *Crimes Against the Foetus*:

... “the process of human procreation is trivialized by equating the foetus with a tumour and abortion with other surgical procedures. Like it or not, abortion destroys a being with the full potential to become a living, breathing person. This distinguishes abortions from other surgical procedures, raises ethical and moral considerations not at issue in other clinical contexts and results in potential psychological complications quite different from those present in most other operations.” (p. 55)

Or why single out coercion to abort but not coercion to continue a pregnancy, as some abortion activists have called for? The reason, of course, is that Roxanne’s Law was about protecting pregnant women *and* their preborn children whom they want to bring to term. By giving a pregnant woman added protection in law, both she and her baby stand a better chance of making it safely through the pregnancy. There is no reason for our laws not to protect both mother and child when their interests are so perfectly aligned. That is what Roxanne’s Law would have done, without affecting legal access to abortion for those women who choose that option. Such a law would have been perfectly in line with the Supreme Court’s 1988 *Morgentaler* ruling which recognized that the state has an interest in the protection of the fetus. (It is worth noting that the Supreme Court has never ruled that the state has an interest in the *destruction* of the fetus.)

(Continued on page 7...Roxanne’s Law)

CPL Welcomes New Board Members

The Canadian Physicians for Life Board added three new members during the 2010 Canadian Physicians for Life AGM in Vancouver on November 12, 2010.

We would like to extend our welcome to **Sherry Chan, MD** (Vancouver, BC), **Launny Faulkner** (UBC - Victoria, Class of 2012), and **David D’Souza** (University of Ottawa, Class of 2013).

We are deeply grateful for their leadership and commitment as CPL continues to grow.

-Will Johnston, CPL President

Why opponents feared “Roxanne’s Law” (and the “Unborn Victims of Crime Act”)

By singling out abortion coercion in the bill (and not “childbirth coercion” or coercion to undergo other “medical procedures”) the message is sent that something worthy of protection is at stake during an abortion. And that is why abortion advocates feared Roxanne’s Law.

It is the same reason they feared MP Ken Epp’s bill C-484, The Unborn Victims of Crime Act, debated in Parliament in 2008. Although C-484 did not recognize any independent legal rights of the fetus or affect the legal status of abortion, it did make it illegal for a third party to kill a woman’s unborn child while committing an offence against her, thus recognizing that the fetus has some value. Outspoken abortion rights activist Joyce Arthur admitted the real reason she opposed C-484 when she told the National Post, *“If the fetuses are recognized in this bill, it could bleed into people’s consciousness and make people change their minds about abortion.”*

Like C-484, “Roxanne’s Law” implicitly recognized that the unborn child is worthy of protection in some circumstances (i.e. when the woman wants her baby to live.) It is this recognition that the fetus has some value which makes the more radical abortion advocates afraid that people will “change their minds about abortion.” It’s why they need to shut down any debate about abortion, not only in Parliament, but also on university campuses across Canada. Opening up a real debate just might make people *think*.

In response to Arthur’s admission to the National Post, Epp observed that if C-484 passed into law “pro-choice advocates will be in a position of having to justify abortion without relying on the illusion that the fetus is absolutely worthless. They will need to defend the view that, in spite of the unborn child being recognized as something of value, the woman’s interests are paramount.”

Are abortion advocates not prepared to defend that view in the public square?

In the meantime, those pregnant women being coerced into unwanted abortions are the “collateral damage” in the “abortion wars.” They are the ones who end up paying the ultimate price—death of their unborn children—just so that “pro-choice” activists aren’t put into the uncomfortable position of having to justify limitless abortion.

What good has come from “Roxanne’s Law” and where do we go from here?

For the sake of those pregnant moms who want to bring their babies safely to term, it’s important we try again for a “Roxanne’s Law.” Compassion and justice demand it. But in the meantime, we can take some solace in knowing that at the very least, no MP was willing to admit that coercing a woman into an abortion is a *good* thing. In fact, Liberal MP and former

Justice Critic Marlene Jennings, a strong abortion rights advocate and promoter of the “redundancy” argument, admitted during debate that “we must educate and inform women to ensure that they are fully aware of their rights when they have a decision to make about a pregnancy and that they know that the Criminal Code protects them against threats, extortion and threats of assault.” She also said, “we need to be talking to police forces to ensure that they enforce the provisions they already have.”

Though Roxanne’s Law failed, there is something positive that has come out of this whole debate: not only has the public’s awareness of the problem of coerced abortion been raised, but also our Parliamentarians have clearly told us it *is* illegal for anyone to coerce a woman to have an abortion.

We must now spread that message by educating and informing as Jennings admonishes us to do. Physicians can make sure any patient seeking an abortion knows that it is illegal for anyone to pressure her into terminating her pregnancy and refer her, when needed, to community resources that can help her.

We cannot abandon a pregnant woman, when she is at her most vulnerable, to protect the child growing inside of her all on her own. As MP Kelly Block said during debate, “We need to give Canadian women the assurance that the law will be there to protect them when they take on the monumental responsibility of bringing children into the world.”

Tragic stories like Roxanne’s demonstrate that women continue to be coerced into having abortions and perpetrators aren’t held accountable. It is clear that our current laws are not sufficient. Canada needs, and Canadian women deserve, “Roxanne’s law.”

Barbara McAdorey is the former Administrator of Canadian Physicians for Life.

Endnotes

- [1] At the International Conference on Population and Development the international community agreed in paragraph 8.25 of the ICPD Programme of Action that “Coerced abortion is explicitly recognized as a violation of basic rights and principles.” (<http://www.unfpa.org/swp/1997/box15.htm>)
- [2] X (Re), 2004 CanLII 56805 (I.R.B.)
- [3] See Liberal MP Marlene Jennings’ speech during debate in the House on Nov. 1 <http://www2.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&Parl=40&Ses=3&DocId=4746353>
- [4] S.E. Marshall & R.A. Duff, “Criminalization and Sharing Wrongs” (1998) 11:1 Can. J.L. & Juris. 7 at 7
- [5] M. Somerville, “A Clone by any Other Name” The Globe and Mail (15 May 2002) A19
- [6] Angela Campbell, “A Place for Criminal Law in the Regulation of Reproductive Technologies”, Health Law Journal, Vol. 10, 2002, p. 96
- [7] “Roxanne’s Law on coerced abortions: Law related Questions and Answers,” <http://activatecpl.theefc.ca/journal/2010/4/19/roxannes-law-on-coerced-abortions-law-related-questions-and.html>
- [8] “Why pro-choice activists fear my bill,” by Ken Epp, special to the Ottawa Citizen, May 15, 2008.
- [9] “Why pro-choice activists fear my bill,” by Ken Epp, The Ottawa Citizen, May 15, 2008.



(Hospice in the Womb...continued from page 5)

"Physicians are trained to do something," says Kuebelbeck. "Termination feels like doing something. They may feel that's the best way of helping."

Another common argument in favour of terminating pregnancies in cases of life-limiting illnesses is that it will lessen the negative psychological impact on mothers. Carrying through with the pregnancy and having the baby, according to this theory, only makes the emotional pain worse. Kuebelbeck disagrees.

"The key point is that there is no shortcut for grief. Getting over it sooner does not make it easier," says Kuebelbeck. "If your baby is going to die, your heart is going to break either way. Why not do what you can to fill your heart first?"

If support and care is offered to families in this situation, many will choose it over pregnancy termination, says Dr. Byron Calhoun, vice-chair of the department of obstetrics and gynecology at West Virginia University-Charleston. "It takes more effort and more time and requires a different thought process, but if you offer it and provide care, people will choose it," says Calhoun. "People want to be parents."

Calhoun is a pioneer in the field of perinatal palliative care. In fact, he coauthored a 2001 paper that coined the term "perinatal hospice." (*Am J Obstet Gynecol* 2001;185:525-9). The paper posits termination of pregnancies in cases of lethal fetal conditions has become the "de facto management of choice" primarily because it is favoured by health care providers rather than by pregnant women or the public in general.

If perinatal hospice was an option, it states, it is likely that many people would choose it. Though it is not difficult to set up such a program, it does require health care professionals to learn about the unique challenges of providing care to families expecting children who won't live long.

"For these families, instead of anticipating the arrival of a new baby, there is contemplation of the impending death of a loved one," the paper states. "Despite the significant increase in awareness and understanding of both prenatal diagnosis and perinatal grief, there remains a great deal of ambiguity, uncertainty, and misunderstanding about how to approach and care for these particular families."

There are certainly no technical barriers to establishing a perinatal hospice, says Dr. Hal Siden, medical director of Canuck Place Children's Hospice, a pediatric palliative care facility in Vancouver, British Columbia. "It's just a matter of sitting down with the people involved and setting up good communication systems," says Siden. "It's not tricky in terms of technology or medications. You just need a good process."

The benefits, however, can be substantial. Families can plan for various scenarios — if the baby lives longer than expected, if the baby lives shorter than expected, if the baby dies in utero, if the baby requires resuscitation measures. Without a plan, parents are often forced to make difficult decisions in the moment, when they are sleep deprived and emotionally spent.

"These children have a very unpredictable course. They could live a few hours or a few weeks," says Siden. "Families are more comfortable if they have a plan."

The results that parents expect from that plan are generally modest and achievable, says Lynn Grandmaison Dumond, an advance practice nurse at Roger's House, a palliative care facility for children in Ottawa, Ontario. "Ultimately, what we found is that these families just want a bit of time with their babies," says Grandmaison Dumond. "They just want to hold their babies, to sing them a lullaby."

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Beloved Child

Do you see me in your dreams?

Every day I wait for you...

I wait

For the wind to bring me your breath

For the light to bring me your colours

I pray

The daytime makes you smile

The night-time brings you peace

Beloved Child

If the rain touches you, it is my tears

If the wind caresses you, it is my hand

The daylight is my watching eye over you

The night-time is my cradling of your dreams

Beloved Child

Do you see me in your dreams?

Every door that opens is my arms embracing you

Thank you

My daughter

Thank you

For being my unforgotten daughter.

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