

ABORTION

A Briefing Book for Canadian Legislators

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Updated July 2002

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WHEN DOES LIFE BEGIN?

Abortion is the deliberate killing of a child in the womb of the mother. (Note: Surgical or medical intervention, designed to prevent the death of the mother, i.e., in cases of tubal pregnancy or cervical cancer, which result in the unintended and undesired death of the preborn child, are not abortions.)

Abortion is not new. It has been with us since before Hippocrates wrote in his famous oath: "...I will not give to a woman a pessary to produce abortion." All societies, all civilizations, and all religions have throughout time condemned the practice. In order to understand the moral and legal issues surrounding abortion, one must first determine when life begins. Is the preborn child a human being, fully alive and, therefore, deserving of protection under the law?

Theologians and philosophers have debated the question for nearly 2,000 years. Today however, the question of when life begins is not an issue of theology or philosophy; it can easily be answered by elementary biology. Scientific evidence and biological data establish beyond a shadow of a doubt that the child in the womb is alive from the very beginning...the moment of conception.

Conception (Fertilization)

For more than a century medical science has known conclusively that the life of every individual begins at conception. In 1857, the American Medical Association's Committee on Criminal Abortion arrived at the unanimous conclusion that the "*fetus in utero is alive from the moment of conception*" and that abortion is the "*wilful killing of a human being.*"

As a result of the many scientific, medical and technological advances in recent years, scientists are now able to observe human development at a molecular level. From the moment of conception, the pre-born child bears the undeniable stamp of a separate, distinct human being, structurally and totally different from his or her mother.

The beginning of each human life at fertilization starts with a single cell, the zygote or conceptus. To reach adulthood that cell and subsequent cells must divide forty-five times. Eight cell divisions (cleavages) occur before the

fifteenth day of development in-utero. Forty-one divisions will be complete by birth and adulthood.

The first cell contains complex molecules which include nucleic acids and proteins. The most important nucleic acid, DNA, contains the genetic code which controls every stage of development from conception to natural death. A recently developed technique can determine the identity of a particular human being by making a genetic “fingerprint” which is obtained from that person’s DNA. This proves not only that human life begins at conception, that that each human life is unique.

Scientific Testimony

In 1981, the United State Senate Judiciary Subcommittee heard testimony on the issue of when life begins. Dr. Jerome Lejeune, Professor of Genetics at the Rene Descartes University in Paris, gave a typical testimony:

When does life begin? I will try to give the most precise answer to that question actually available to science...Life has a very long history, but each individual has a very neat beginning, the moment of its conception...To accept the fact that after fertilization has taken place a new human has come into being is no longer a matter of taste or opinion. The human nature of the human being, conception to old age, is not a metaphysical contention, it is plain experimental evidence.

Dr. Micheline M. Matthews-Roth of Harvard Medical School, testifying before the same committee, stated:

In biology and in medicine, it is an accepted fact that the life of any individual organism reproducing by sexual reproduction begins at conception, the time when the egg cell from the female and the sperm cell from the male join to form a single new cell the zygote; this zygote is the starting cell of the new system.

Most textbooks of embryology have chapters describing history of embryology and the experiments done to show that multicellular organisms develop from a single cell, the zygote. Because these kinds of experiments in embryological development have been repeated so many different times on so many different species, and have always led to the same result...that organisms reproducing by sexual reproduction always arise from a single cell, and that they are always of the same biological species as their parents...this fact is universally accepted and taught at all levels of biological education. It is the continuous repetition, duplication and confirmation of experimental results that proves that the fact is indeed true...

It is scientifically correct to say that an individual life begins at conception...Our laws, one function of which is to help preserve the lives of our people, should be based on accurate scientific data.

Dr. Watson A. Bowes Jr. of the University of Colorado Medical School testified:

The beginning of a single human life is from a biological point of view a simple and straightforward matter...the beginning is conception. This straightforward biological fact would not be distorted to serve sociological, political or economic goals.

Dr. Alfred Bongiovanni of the University of Pennsylvania, agreed:

I am no more prepared to say these early stages represent an incomplete human being, than I would be to say the child prior to the dramatic effects of puberty...is not a human being. This is human life at every stage albeit incomplete until late adolescence.

Dr. McCarthy De Mere, a practising physician as well as a law professor at the University of Tennessee testified:

The exact moment of the beginning [of] personhood and of the human body is at the moment of conception.

In March 1990, Dr. Jerome Lejeune testified before the Canadian Legislative Committee studying Bill C-43, An act Respecting Abortion. Dr. Lejeune told the Parliamentary Committee:

We know, beyond any possible, doubt, that when the sperm enters the ovum all the information required to make a human being...is present. We also know, with the same degree of certainty, that no subsequent genetic information, after fertilization is passed on to a human being. This is neither the opinion of a moralist nor the hypothesis of a metaphysician, it is a very specific observation made in the course of experiment.

If it were not true that all the information required to define each human being is present at fertilization, In-Vitro Fertilization would not be possible. If a human being did not exist at fertilization, it would be impossible for a sperm to enter an ovum in a test tube and for the embryo that may result to be transferred to a woman who is not the biological mother. In other words, the fact that In-Vitro Fertilization exists proves, beyond a doubt, that human life begins at fertilization.

In 1986, the Senate Committee on Human Experimentation in Australia concluded that, “the embryo is genetically new human life organized as a distinct entity oriented towards further development.” Senator Shirley Walters, a member of the committee, told the Australian Parliament:

There is no doubt that the human embryo genetically is a new human life. The Committee took evidence from eminent scientists and medical and individual experts...None attempted to argue that the human embryo was other than a developing human being...From such evidence the Committee formed the opinion that the human embryo deserved respect and protection according to its status as human.

In 1986, the Council of Europe’s Parliamentary Assembly took the view, in Recommendation 1041/1986, that human life develops in a continuous manner from the time of fertilization, and that human embryos are thus to be handled in all cases with due respect for their dignity.

WHEN DOES LIFE BEGIN?

Supporting References

A new individual is created when the elements of a potent sperm merge with those of a fertile ovum, or egg.

Encyclopedia Britannica, "Pregnancy," page 968, 15th Edition, Chicago 1974.

Development begins at fertilization when a sperm fuses with an ovum to form a zygote; this cell is the beginning of a new human being.

Moore, Keith L., *The Developing Human: Clinically Oriented Embryology*, page 12, W.B. Saunders Co., Philadelphia, 1974.

It is the penetration of the ovum by a spermatozoa and the resulting mingling of the nuclear material each brings to the union that constitutes the culmination process of fertilization and marks the initiation of the life of an individual.

Patten, Bradley M., *Human Embryology*, page 43, McGraw Hill, New York, 1968.

Almost from the moment of conception, great quantities of these biochemical messengers appear in the cell, indicating that at the direction of the DNA, the vital processes of the new organism have swung into action...Even when the organism consists of only one cell, researchers have been able to demonstrate the presence of two new proteins...complex molecules which were not present in the unfertilised egg...By all criteria of modern molecular biology, life is present from the moment of conception.

Gordon, Hymie, M.D., F.R.C.P., Chairman of Medical Genetics, Mayo Clinic, Rochester, Minnesota, Testimony to the U.S. Senate Judiciary Subcommittee, April 13, 1981.

...The merger is complete within twelve hours, at which time the egg – which may have "waited" as many as forty years for this moment – is fertilized and becomes known technically as the "zygote," containing the full set of forty-six chromosomes required to create human life. Conception has occurred. The genotype – the inherited characteristics of a unique human being – is established in the conception process and will remain in force for the entire life of that individual. No other event in biological life is so decisive as this one; no other set of circumstances can even remotely rival genotype in "making you what you are." Conception confers life and makes you one of a

kind. Unless you have an identical twin, there is virtually no chance, in the natural course of things, that there will be “another you” – not even if mankind were to persist for billions of years.

Shettles, Landrum, M.D., Rorvik, David, Rites of Life: The Scientific Evidence for Life Before Birth, page 36, Zondervan Publishing House, Grand Rapids, Michigan, 1983.

The zygote therefore contains a new arrangement of genes on the chromosomes never before duplicated in any other individual. The offspring destined to develop from the fertilized ovum will have a genetic constitution different from anyone else in the world.

DeCoursey, R.M., The Human Organism, 4th edition, page 584, McGraw Hill Inc., Toronto, 1974.

In that fraction of a second when the chromosomes form pairs, the sex of the new child will be determined, hereditary characteristics received from each parent will be set, and a new life will have begun.

Kaluger, G., and Kaluger, M., Human Development: The Span of Life, page 28-29, The C.V. Mosby Co., St. Louis, 1974.

The science of the development of the individual before birth is called embryology. It is the story of miracles, describing the means by which a single microscopic cell is transformed into a complex human being. Genetically the zygote is complete. It represents a new single celled individual.

Thibodeau, G.A., and Anthony, C.P., Structure and Function of the Body, 8th edition, pages 409-419, St. Louis: Times Mirror/Mosby College Publishers, St. Louis, 1988.

The development of a new human being begins when a male’s sperm pierces the cell membrane of a female’s ovum, or egg...The villi become the placenta, which will nourish the developing infant for the next eight and a half months.

Scarr, S., Weinberg, R.A., and Levine A., Understanding Development, page 86, Harcourt Brace Jovanovich, Inc., 1986.

Each human begins life as a combination of two cells, a female ovum and a much smaller male sperm. This tiny unit, no bigger than a period on this page, contains all the information needed to enable it to grow into the complex structure of the human body. The mother has only to provide nutrition and protection.

Clark, J. ed., *The Nervous System: Circuits of Communication in the Human Body*, page 99, Torstar Books Inc., Toronto, 1985.

A zygote (a single fertilized egg cell) represents the onset of pregnancy and the genesis of new life.

Turner, J.S., and Helms, D.B., *Lifespan Developmental*, 2nd ed., page 53, CBS College Publishing (Holt, Rhinehart, Winston), 1983.

...Since the old ethic has not yet been fully displaced it has been necessary to separate the idea of abortion from the idea of killing, which continues to be socially abhorrent. The result has been a curious avoidance of the scientific fact, which everyone really knows, that human life begins at conception and is continuous whether intra- or extra-uterine until death...The very considerable semantic gymnastics which are required to rationalize abortion as anything but taking a human life would be ludicrous if they were not put forth under socially impeccable auspices.

California Medicine, Editorial, "A New Ethic for Medicine and Society," page 67, September, 1970.

FETAL DEVELOPMENT

Fetology

Fetology, the study of the preborn child in utero, has become one of the fastest growing and promising fields of medicine. New techniques and sophisticated instruments have given us a view into the previously hidden world of the preborn child. We can now watch a child developing, moving, touching and responding to external stimuli.

Much more has been learned about the life of the preborn child in the last quarter century than in all previous centuries. Fetology was recognized as a medical specialty in 1973; today it is one of the fastest growing medical specialties, with many sub-specialties.

The first professional papers on realtime ultrasound began appearing in 1971 and documented the child moving at six weeks: movements not felt by the mother until about four months. The fetal heartbeat, which only a few years ago was not heard until 17 weeks, was heard at 11 weeks, and seen later on realtime ultrasound at five weeks and then at three-and-a-half weeks.

The terms “zygote,” “embryo,” and “fetus” are arbitrary terms used to describe the stages of development prior to birth, just as “toddler,” “adolescent,” and “adult” are terms used to describe the stages after birth.

In his authoritative book, *Rites of Life, The Scientific Evidence for Life Before Birth* (Zondervan Publishing House, Grand Rapids, Michigan, 1983), Dr. Landrum Shettles explains the various usages of these terms:

It should be understood that though I use different terms to describe the unborn—zygote, embryo, fetus—these labels do not reflect distinctly different phases of development; these terms are used as a matter of convenience to describe general changes. Some describe the “zygote” as becoming the “embryo stage” at the time of implantation; others say the “embryo stage” begins in the third week of pregnancy. Some say the “fetal stage” begins in the fifth week of development; others say eight weeks, and still others say the embryo does not become the fetus until the end of the first trimester. It is my view that once the major processes of differentiation are largely complete, the embryo becomes the fetus. That occurs by the end of the eighth week.

Whatever the terminology, the unborn is always a distinct entity, an individual human life in its own right and not simply some “disposable part of the mother’s body.”

According to research released in late 2000, unborn babies develop a familiarity with the language spoken by their mothers. They can distinguish between this language and foreign tongues within four days of being born, said British researchers. Dr. Todd Bailey of Cardiff University says, “We think that the baby hears the sounds of the mother’s voice in the womb, even though it is heavily filtered, and takes in the speech rhythms of the mother tongue, especially during the last five months of gestation.”

Later in September 2000, research from the Netherlands was published, demonstrating that unborn children can learn and remember. They used sound to determine if an unborn baby could recognise and respond to a specific noise. The study was with unborn children 37 to 40 weeks old. A decline in evident reaction to a certain noise indicated to doctors that fetuses were able to remember the sound and “learn” that it was harmless. Previously, researchers were of the view that babies were born without a functional memory, noted BBC news in its report on the findings.

A report discussed in *New Scientist* magazine at the beginning of 2001 seems to indicate that newborn children have a response to taste that suggests different degrees of familiarity that can only have developed while the child was in his mother’s womb. The research is being performed at the European Centre for Taste Science in Dijon, France. Lead researcher, Dr. Benoit Schaal says it is the first solid scientific evidence that maternal diet can influence the food preferences of babies.

The First 15 Days of Life

Fertilization (conception) is completed when the human sperm has entered the ovum and the two pronuclei have united to form a single cell with one centre. The cell is called the zygote, or conceptus.

All the scientific evidence today confirms that the zygote not only has developmental potential, but that it organizes its own development so that its growth proceeds in an orderly fashion. Fetology expert Sir William Liley has stated:

In this regard the baby zygote with his cargo of genetic information is much more than a blueprint of the new human. A blueprint simply is a plan, and does not have the machinery to fulfil that plan — but a zygote does.

Some 30 to 36 hours after conception the first cell divides into two cells, and cleavage continues until by the fourth day there are 16 cells. The zygote moves along the Fallopian tube towards the uterus.

By the end of the first seven days of life the young human being sinks into the nutrient wall of the uterus where she implants herself. At the end of two weeks, a primitive streak appears which distinguishes the different germ layers of the individual. Over the next three weeks, these layers give rise to specialized tissue and organ systems.

Implantation marks a stage in the preborn child's development, and physical changes to the mother. The embryo, which up until now has nourished itself on the substance of the fertilized ovum and liquids along the Fallopian tube, must find another source of nutrition. This nutrition will come from the blood of the mother by means of the placenta and umbilical cord — and these means are built by the developing child.

The changes to the mother's uterus at implantation send a series of hormonal signals that she is pregnant. The pregnancy can now be confirmed by blood and urine tests.

Dr. Raymond Glaser, Professor of Anatomy at Louisiana State University Medical Center is one of the many embryologists and fetologists who has emphasized the astonishing developments which take place between the second and eighth week of life:

During the entire life span of each individual, the most dramatic changes take place during the embryonic period. This period is characterized by rapid differentiation. The major parts of the body systems are formed during this period called organogenesis. The speed at which the systems form is astounding. It is even more remarkable that all of them are derived from the same cell formed at fertilization. Since most of the structures in the adult body are established during this brief seven-week period, it is naturally the most critical time in the entire life span of every individual.

The fifteenth day marks the development of the primitive streak. The inner cells develop a ridge of tissues which form the neural tube. That tube is the future nervous system, the spinal cord and the brain. Six weeks later, by the end of the eighth week, all internal organs are present and the heart is beating, the kidneys are functioning, the skeleton is formed and the preborn child is recognizably a human being. Electrographic activity from the brain can be recorded as early as six weeks.

Six to Eight weeks of Prenatal Development

Thirty cell divisions, or two-thirds of the 45 generations that encompass the total development of an individual's life will have taken place within eight weeks after fertilization. At eight weeks all organs and body systems are in place and will mature over the next fourteen years. Visible under a microscope are her unique fingerprints, never to change except in size. The creases on the child's hands are also visible. External genitals appear.

At six weeks the eyes, nose, and mouth are evident, yet only at eight weeks do the nose, chin and outer ear become prominent. Although teeth do not appear until six to 24 months after birth, all 20 milk-teeth buds are present at six and a half weeks.

The baby first moves between the sixth and seventh weeks. If the lips are stroked the child bends the upper body to one side and makes a quick backward movement. This total pattern response involves movement of most of the body.

At eight weeks, tickling the preborn's nose will cause her to flex her head backwards away from the stimulus. Tapping the amniotic sac results in arm movements. The preborn swims in the amniotic fluid with a natural swimmer's stroke.

At merely 40 days the skeleton begins to develop in cartilage. The movement of electrical impulses through neural fibres and spinal column takes place between six and seven weeks, and at the end of the second month most parts of the adult skeleton can be identified as well as most nerves and muscles.

Ninth Week to Birth

At eight to nine weeks the eyelids have begun forming and hair appears. By the ninth and tenth week the preborn child sucks her thumb, turns somersaults, jumps, can squint to close out light, frown, swallow, and move her tongue.

If you stroke a preborn's palm at nine to ten weeks she will make a fist. At nine weeks she will bend her fingers round an object in the palm of her hand. At 11 weeks the face and all parts of the upper and lower extremities are sensitive to touch, as well as the genital and anal areas.

By three months the baby is sensitive all over, can move smoothly and has strong reflexes. She can wriggle, make a fist, turn her head and open and close her mouth. She practices breathing by inhaling and exhaling fluid. Her bones, including the rib cage, are developing rapidly, and she responds to light, noise, temperature and pressure. Dr. Landrum Shettles (Rites of Life, The Scientific Evidence for Life Before Birth, Zondervan Publishing House, Grand Rapids, Michigan, 1983) described the activities and development of the fetus in utero from the third month on, based on his own observations:

Activity is far from merely random, by the end of the [third month]. There is a purpose in what the fetus does. It is already practising for life outside the womb. Brain development is sufficiently advanced that the fetus can react to touch, turn its head, kick its legs, flex its wrists, make fists and even curl its toes. It also sucks its thumbs and swallows amniotic fluid, getting ready for the day when it will have something more substantial to consume. It practices breathing, even though it still has no air; using features that are no distinctly baby-like, the fetus begins to perfect some of the facial expressions by which is till later let its parents know its moods, its likes and its dislikes.

By the end of the third month all arteries are present, including the coronary vessels of the heart. Blood is circulating through these vessels to all body parts. The heart beat ranges during the fetal period from 110 to 160 beats per minute. All blood cells are produced by the liver and spleen, a job soon taken over by the bone marrow. White blood cells, important for immunity, are formed in the lymph nodes and thymus.

During the fourth, fifth and six months, the fetus more than quadruples its weight, going from one ounce to as many as seven ounces. By the end of the

sixteenth week, it is likely to be six inches or more in length. During the fourth month the ears begin functioning, and the heart is pumping several quarts of blood each day.

The fifth month adds about two more inches of growth. The fetus may weigh a pound, and if born prematurely at one of the best neonatology centres has a 70 percent chance of survival. By the end of the fifth month, fingernails and toenails are present and growing, and the nipples have appeared in the mammary glands of both sexes.

In the sixth month, movement, which began much earlier, becomes more pronounced. Hair follicles and sweat glands develop. Cartilage gives way to real bone. The eyelids are open. The fetus weighs almost two pounds and by the end of the second trimester will measure a foot in length.

During the seventh, eighth and ninth months the fetus will more than triple its weight. During the seventh month, the weight increases to about three pounds. Hair may be long enough to cut. The fetal brain is now better equipped to control breathing and swallowing. In the presence of air, the fetus would now be capable of crying out. The eyes are open and sensitive to light.

In the eight month, the preborn child may weigh as much as five pounds and exceed 14 inches in length. The final touches take place in the ninth month. Growth continues to an average of 20 inches in length and seven and a half pounds in weight. The skin undergoes cosmetic touches as the waxy protection on the skin is shed as the baby awaits birth.

Fetal Pain

The scientific evidence that preborn children are capable of feeling pain is overwhelming. Modern technologies such as fibre optics, sonogram and electroencephalograms (EEG) lend further proof by giving us a clear picture of the baby before birth. As one researcher put it, a “window to the womb.”

Unpleasant sensations are not tolerated very well by the child in the womb. When the mother moves too much, the baby kicks her. If something hurts, she throws out her arms, wiggles her entire body, opens her mouth and cries, just as she will after birth. During intrauterine manipulations, such as

transfusions, the child must be heavily sedated, or she will move away from the needle. Changes in the heart rate and increase in movement indicate that these stimuli are painful.

In *America Medical News*, February 24, 1984, Dr. Vincent Collins, Diplomat and Fellow of the American Board of Anesthesiologists, stated:

As early as eight to ten weeks' gestation, and definitely by thirteen-and-a-half weeks, the human fetus experiences organic pain.

Dr. Collins listed the following factors as evidence that the fetus is capable of pain:

- *The cortex is developed between four and five weeks of age.*
- *Reflex actions can be observed between four and seven weeks.*
- *Brain waves are detectable between six and seven weeks.*
- *Nerves connecting the spinal cord to peripheral structures have developed between six to eight weeks.*
- *Adverse reactions to stimuli are observed between eight and ten weeks.*

Neurotransmitters capable of sending pain signals to the brain are present at twelve weeks.

From evidence given to the Supreme Court of the United States in *J.M. v. V.C.*, October term, 1992, we know that at seven weeks the skin pain receptors are present, and they have been preceded by the nerve fibres of the neural pathways, and the nerve junctions (synapses) with the spinal cord; we also know that by 12 weeks, the thalamus, mid-brain, brain stem and cerebellar hemisphere have developed.

Doctor Ken Craig, a researcher of pain in premature babies at the University of British Columbia, told the *Vancouver Province* (August 30, 1995) that “by every measure, the fetus from 16-19 weeks reacts to a painful stimulus in a manner consistent with the perception of pain. At 24-25 weeks post conception, a fetus displays all of the physiological and behavioural reactions you observe in children and adults.”

Doctor Paul Ranalli, a neurologist at the University of Toronto, told *National Right to Life News* ("The emerging reality of fetal pain in late abortions," September, 2000, p. 14), that,

...careful anatomical studies reveal, in fact, that the ascending pain fibers reach the cortex by 20 weeks. They then 'sit' briefly, for a few days to a few weeks, before making their final push upward to establish their ultimate connections (synapses) with the surface grey matter neurons that register a conscious awareness of pain. Allowing some room for individual variability, the brain of an unborn child will begin to register pain impulses just after 20 weeks with ever-increasing amounts of pain reception reaching millions of surface cortical neurons between 20 and 24 weeks.

Between 17 and 26 weeks it is increasingly possible that it starts to feel something and that abortions done in that period ought to use anaesthesia," Dr. Vivette Glover, told to the British Broadcasting Corporation (August 28, 20000). Dr. Glover is a researcher at the Queen Charlotte's and Chelsea Hospital in London, England.

FETAL DEVELOPMENT

Supporting References

From conception on, human life is a complex, dynamic rapidly growing organism with a specific pattern of maturity and function. The pace of growth and development in the first 40 weeks (intra-uterine) is faster than that after birth, but the process is the same — as long as the specifically suitable nourishment and support systems are supplied the maturation continues in an orderly pattern and the functioning genes are programmed in at the appropriate time: e.g. heart begins beating at 24 days, reflexes begin at 42 days, air breathing begins at birth, — natal life where there are established norms of development by which a child's growth and maturation is considered precocious, normal or deficient...the same is true for the ante-natal states of development and a diagnosis of growth retardation can be established while the child is still in the uterus.

E. Dawne Jubb, M.D., *Intra-Uterine Life and Development, Death Before Birth*, page 56, Griffin House, Toronto, 1974.

In 21 days the heart begins to beat, and much later, at about two months, you have a small human being, which at this point is two and a half centimetres long from the crown to the rump. It is so small that if I were to hold it in a closed fist, you could not tell whether I had something in my hand or not. I could in fact crush it without your knowing. However, if I were to open my hand, no one could fail to recognize a tiny two-month-old human being... . At three months, if you touch the fetus' upper lip with a hair, it can turn away and even try to brush the hair with its hand. Even before the fourth month, this tiny human being can suck its thumb when it finds itself in a comfortable position in the uterus. If you upset it, it consoles itself with a swig of amniotic fluid.

Lejeune, Professor Jerome, M.D., *Minutes of Proceedings, Wednesday, March 21, 1990, Legislative Committee on Bill C-43, An Act Respecting Abortion*, 18:8.

Indirectly it has been possible to record electrographic activity from the brain between six and eight weeks.

Smyth, Harley J., M.D., *Borowski v. The Attorney General of Canada, Transcript of Evidence and Proceedings at Trial*, page 492, Regina, Saskatchewan, May, 1983.

...with the advent of realtime ultrasound in 1976, obstetricians abandoned the trimester concept as a crude and unscientific antique and began to describe pregnancy in the more precise language of weeks... Viability is a pathetically

unreliable criterion for protection of a human being under the law; there are so many variables and it is so poorly defined that it is all but useless.

Nathanson, Bernard, M.D., Bernadell Technical Bulletin, Vol. No. 1, October 1989, page 1-3, Bernadell Inc., New York.

Lip tactile response may be evoked by the end of the seventh week. By 10.5 weeks, the palms of the hands are responsive to light stroking with a hair, and at 11 weeks, the face and all parts of the upper and lower extremities are sensitive to touch. By 13.5 to 14 weeks, the entire body surface, except for the back and top of the head, are sensitive to pain.

Reinis, S., and Goldman, J.M., The Development of the Brain, Charles C. Thomas, Springfield, Illinois, 1980.

It can be clearly demonstrated that fetuses seek to evade certain stimuli in a manner which in an infant or an adult would be interpreted as a reaction to pain.

Schmidt, Richard T.F., M.D., Past President of American College of Obstetricians and Gynaecologists, Statement, February 13, 1984.

'You can tell by the contours on their faces that aborted fetuses feel pain,' said obstetrician Matthew Bulfin, M.D....He described the case of a 25 year-old woman administered a prostaglandin abortion, who expelled her fetus in the middle of the night. Before hospital nurses arrived, she witnessed, 'thrashing around and gruesome trauma on his face, and knew that the fetus had suffered.'

"M.D. group claims that fetuses suffer pain," American Medical News, February 24, 1984

One of the problems about pain is that it is a peculiarly subjective and personal phenomenon. There is no biochemical or physiological test you can do to tell if anyone is in pain...But by the same token we have no proof that animals feel pain; we only infer that they do. But it seems charitable to infer that, otherwise there would be no point in having societies for the prevention of cruelty to animals...And in that regard I am prepared to charitably assume that the baby before birth feels pain because I would be reluctant to extend consideration to animals that I would withhold from a human.

Liley, Sir Albert William, Professor Perinatal Medicine, Borowski v. The Attorney General of Canada, Transcript of Evidence and proceedings at Trial, page 194, Regina, Saskatchewan, May, 1983.

There's no question [the fetus] feels pain...When we would put the needle into the uterus to withdraw the amniotic fluid and insert the corrosive saline, invariably the unborn child would be seen to move. It was not always in response to being directly stuck by the needle. It seemed to have some inchoate sense of invasion of its territory, an unwelcome intrusion to its environment.

Nathanson, Bernard, M.D., *Borowski v. The Attorney General of Canada*, Transcript of Evidence and Proceedings at Trial, page 399, Regina, Saskatchewan, May, 1983.

when doctors first began invading the sanctuary of the womb, they did not know that the unborn baby would react to pain in the same fashion as a child would. But they soon learned that he would. By no means a vegetable, as he has so often been pictured, the unborn knows perfectly well when he has been hurt, and he will protest it just as violently as would a baby lying in a crib.

Liley, H.M.I., M.D., *Modern Motherhood*, page 50, Random House, New York, rev. ed., 1969.

...as soon as pain mechanism is present in the fetus — possibly as early as day 45 — the methods used will cause pain. The pain is more substantial and lasts longer when the method is salt poisoning...They are undergoing their death agony.

Noonan, John Jr., Professor Law, Berkeley, "The Experience of Pain by the Unborn," *New Perspectives on Human Abortion*, page 213, Aletheia Books, 1981.

By the eleventh week, the fetus develops sensitivity to touch on the hands, feet and genital areas...it may be more comfortable for us to attribute a vegetative state to the fetus in the first trimester, but in fact this is the most active period of our lives.

Cavanaugh, Denis, M.D., Testimony before Florida Legislature on Fetal Pain Bill, May 10, 1983.

HOW ARE ABORTIONS PERFORMED?

There are many methods of abortion. The procedure used depends largely upon the stage of pregnancy and the size of the unborn child. Dr. J.C. Willke, in his book, *Abortion Questions and Answers* (Hayes Publishing Co. Inc., Cincinnati, 1985), has divided the methods of abortion into three main categories: those that invade the uterus and kill the child by instruments which enter the uterus through the cervix; those that kill the preborn child by administration of drugs and then induce labour and the delivery of a dead baby; and, those that invade the uterus by abdominal surgery.

Dilation of the cervix is required in curettage methods of abortion. The usual method of dilation is to insert a series of instruments of increasing size into the cervix. A set of dilators, metallic curved instruments, are used to open the cervix sufficiently to accommodate the instruments of abortion. By contrast with a normal birth, where the dilation occurs slowly over a period of many hours, the forceful stretching by the abortionist to open the cervix takes a matter of seconds. This premature and unnatural stretching of the cervix can result in permanent physical injury to the mother.

Laminaria (dehydrated material, usually seaweed) is sometimes used to reduce damage to the cervix. Inserted into the cervix the day before the scheduled abortion, it absorbs water and swells, pushing open the cervix in the process.

Suction Aspiration

This is the most common method of abortion during the first 12 weeks of pregnancy. General or local anesthesia is given to the mother and her cervix is quickly dilated. A suction curette (hollow tube with a knife-edged tip) is inserted into the womb. This instrument is then connected to a vacuum machine by a transparent tube. The vacuum suction, 29 times more powerful than a household vacuum cleaner, tears the fetus and placenta into small pieces which are sucked through the tube into a bottle and discarded.

Menstrual Extraction

At a very early stage in pregnancy, suction abortions are performed using a smaller tube, requiring little dilation of the cervix. This is called “menstrual extraction.” However, if all the fetal remains are not removed, infection results, requiring full dilation of the cervix and a scraping out of the womb.

Dilation and Curettage (D & C)

This method is similar to the suction method with the added insertion of a loop-shaped knife (curette) which cuts the fetus into pieces. The pieces are scraped out through the cervix and discarded [Note: This abortion method should not be confused with a therapeutic D&C done for reasons other than pregnancy.]

Dilation and Evacuation (D&E)

This method is used up to 18 weeks’ gestation. Instead of the loop-shaped knife used in D&C abortions, a pair of forceps is inserted into the womb to grasp part of the fetus. The teeth of the forceps twist and tear the body of the unborn child. This process is repeated until the fetus is totally dismembered and removed. Usually the spine must be snapped and the skull crushed in order to remove the unborn child from the uterus.

Dilation and Extraction (D&X) — Partial Birth Abortion

The D&X method is used when the fetus is 20 to 26 weeks of age. At this stage of development, the toughness of the fetal tissues make the D&E method difficult. Partial birth abortion evolved to overcome this problem. After dilating the cervix for two days, the abortionist uses ultrasound to locate the legs of the fetus. One leg is pulled into the vagina with forceps, then the other leg and torso are delivered by hand. The head of the fetus remains in the uterus. Using blunt-tipped surgical scissors in a closed position, the abortionists pierces the head of the fetus at the base of the skull, and then opens the scissors to enlarge the hole. A suction catheter is inserted into the wound and the skull contents vacuumed out. The corpse is then pulled completely from the mother’s body.

Saline Abortion

“Salt poisoning,” or the saline method, is used after the sixteenth week of pregnancy. A needle is inserted through the abdominal wall, through the uterine wall and into the amniotic sac. Some of the amniotic fluid is removed and replaced with a concentrated salt solution. The fetus breathes in and swallows the salt and is poisoned by it. The outer layer of skin is usually burned off by the corrosive effect of the salt. The mother goes into labour and a dead or dying baby is delivered 24 to 48 hours later.

Fetal Reduction or Selective Reduction

Fetal reduction/selective reduction are terms coined by some in the medical profession to describe a particular method of killing a child in utero in the belief that the other, remaining children of a multiple pregnancy may have a stronger chance of survival to birth.

A needle is used to enter the womb and with the aid of ultrasound, to seek out one or more gestating children. The needle enters the chest cavity of the fetus and injects potassium chloride directly into the heart which causes immediate death. The killing is sometimes accomplished by injecting air into the heart, or in some cases, to suck out the majority of the blood volume of the selected fetus.

The dead are left in the womb, and are expelled with the remaining children are born.

The reason that these abortions are performed is due in large part to hyperstimulation of a woman’s ovaries in cases of assisted reproduction due to infertility. The rationale is that it is justifiable to eliminate some embryos in order to help save at least some of the others.

A July 6, 2000 editorial in the *New England Journal of Medicine*, (Vol. 343, No. 1) asks whether multiple pregnancies in infertility treatments are avoidable. Superovulation causes a 20 percent incidence of twin pregnancies and 10 percent multiple pregnancies. This is considered an unacceptable rate and the editorial suggests that other methodologies be used to prevent high risk multiple conceptions.

Prostaglandin Abortion

Prostaglandins are hormones needed for birth. Injecting them into the amniotic sac induces intense labour and the premature birth of a child, usually too young to survive. This method is generally used for abortions done during the second half of pregnancy. Saline or urea are sometimes injected first to kill the baby before delivery and make the procedure less distressful for the mother and abortion staff.

Hysterotomy

Hysterotomy abortion is similar to a Caesarean Section delivery. This method is sometimes used when a tubal ligation is performed at the same time. The mother's abdomen and womb are opened surgically, the baby is lifted out, and the umbilical cord is clamped. Almost all hysterotomy abortion babies are born alive. The child often struggles before dying. Some babies have survived this procedure and have either been raised by their natural mothers or adopted.

Abortifacient or Morning After Pills

Preven

In 1999, the so-called morning after pill (MAP) became available in Canada under the brand name Preven. It is only one of a family of chemical abortifacients which kill the developing human being after fertilization. These pills are sometimes referred to as "contragestives," "menses regulators" or "post-coital contraceptives."

Preven is a kit containing a pregnancy test and four pills, the first two of which are to be taken within 72 hours after sexual intercourse. These pills contain high dosages of the hormones estrogen and progestin. (Similarly high amounts of estrogen in the early birth control pills had been reduced due to serious side effects).

Preven can inhibit ovulation to prevent conception but most often it acts upon the uterine lining to make it hostile to the implantation of the human embryo. This is, therefore, an abortifacient action. The promotion of Preven has been based upon inaccurate science which claims that life begins at implantation. An individual human life begins at fertilization/conception, and that human

being dies if he is prevented from obtaining nourishment from his mother through being implanted in her womb.

On January 29, 2001, Shire Canada, the pharmaceutical provider of Preven announced that it was discontinuing the kit. The company cited lack of demand and negligible sales as the reason (even though they had reduced the price from \$25 to \$5 per kit).

The reluctance of doctors to prescribe Preven and vocal opposition from pro-life groups appear to have contributed to the failure of Preven. Many young women feared the harmful side effects of high doses of hormones.

Much controversy surrounded the distribution of Preven when, in British Columbia, pharmacists were allowed to dispense this “emergency contraceptive” without prescription. Other provinces were set to follow suit. The Society of Obstetricians and Gynaecologists of Canada and the Canadian Pharmacists Association expressed their support for such moves to give women greater access to these pills.

Depo-Provera

Upjohn, the manufacturer of Depo-Provera, calls its product a contraceptive injection. The drug, medroxyprogesterone acetate, is a synthetic hormone similar to progesterone. It is injected subcutaneously every three months and in its action prevents the release of the mature egg from a woman’s ovary. This is the contraceptive action. But according to the literature provided by Upjohn, “Depo-Provera also causes changes in the lining of your uterus that makes it less likely for pregnancy to occur.” This is an abortifacient action. Depo-Provera prevents the implantation in the mother’s womb of the newly-conceived zygote. The “pregnancy” is already a reality, but a very early abortion is caused by the drug.

Depo-Provera was approved for contraceptive use in Canada in April 1997 despite warnings that the negative side effects could cause long term health problems. Fears have been raised of coercion in the forcing of injections upon non-compliant young women and upon women who are poor, or disabled, or vulnerable in other ways. Side effects attributed to Depo-Provera include weight gain and irregular bleeding. Other serious problems include: convulsions, jaundice, deep vein thrombosis, pulmonary embolus,

osteoporosis and breast cancer. Once a woman stops using Depo-Provera, it can take more than a year for her fertility to return to normal.

Plan B

In the spring of 2000, Paladin Laboratory of Montreal launched a morning after pill (MAP) called Plan B. Plan B was said to have fewer side effects and to be more effective than other MAP's because the pills did not contain estrogen. The Plan B active ingredient is levonorgestrol, a progestin. The package contains two pills, the first to be taken within 72 hours of intercourse and the second pill 12 hours later.

The Society of Obstetricians and Gynaecologists of Canada (SOGC) adopted as policy the work of The Canadian Consensus Conference on Contraception 1998, and the Conference explained clearly how the progestin-only pill works. "The progestin-only pill (POP) relies on endometrial and cervical mucus change for the contraceptive effect" (Journal SGOG, June 1998, p. 27). This action renders the endometrium of the womb unsuitable for implantation of the embryo, and without the ability to obtain nourishment in the womb, the newly formed human being dies.

Plan B was also recommended by the SOGC in July 2000 for distribution without prescription at pharmacies. There is much concern that women's health is at risk because the pharmacist cannot be aware of the contraindications for MAP's. Pharmacists have valid objections that dispensing MAP's involves them directly in abortion provision. This presents the risk of legal liability for the complications surrounding abortion and is, for many, in violation of their conscience.

RU-486

The best known abortion pill is RU-486, also known as Mifepristone. RU-486 is a synthetic steroid that blocks the action of the hormone progesterone, which is essential to maintaining pregnancy. Deprived of progesterone, the lining of the uterus sloughs off, killing the developing child. In most cases the response of the mother's body is to release prostaglandins to cause a miscarriage. The "success" rate of the pill is raised by administering artificial prostaglandins several days after RU-486 is used. Although promoted as a safe alternative to surgery, the long-term effects of this drug, and others like it, are as yet unknown.

The prostaglandin most commonly used is misoprostol, under the trade name, "Cytotek," manufactured by Searle pharmaceuticals. In a letter of August 23, 2000, Searle wrote to the U.S. Food and Drug Administration (FDA) about the "specific contraindications to the use of Cytotek during pregnancy" and that, "intra-vaginal or oral use of Cytotek for abortion is not approved." The company also warned of "serious adverse events," including maternal death when the drug is used for purposes other than that originally intended — to prevent gastric ulcers.

Nevertheless, on September 28, 2000, the FDA approved the use of RU-486 and Cytotek as the regimen for procurement of a chemical abortion. The rights to manufacture RU-486 are held by Danco Laboratories, but the drug is actually being manufactured by Hua Rian Pharmaceutical of Shanghai, China. In Canada, where the rights are held by a French Company Exelgyn, RU-486 is undergoing year long clinical trials in four cities. It is expected that 1,000 women will be given chemical abortions, with RU-486 as part of the regimen. The *Globe and Mail* reported that on July 6 [2000], Dr. Ellen Wiebe, based in Vancouver, announced that she had started clinical trials of RU 486 in late June and that she "will be joined by other researchers at Women's College Hospital in Toronto and in locations in Quebec City and Sherbrooke, Quebec.

According to information obtained by a Freedom of Information request, since 1995, Health Ministers of British Columbia have been in correspondence with Federal Health ministers requesting expeditious approval of RU-486 for these clinical trials. (Note: Lost in the wake of Sept. 11 was the announcement that an unidentified Canadian woman died following a gangrene infection during these trials of RU-486. While the mainstream media ignored this issue, the *National Catholic [NCR]* reported that Vancouver abortionist and clinical trial overseer Ellen Wiebe failed to inform participants of the dangers of the abortion cocktail. In the Oct. 7 NCR Wiebe admits she did not inform participants that Searle had warned against the use of its product in chemical abortion because of "serious, adverse" effects including uterine bleeding and even maternal death.)

Other Chemical Abortion Drugs

Recently there has been a move to promote a chemical abortion method using a combination of methotrexate/misoprostol. Methotrexate is a highly toxic, powerful anti-metabolite commonly used in chemotherapy and in some advanced cases of rheumatoid arthritis and psoriasis. Used for abortion, it apparently inhibits or arrests cell growth in the trophoblast, the tissue surrounding the embryo, that later becomes the placenta. Deprives of nutrition, oxygen, and water that she needs to grow and survive, the unborn child dies. Misoprostol, a prostaglandin normally used to treat ulcers, stimulates uterine contractions which eventually expel the tiny human. Also known by its brand name Cytotec, this is the same prostaglandin used in tandem with RU-486.

Other Methods

In addition to the methods listed above, there are other methods of abortion used less frequently in Canada. One is the use of urea, injected into the womb in the same manner as saline. Another category of abortion is listed as hysterectomy: surgical removal of the unborn child and the uterus.

HOW ARE ABORTIONS PERFORMED

Supporting References

[A] physician performing a D&E must deal with the second trimester foetus in an intimate, physical way...ossified parts, such as the skull, must be crushed. The bone fragments must be extracted carefully to avoid tearing the cervix. Reconstruction of the fetal sections after removal from the uterus is necessary to ensure completeness of the abortion procedure.

“Emotional Impact of D&E vs. Instillation,” Family Planning Perspectives, Nov./Dec., 1977.

“You are doing a destructive process,” said Dr. William Benbow Thompson of the University of California at Irvine. “Arms, legs, chests come out in the forceps. It’s not a sight for everybody.”

“Abortion: The Dreaded Complication,” Liz Jeffries and Rick Edmonds, The Philadelphia Inquirer, Aug. 2, 1981.

We have reached a point in this particular technology where there is no possibility of denial of an act of destruction by the operator [performing the D&E abortion]. It is before one’s eyes. The sensations of dismemberment glow through the forceps like an electric current. It is the crucible of a raging controversy, the confrontation of a modern existential dilemma. The more we seem to solve the problem, the more intractable it becomes.

Hern, Walter, M.D., prominent Colorado abortionist, report to Planned Parenthood Physicians, Oct. 26, 1978.

Although technically the result of legal abortion, each foetus expelled alive because of prostaglandin lives for several hours...One series of 607 second trimester abortions from Mt. Sinai Hospital in Hartford, Connecticut, resulted in 45 live births including one set of twins. None of the babies survived more than 13 hours.

Koop, C. Everett, M.D., ScD, former U.S. Surgeon General, The Right to Live, The Right to Die, page 34, Life Cycle Books, Toronto, 1980.

Hysterotomy is an operation like a Caesarean section in which the infant is surgically removed from the mother’s abdomen and uterus. With the hysterotomy type of abortion there is no chemical that is inducing fetal death. When the surgeon [cuts open] the uterus the baby is still alive.

Hilgers, Thomas W., M.D., Associate Professor of Obstetrics and Gynaecology, Creighton University, in testimony before the U.S. Senate Constitution Subcommittee, Oct. 14, 1981.

One could see where the arms and legs had been ripped from the body and removed separately, how the spine had been snapped in two and removed with dispatch, how the skull had been crushed and the brain drained out before the bony parts were removed.

Nathanson, Bernard, M.D., *Abortion America*, Life Cycle Books, Toronto, 1979.

As the infant is lifted from the womb, said one obstetrician, "He is only sleeping, like his mother. She is under anaesthesia, and so is he. You want to know how they kill him? They put a towel over his face so he can't breathe. And by the time they get him to the lab, he is dead."

Chervanek, Frank A., M.D. et al., "When is Termination of Pregnancy During the Third Trimester Morally Justifiable?" *The New England Journal of Medicine*, page 17, vol. 310, no. 8, February 23, 1981.

In studying the reports on abortion from the Centers for Disease Control, it becomes clear that the standard abortion techniques...do not encompass all the means used to destroy the unborn. Invariably in listing means of abortion, there is a column marked "other." I have often wondered what the term encompasses. We do have some indication. The New England Journal of medicine featured an article that describes how to abort one twin without destroying the other. Using ultrasound, Dr. Thomas Kerenyi guided a needle through the mother's abdomen and then punctured the heart of the twin who had been diagnosed as having Down Syndrome. He withdrew approximately 40-50 percent of the infant's blood, and the baby died. Several months later, the mother gave birth to the survivor and discharged the remains of the dead infant. At a news conference shortly thereafter, Dr. Kerenyi described the corpse as "flat, fragile and paperlike...like a rose that had been pressed in a Bible for five years." But that was not a rose pressed lovingly in a Bible. It was the remains of an infant.

Young, Curt, *The Least of These: What Everyone Should Know About Abortion*, page 99, Moody Press, Chicago, 1984.

COMPLICATIONS OF ABORTION

Physical Complications

One of the most comprehensive classifications of serious physical complications of induced abortion is that of Dr. David Grimes and Dr. Willard Cates, Jr. from the Centers for Disease Control in Atlanta. They divided the complications into three broad categories:

Immediate Complications (within three hours of the procedure):

- *Uterine haemorrhage*
- *Hypernatremia*
- *Uterine perforation*
- *Kidney failure*
- *Cervical injury*
- *Embolism*
- *Anaesthesia complications*
- *Live-born fetus*
- *Coagulation defects*

Delayed Complications (within twenty-eight days):

- *Retained products of conception*
- *Infection*

Late Complications (occurring after twenty-eight days):

- *Menstrual abnormalities*
- *Prematurity*
- *Ectopic pregnancy*
- *Rh sensitisation*
- *Infertility*
- *Mortality*
- *Spontaneous abortion*

As the number of women who have had abortions increases steadily, the negative effects are being studied more intensely than ever before. Reporting on a long-term study of the sequelae of abortion, Frank, Kay et al. state that, "The results of the present study indicate a consistent increase in the relative

risk of adverse outcome in the pregnancy following induced abortion.” Writing in the April, 1985 British Journal of Obstetrics and Gynaecology, they conclude that “widespread use of abortion has revealed problems and posed new questions which were not and could not have been answered at an earlier date.”

Reproductive Health

Of growing concern to the medical community are the longer-term complications which affect a woman’s future reproductive ability. These include higher incidence of early miscarriage, mid-trimester spontaneous abortion, ectopic pregnancy, pre-term delivery, difficulty at the time of delivery, and small-for-gestational-age infants.

The reasons why abortions are so damaging are easily explained by the abortion procedure which cause the harm. If the abortionist’s curette scrapes too deeply, scars are formed. If the blockage is partial, future pregnancies can become ectopic. If the blockage is complete, the woman will be infertile.

Subsequent spontaneous abortions are closely associated with induced abortion procedures which require forceful dilation of the cervix, such as vacuum suction or dilation and curettage. This unnatural, abrupt and forced stretching often tears enough of the muscle fibres to permanently weaken the cervix. This may lead to cervical incompetence, and the woman may be unable to carry future children to term.

A 1983 New York study by Dr. Carol Hogue, et al. (“Impact of Vacuum Aspiration Abortion on Future Childbearing: A Review,” *Family Planning Perspectives*, pages 199-126, vol. 15, no. 3, May-June, 1983) showed that women who aborted their first pregnancy were 3.4 times more likely to have a spontaneous abortion in their second pregnancy than women who had carried their first pregnancy to term. An earlier Australian study in 1973 showed problems of cervical competence leading to potential spontaneous abortion in 75 percent of women who had procured abortions with cervical dilation.

Studies indicate that some of the most serious complications occur in teenagers, as the immature, unripe cervix can be severely damaged by abortion. “The cervix of the young teenager, pregnant for the first time, is invariably small and tightly closed and especially liable to damage on dilation,”

says Dr. J. Russell ("Sexual Activity and its Consequences in the Teenager," Clinics in OB, GYN, vol. 1, no. 3, December, 1974). Reporting on a follow-up study of subsequent pregnancies in 50 teenagers who had aborted their first pregnancy, Russell states that the young women had a total of 53 pregnancies of which: "...Six had another induced abortion...Nineteen had spontaneous miscarriages...One delivered a stillborn baby at six months...Six babies died between birth and two years...Twenty-one babies survived."

There is great concern about the growing problem of infertility which can be directly linked to the abortion procedure in many instances. There has been a marked increase over the last number of years in salpingitis and tubal adhesions. According to prominent experts, invasion of the womb can cause tubal infection which in turn can cause infertility.

Damage to the endometrium during abortion can result in defective implantation and faulty development of the placenta. The faulty development is associated with Perinatal mortality and congenital handicaps.

Breast Cancer

For over a decade, a growing body of research studies has shown a connection between abortion and breast cancer. The positive association between induced abortion of a first pregnancy and the incidence of breast cancer emerged in scientific literature as far back as 1970. A 1983 study by Brinton, Hoover and Fraumeni Jr., ("Reproductive Factors in the Aetiology of Breast Cancer," British Journal of Cancer, vol. 47, no. 6, 1983) stated that there are indications that "an induced abortion in the absence of having a live birth shows some elevation of risk for breast cancer."

Statistical evidence reveals that the breast cancer rate is rising despite all attempts at treatment and prevention. When the known risk factors are investigated, there remains a very significant number of women (60-70 percent) who have been diagnosed with breast cancer but do not have any of the known classic risk factors for cancer. This has led to the search for previously unrecognised factors which could affect the incidence of this disease.

The changes which occur in the female breast tissue after conception cause a woman's breast cells to reach a mature state by the completion of a full term

pregnancy and subsequent lactation. The cells, in response to hormonal stimulus, differentiate, or specialize, and thus permanently alter the structure of the female breast. Once maturation has occurred, the cells will never return to their earlier and undifferentiated state.

Scientists agree that a full-term pregnancy protects against breast cancer, and that breast cells are most vulnerable to cancer during their transitional, unstable, stage, before maturation is complete.

In particular, the work of Dr. Joel Brind, Professor of Biology and Endocrinology at Baruch College, City University of New York, concludes that aborting a first pregnancy or having multiple abortions without an intervening full-term pregnancy increases a woman's risk of breast cancer.

In 1996, Dr. Joel Brind and Colleagues produced a meta-analysis of 33 international studies concerning the abortion/breast cancer connection. It was published in October 1996 in the British Medical Association's Journal of Epidemiology and Community Health. Twenty-seven studies showed a positive link between abortion and breast cancer leading to the conclusion that induced abortion increases a woman's risk of developing breast cancer by an average of 30 percent.

The Royal College of Obstetricians and Gynecologists in Britain, in March 2000, stated in a published Guideline that the Brind meta-analysis, "had no major methodological shortcomings and could not be disregarded."

In many jurisdictions legislators are becoming concerned about the possibility of lack of "informed consent" for women about to undergo abortion and of the possible legal ramifications of ignoring an increase in breast cancer risk to these women. *USA Today*, in an article titled, "States eye abortion warnings" (March 1, 2001), reports that at least 11 states are looking at legislative proposals to require abortion providers to make available information concerning the increased risk of breast cancer. Three states already have "right to know" laws.

Many people, however, continue to criticize the notion of a link between abortion and breast cancer. A typical line of reasons, says Babette Francis, is illustrated by a brochure distributed to clinicians at Australia's Peter

MacCallum hospital. It uses the claim that there is no plausible carcinogenesis in abortion to dispute the idea of an abortion-breast cancer connection. Ms. Francis, who is the national and overseas coordinator of the Australian organization, Endeavour Forum Inc., however, observes that “there is no carcinogenesis either in early puberty, late menopause, late first birth, obesity or being childless, but these are all accepted risk factors for breast cancer. What all have in common is greater cumulative exposure to oestrogen. ... Oestrogen is a tumor promoter.”

Psychological Complications

Abortion supporters usually claim that a woman feels relief after her abortion, or at most, a temporary "sense of loss." However, more and more researchers are documenting actual responses to abortion that are more severe, more lasting and therefore more troubling to all concerned.

The immediate reaction after an abortion may be one of relief. However, a number of psychological problems may begin to surface one month, one year or even ten years later. The problems may take the form of guilt, anxiety, depression, or a sense of loss, hostility, suicide or psychosis. A woman may suffer from one or more of these difficulties.

Post-Abortion Syndrome

Post-abortion symptoms are now identified in medical literature as "Post-Abortion Syndrome," or PAS. The American Psychiatric Association has identified abortion as a "psycho-social stressor" that can trigger post-traumatic stress disorder.

A World Health Organization report (Technical Report Series, "Scientific Group on Spontaneous and Induced Abortion," Geneva, 1970) states:

“There is no doubt that the termination of a pregnancy may precipitate a serious psychoneurotic or even psychotic reaction in a susceptible individual.”

In an article, “The Familial Context of Induced Abortion” (Restoring the Right to Life, ed. J. Bopp, Provo, Utah, 1984) Professor Vincent Rue, an authority on the subject, lists characteristics of PAS as: guilt, anger, fear, depression, grief, anxiety, sadness, shame, helplessness, hopelessness, sorrow, lowered self-esteem, distrust, hostility toward self and others, regret, insomnia,

recurring dreams, nightmares, anniversary reactions, suicidal behaviour, alcohol and/or chemical dependencies, sexual dysfunction, insecurity, numbness, painful re-experiencing of the abortion, relationship disruption, communication impairment, isolation, fetal fantasies, self-condemnation, flashbacks, uncontrollable weeping, eating disorders, pre-occupation, distorted thinking, bitterness and a sense of loss and emptiness in association with one or several abortions.

Also according to Dr. Rue, the most common feelings experienced by women who have undergone abortions seem to be unresolved grief, denial, anger and guilt. The most likely PAS sufferers are teenagers, women who have second-trimester abortions, women with low self-esteem and those with prior emotional problems.

In *The Psycho-Social Aspects of Stress Following Abortion* (Sheed and Ward, Kansas City, 1987), author Anne Speckhard lists the ten most commonly reported reactions to abortion:

- *grief reactions (100 percent)*
- *feelings of depression (92 percent)*
- *feelings of anger (92 percent)*
- *feelings of guilt (92 percent)*
- *fear that others would learn of the pregnancy and abortion (89 percent)*
- *surprise at the intensity of the emotional reaction to the abortion (85 percent)*
- *feelings of lowered self worth (81 percent)*
- *feelings of victimization (81 percent)*
- *decreased effectiveness, or suppressed ability to experience pain (73 percent)*
- *feelings of discomfort around infants and small children (73 percent).*

What women really feel at the deepest level about abortion is different from what they say on the surface. In-depth psychotherapy has revealed that, even for those who felt abortion was their only option, women may feel deep pain and deep rejection of the abortion experience.

In her article, "Illegal Abortion as a Public Health Problem," (American Journal of Public Health, vol. 50, no. 7, 1960), Dr. Mary Calderone states:

Aside from the fact that abortion is the taking of a life, I am also mindful of what was brought out by our psychiatrists...that in almost every case, abortion whether legal or illegal, is a traumatic experience that may have severe consequences later on.

In their article "Psychological Effects of Induced Abortion," published in Abortion's Aftermath, (Human Life Research Institute, Toronto, 1987) researchers Mary Parthun and Anne Kiss conclude:

Review of a wide range of psychological and medical literature indicates that negative post-abortion psychological sequelae are a phenomenon worthy of consideration. Transient, short-term distress is common and more serious long-term effects occur...We can expect increasing numbers of women to seek help for post-abortif grief and distress. It is heartening that health care workers from a variety of professions are responding to the needs of these women. However, there may be many more who remain unrecognized and unhelped. Unfortunately, few of the professionals involved in carrying out abortions are the ones approached by the distressed women after abortion. Hence, there is a great need for all involved in abortions to be aware of the serious problem of post-abortion psychological sequelae.

Self-help groups for women suffering from PAS are being organized in all parts of Canada. Other groups, including pro-life nurses, professional counsellors and pro-life organizations also provide post-abortion counselling. Perhaps because of this help, the number of women willing to speak out on the negative effects of abortion is growing dramatically.

COMPLICATIONS OF ABORTION

Supporting References

...Abortion clinics and pro-abortion entities...have long advertised the relative safety of abortion. But such statements about safety of abortion made by such entities are as suspect as statements about the safety of smoking by cigarette companies...

Wardle, Lynn, Professor of Law, Brigham Young University, A Lawyer Looks at Abortion, pages 111-112, Brigham Young University Press, Provo, Utah, 1982.

There has been almost a conspiracy of silence in declaring [abortion's] risks. Unfortunately, because of emotional reactions to legal abortion, well documented evidence from countries with a vast experience of it, receives little or no attention in either the medical or lay press. This is medically indefensible when patients suffer as a result...It is significant that some of the more serious complications occurred with the most senior and experienced operators...

Stallworthy, J.A., et al., "Legal Abortion: A Critical Assessment of Risk," The Lancet, December 4, 1971.

Of the 252 women surveyed, approximately one-half complained of suffering from at least one type of physical complication following their abortions. Moreover, at least 18 percent of those surveyed reported having suffered permanent physical damage traceable to the procedure...

...Of the 47 percent who reported suffering from a complication, 40 percent said it was a very minor problem, 26 percent said it was moderately severe, and 35 percent claimed that it was very severe...

...Of the short term complications, the most frequently identified was post-operative haemorrhage, noted by 15 percent of all women surveyed. Infection was the second most likely complication, reported by 9 percent of those surveyed...

...Of the aborted women surveyed, approximately 6 percent were forced to undergo a total hysterectomy to remove a uterus that had been damaged or infected by the abortion procedure. Another 8 percent reported that post-abortion infection had left them sterile by blocking their fallopian tubes or through some other means. Yet another 4 percent contracted cervical cancer, which they attribute to the abortion...

...Besides suffering sterility from the above causes, many aborted women suffer a reduced ability to carry a later wanted pregnancy to term. Of the women surveyed, approximately 20 percent later suffered miscarriage of a In

addition, no less than 8 percent were diagnosed as suffering from cervical incompetence after their abortions. Other birthing problems and reproductive damage were frequently reported.

Reardon, David C., *Aborted Women: Silent No More*, pp. 22-25, Loyola University Press, Chicago, 1987.

[It] should be noted that physical complications of induced abortion fall into several well-defined groups. Medical practitioners have particular concern about the impact of abortion on the patient's capacity for future childbearing. Such capacity can be seriously affected by ectopic pregnancy, spontaneous abortion, premature delivery and difficulties at the time of delivery. Maternal death, while rare, is still a documented event, with fatal haemorrhage, embolism or infection as the usual causes.

Morris, H., M.D., and Williams, L., M.S.W., "Physical Complications of Abortion," *Abortion's Aftermath*, second edition, page 39, Human Life Research Institute, Toronto, 1987.

Preliminary findings from several studies suggest that there may be an increased risk of subsequent second-trimester spontaneous abortions and premature births among women who have had only one abortion. These results are not definitive. But they underscore the need for further research on the long-term consequences of abortion..

Jaffe, Frederick, *Politics of Abortion*, page 27, McGraw-Hill, New York, 1981.

The younger the patient, the greater the gestation, the higher the complication rate...Some of the most catastrophic complications occur in teenagers.

Bulfin, J., M.D., *OB.-GYN Observer*, Oct.-Nov., 1975.

It is necessary that a woman undergoing a saline abortion remain conscious during salt injection so that her reactions can be monitored. Emergency measures must be taken at the first sign of shock. For this may mean that the needle has pierced one of the woman's blood vessels. Introduction of the salt solution into her bloodstream can lead to rapid convulsions, cardiac failure and death.

"Fetal Pathology and Mechanisms of Death in Saline Abortion," *American Journal of Obstetrics and Gynaecology*, 120(1974), pages 347-355.

Every abortion kills two – the child and the conscience of the mother. She will never forget that she herself killed her own child.

Mother Teresa of Calcutta, speech, Parliament Hill, Ottawa, September 17, 1988.

...no amount of rationalization, intellectualization or humanistic considerations can relieve the overwhelming guilt which is present at the unconscious level as a result of an abortion. Furthermore, much of what we encounter at the conscious level regarding the feelings which patients report about abortion represents denial, displacement or rationalization, and we find it rather strange that so many professionals are misled by these commonly employed defensive procedures.

Maddox and Sexton, "The Rising Cost of Abortion," Medical Hypoanalysis, page 67, Spring, 1980.

...This letter is to bring to your attention a serious public health hazard associated with use of RU-486 and other anti-progestational steroids as abortifacients, namely, a markedly increased risk of breast cancer. To the best of my knowledge this issue has not been raised in any government hearings....despite the fact that increased risk of breast cancer associated with abortion of first pregnancy is well established in the literature.

...What is the magnitude of the breast cancer hazard inherent in abortion? A review of relevant literature... puts the relative risk of abortion of first pregnancy at between 1.5 - 2, over and above the increased risk resulting from delaying first full-term pregnancy by any means. (For multiple abortions relative risks estimates range as high as 4 or 5.)

Brind, Joel, PhD., Baruch College, Professor of Endocrinology, Letter to David Kessler, M.D., Commissioner, Food and Drug Administration, January 27, 1993.

...Our data support the hypothesis that an induced abortion can adversely influence a woman's subsequent risk of breast cancer

Daling, Janet R., Malone, Kathleen E., Voigt, Lynda F., White, Emily, "Risk of Breast Cancer Among Young Women: Relationship to Induced Abortion." Journal of the National Cancer Institute, pages 1589-1591, Vol. 86, No 21, November 2, 1994.

ABORTION TO PROTECT THE LIFE OR HEALTH OF THE MOTHER

Life of the Mother

Many people mistakenly believe that abortions are performed to preserve the mother's life or health and, as such, should be legal. However, as early as 1951, Dr. Roy Hefferman, Tufts University, told the Congress of the American College of Surgeons that:

Anyone who performs a therapeutic abortion is either ignorant of modern methods of treating complications of pregnancy or unwilling to take the time to use them.

In his book *The Right to Live, The Right to Die*, (Life Cycle Books, Toronto, 1980) former U.S. Surgeon General C. Everett Koop states:

The life of the mother argument surfaces in every debate concerning abortion. The fact of the matter is that abortion as a necessity to save the life of the mother is so rare as to be non-existent.

An article in the *American Journal of Obstetrics and Gynaecology*, 1965, shows that, in a number of American hospitals, in as many as 24,417 deliveries, not one abortion was required. Other hospitals averaged one abortion in 36 deliveries. This indicates that it is more apt to be the quality of the health care provided and/or the attitude of the hospital staff that colours the recommendation to abort on the basis of the life or health of the mother.

The widely-held view that abortion is needed to save the life of the mother is not based in fact. It is based upon confusion and misunderstanding. Most people who state that abortion must be legal where there is a threat to the life of the mother are actually thinking of cases which, in fact, do not involve induced abortion. Usually they have in mind two types of cases.

The first of these cases involves ectopic pregnancies – those pregnancies where the fertilized ovum (the preborn child in the earliest stage of his development) has lodged not in the uterus, but in the fallopian tube. The second case involves cancer of the uterus. Each of these conditions is a direct and serious threat to the life of the mother.

Both ectopic pregnancies and uterine cancer are routinely treated by recognized medical procedures which are intended to cure the mother of her condition. The intent of the surgery is not to destroy the developing child. In each case, however, treatment has a secondary, indirect effect of causing the death of the preborn child. In both instances, the principle of double effect applies, and the death of the child is an indirect result of a medical procedure which is necessary to save the life of the mother.

These cases, and others where essential life-saving treatments are undertaken which unfortunately imperil the child have never medically, nor legally, been considered to be abortions.

Actual cases of induced abortions which are carried out to save the life of the mother are extremely rare. Statistical evidence from Britain, gives startling proof of this fact. The British Hansard Written Answers of July 1, 1987 discloses that of 2.6 million abortions carried out in England and Wales between 1968 and 1986, 123 (or .005 percent) were performed to save the life of the mother.

This data is similar to that obtained in a study conducted by Dr. John Murphy at the National Maternity Hospital in Dublin from 1970 to 1979. In studying the 21 maternal deaths resulting from the 74,317 births at the hospital during those years, Murphy concluded that in only three cases could a medical argument have been made for the performance of an abortion to save the life of the mother.

Close examination however, revealed that in two of these cases the women in question had previously had successful deliveries in spite of their medical conditions. This left one remaining case (out of more than 74,000) for which a medical argument for abortion could have been made.

In the rare event that pregnancy could be life-threatening, every attempt should be made to save both mother and child. Performing an abortion because of the possibility that the continuation of the pregnancy might threaten the mother's life is to presuppose medical complications which may never arise.

If an actual emergency situation should occur, English Common Law would allow an intervention to save the life of the mother. We do not need a law permitting abortions to protect those women who, under extremely rare conditions, may find themselves in this situation.

Health of the Mother

There are many indicators which point to the fact that abortion is a completely elective procedure. Perhaps the most compelling evidence that abortion is a procedure performed for socio-economic reasons, unrelated to maternal health, comes from those who for 20 years were responsible for abortion approvals: the Therapeutic Abortion Committees (TACs).

Therapeutic Abortion Committees were put in place in 1969 when Canada's abortion law was liberalized to include "health," which was interpreted to include the emotional, psychological, physical, mental and socio-economic health of the mother. The TACs became redundant when the Supreme Court ruled Canada's abortion law unconstitutional in 1988.

A 1986 inquest into the abortion-related death of an Ottawa teenager provides an insight into the philosophy of the TAC members. The Chairman of the Ottawa Civic Hospital TAC testified regarding the two different indications under which her committee approved abortions. The first, termed a "medical indication" was used if the "the foetus itself was abnormal." The second was used in cases where there were non-medical but psycho-social indications. In this category a woman's "wish for an abortion" was sufficient justification for granting its approval. Not surprisingly, this resulted in the approval of each and every application. Further testimony at the inquest indicated that this attitude was common with Therapeutic Abortion Committees across Canada.

A Matter of Choice

By defining abortion in terms of "freedom of choice," "reproductive choice," "childbirth by choice," and "the right to choose," Canadian advocates of abortion on demand have removed from the debate any hint of medical necessity. By their demand for a "woman's right to choose" those lacking a moral imperative against abortion have themselves produced compelling evidence that abortion is not medically necessary.

The arguments raised by abortion advocates are based on a perceived "right" of a woman to choose when she will bear children, and how many children she will bear. The "need" for abortion in the context of this argument is not founded in medical necessity, but rather in social and economic considerations. Induced abortion cannot be either an "option" or "choice" and at the same time a medical necessity.

The philosophy of "choice" as the standard of assessment of abortion has permeated even supposedly objective studies of abortion in the recent past. It is interesting to note, for example, that in the 1987 Study of Abortion Services in Ontario, commissioned by the provincial government, abortion was viewed as a "legally defined health service." The author, Dr. Marion Powell, stated that she approached the issue of access to abortion in terms of "equity" and "public concern whether abortions are publicly available to all women who want them..."

This attitude is shown explicitly in Powell's reference to the increased "demand for services to terminate unwanted pregnancies so that young women can continue with their education and careers." Nowhere in the 42-page report is there any discussion of a prevailing medical need for abortion such as one would expect in an analysis of the accessibility of a medically-necessary service.

Such a need does not exist. As neurosurgeon Dr. Harley Smyth states in his book, *Motive and Meaning in Medical Morals* (Battleford, Saskatchewan, 1977):

The operative procedure is listed as "therapeutic" though in fact such a procedure satisfies no therapeutic criteria; it treats no disease, cures no symptom, and removes, in the vast majority of cases, no abnormal tissue.

Mental Health

There is ample evidence to show that the mental health of women is damaged, and not preserved, by abortion. In 1978, a report of a symposium on the Psychological Aspects of Abortion, held in Chicago, showed that ten leading Canadian and American specialists in psychiatry said that abortion produces its own "psychic morbidity." They were unable, after searching psychiatric literature, to find one bona fide psychiatric condition for which abortion is recognized as a cure.

A World Health Organization technical report (Technical Report Series, "Scientific Group on Spontaneous and Induced Abortion," Geneva, 1970) stresses the same points:

Studies concerned with women who have had legal abortions in hospitals, mainly for psychiatric reasons, show that serious mental disorders arise more often in women with previous emotional problems. Thus, the very ones for whom legal abortion is considered to be justified on psychiatric grounds are the very ones who have the highest risk of post-abortion psychiatric disorders.

A study by Ford et al., "Abortion: Is it a Therapeutic Procedure in Psychiatry?" published in the Journal of the American Medical Association in November, 1971 stated:

...it would appear that the more serious the psychiatric diagnosis: the less beneficial was the abortion...As might be expected chronic characterological neurotic or psychotic conditions are not solved by abortion, which is in essence a form of environmental manipulation.

Noyles and Kolbe's standard textbook of psychiatry (Modern Clinical Psychiatry, 7th ed., W.B. Saunders Co., Philadelphia, 1968) states that "experience does not show that pregnancy and the birth of a child influence adversely the course of schizophrenia, manic depressive illness or the majority of psychoneuroses."

It is openly admitted that the excuse of mental health has served to cover up abortions for convenience and socio-economic reasons. In September 1975 the Canadian government commissioned a committee, which became known as the Badgely Committee, to determine whether the abortion law was "operating equitably across Canada."

The members of the committee were Toronto sociologist, Robin Badgely, the chairman; Dr. Marion Powell, also of Toronto and active in family planning groups; and Denyse Fortin-Caron of Montreal who specialized in family law. Their terms of reference included several specific questions about the availability of hospitals, the rules the Therapeutic Abortion Committees should be required to base their decisions on, and "the timeliness with which this procedure makes an abortion available in light of what is desirable for the safety of the applicant."

The Report of the Badgely Committee was tabled in the House of Commons on Wednesday, February 9, 1977. It stated:

Many physicians whom the committee met on its visits to hospitals across Canada openly acknowledged that their diagnoses for mental health were given for purposes of expediency and they could not be considered as valid assessment of an abortion patient's state of mental health.

In other words, doctors who signed approvals for abortions while operating with Therapeutic Abortion Committees falsified reports as to the applicant's mental state in order to obtain approval. Under the guise of "psychological health," abortions were performed for eugenic reasons, single motherhood, or simply because the child was not wanted.

Maternal Suicide

Abortion has been justified by the claim that unwanted pregnancy is a common cause of suicide. In reality, pregnant women rarely commit suicide.

In his testimony before the Court of Queen's Bench for Saskatchewan in the Borowski case (Borowski v. The Attorney General of Canada, Transcript of Evidence and Proceedings at Trial, page 409, Regina Saskatchewan, May, 1983), former abortionist Dr. Bernard Nathanson stated that pro-abortion advocates have been aware of the rarity of maternal suicide for over three decades:

Women do not kill themselves and never have as a result of being pregnant. Interestingly, when we were pushing abortion – we, meaning the high command of the National Abortion Rights Action League, including myself, (Larry) Lader, (Betty) Friedan, in the late '60s, we asked the Medical Examiner of New York City to go through his files to discover, to give us a figure on how many women who were pregnant

had killed themselves, were suicides as a result merely of being pregnant...The Medical Examiner was unable to give us even one case, one case, where a woman had clearly committed suicide because she was pregnant...this was in New York City – so we were chagrined and never, of course, publicized that finding.

One well-known study conducted by Sim and Neisser (“Post-abortion Psychoses: A Report from Two Centers,” in *The Psychological Aspects of Abortion*, eds. D. Mall and W.F. Watts, University Publications of America, Washington, D.C., 1979) found, in the city of Birmingham, with a population of 1,250,000, one case of suicide of a pregnant woman over a twelve-year period.

An article by Whitlock (“Pregnancy and Attempted Suicide,” *Comparative Psychiatry*, vol. 9, no. 1, 1968) reported a similar study conducted in Brisbane, Australia, where not one pregnant woman within the city area had ever committed suicide.

By contrast to these, and numerous other studies which indicate that pregnant women rarely commit suicide, suicide of women after abortion is well-documented. In an address to the British Royal College of Physicians on May 25, 1976, Dr. Margaret White reported that out of 1,000 attempted suicides dealt with by the Westminster Group of Hospitals, nine times as many women who had tried to kill themselves had had abortions, compared with women in the general population.

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Now we have the paradoxical situation that women with the strangest conditions and most serious disorders that you can imagine are having babies – this is the safety of modern obstetrics. ... We have women who have never been out of a wheelchair in their lives with their spinal deformities, their spina bifida; women who have heart-valve transplants, or have ... steel ball valves – replacing normal heart valves; women who have artificial kidneys; women who have a transplanted kidney, women who have all manner of strange disorders, are having babies to fulfil themselves, and this is ... the safety of modern obstetrics. And yet, other women, with little or nothing wrong with them are requesting abortion, a therapeutic abortion ... because their child represents an inconvenience or nuisance.

Liley, Sir Alfred William, Borowski v. The Attorney General of Canada, Transcript of Evidence and Proceedings at Trial, pages 221-222, Regina, Saskatchewan, May, 1983.

...there's virtually no situation now where you must abort or the mother will die.

Beirne, Patrick, M.D., Borowski v The Attorney General of Canada, Transcript of Evidence and Proceedings at Trial, page 444, Regina, Saskatchewan, May, 1983.

Since 1953, I have never seen a patient die who died because she needed an abortion and it could not be performed...Doctors now have tools and the knowledge with which to work so that they can handle almost any disease a patient may have, whether the patient is pregnant or not, and without interrupting the pregnancy.

Williams, Jasper, Jr., M.D., Bernard Hospital, Chicago, Illinois, Past President of the National Medical Association, October 19, 1981.

I would like to confirm in writing that today with the advanced state of medicine in Canada, there does not exist a medical reason for an abortion. One must understand that some treatments rarely undertaken to save the life of the mother have the unintentional effect of causing the child in the uterus to die, but these circumstances do not constitute an abortion – medically or morally.

Kryn, Edward, M.D., Letter to Alliance for Life Ontario, November 3, 1995.

ABORTION FOR RAPE OR INCEST

Rape

No one can deny that a woman who is pregnant as a result of a violent attack has special needs.

Rape is an abhorrent, violent crime. Discussion of it is charged with emotion. Due to this fact a large portion of the public would permit an abortion for a pregnancy resulting from rape, and many legislators would allow an exception in law for this reason. However, once the emotion is stripped away, the logic and reality of this issue becomes clear, as expressed by former abortionist, Bernard Nathanson who made the following statement to the Virginia Legislature, February 11, 1982:

Rape is a heinous, ineradicably humiliating act of violence imposed upon a defenceless human. The key word is "ineradicable," for the destruction of the innocent human being as a result of that act can never eradicate the unspeakable emotional and psychological residue of that rape. To the contrary, it can only compound the residue with another deadly act of violence.

Statistics confirm that pregnancy resulting from rape is extremely rare. In Canada, not one pregnancy as a result of rape has been recorded by Health and Welfare Canada or Statistics Canada.

A 10-year study of 3,500 cases of sexual assault in the hospitals in the Minneapolis-St. Paul area revealed zero cases of pregnancy, according to a report in *The Educator*, September 1970.

Dr. J.C. Willke, in "Handbook on Abortion" (Hayes Publishing, Cincinnati, 1979) reports that, "at a recent obstetrical meeting at a major mid-west hospital in the United States, a poll taken of those physicians present (who had delivered over 19,000 babies) revealed that not one had delivered a bona fide rape pregnancy."

A publication by Alliance for Life, "Should Rape Be an Argument for Abortion?" (Winnipeg, 1986) outlines the following facts which account for further decreases in the probability of pregnancy:

- *Approximately one-fourth of Canadian women of childbearing age have been permanently sterilized.*

- *In addition, 15 percent of women are naturally sterile.*
- *Another 15 percent of women use oral contraceptives.*
- *There is a high rate of sexual dysfunction related to assault. Half of the assailants penetrate the woman's body and many do not deposit sperm. Inability to deposit sperm eliminates the possibility of pregnancy.*
- *With 15 percent of men naturally sterile and close to one-fourth of Canadian men surgically sterilized, the chance of pregnancy resulting is drastically reduced.*

Studies indicate that 50 percent of all rape cases involve oral or anal sex. It is also a medical fact that in a high percentage of cases where women experience genuine fear, ovulation is suppressed rendering the woman incapable of becoming pregnant as a result of rape.

It is significant that a New Zealand Commission on Contraception, Abortion and Sterilization, which suggested the liberalization of the country's abortion law in 1977, recommended excluding abortions for rape. The Commissioners gave two reasons: the incidence of such pregnancies was too low, and the likelihood of false claims was too great.

The choice to abort a pregnancy resulting from rape is most often based upon the attitude of society, rather than on the preferences of the rape victim. Dr. Sandra Mahkorn is the author of "Pregnancy and Sexual Assault," *The Psychological Aspects of Abortion*, (University Publications of America, Washington, D.C., 1979). Her studies show that only half of the women pregnant from rape choose to abort, and that their chief complaint was not that they were pregnant: it was how other people treated them. These findings seem to indicate that if all rape victims are given generous love and support, instead of judgement and condemnation, many more would choose to carry their babies to term.

Some pregnant victims of rape are able to accept the pregnancy, but cannot accept the child. They feel that it would be best for the child and for themselves if the child is placed for adoption. With most adoptive couples waiting years for a child, it is not difficult to find adoptive parents for children conceived through rape.

Post-abortion Syndrome does occur in rape victims who have abortions. When PAS develops, a woman can carry the same burdens of guilt, denial, and depression as a woman who aborted a child conceived through consensual sex in a loving relationship. The reason for this may be her own involvement in the act of abortion. Her thinking may be that she agreed to it; she was a participant in the act of violence which resulted in the death of an innocent child, a child who was by no way responsible for the rape, but who became the second victim.

The rape on the other hand was done to her; she was in no way responsible for it. She was the innocent victim and should feel no guilt. Rape is so violent, and so traumatic, that she may never be able to completely erase it from her mind, however with proper counselling, she may with time learn to live with the memories.

It is important that we do not in anyway minimize the trauma, agony and injustice of such a crime, or a woman's tremendous difficulty if faced with a pregnancy caused by rape. We must, however, ensure that we do not allow compassion to override reason and accept abortion as the answer.

Incest

Incest breaks one of the oldest and most rigid social taboos and usually results when the person who should be the protector (most frequently the father) becomes the abuser. Incest involves an abusive man and an exploited child. Unlike rape, the sexual assault may occur on many occasions over a long period of time.

A pregnancy caused by incestuous intercourse is a symptom of a serious disorder within a family. It is a family disorder which needs to be treated. Aborting a child who is the result of an incestuous relationship could well lead to further abuse of the victim.

Basile Uddo, Professor of Law, Loyola School of Law, in an address to the 1983 National Right to Life Convention, stated:

...Incest is more likely to be prolonged by the availability of easy abortion...In fact, quick disposal of the evidence of incest – the child – could well subject the victim to continued exploitation. What evidence there is on the subject suggests that this is exactly what happens. The

abortion sweeps the whole incestuous relationship under the rug. The evidence that there was an incestuous relationship is gone. This approach not only treats symptoms rather than causes, it could cause exploitation of the incest victim...

When Dr. Heather Morris gave evidence at the Borowski hearing (Borowski v. The Attorney General of Canada, Transcript of Evidence and Proceedings at Trial, page 597, Regina, Saskatchewan, May, 1983), she stressed that, in incest cases, it is the whole family which is in urgent need of very special help. When asked whether incest could be a valid reason for abortion, she was adamant in her denial:

And it seems to me that the biggest need for help in that family, is for the whole family to be helped, probably psychiatrists, social workers, etc. and this is the kind of help I would try to offer to that family. After all, in that family the people that are probably the most diseased are the male who impregnated the young girl; the girl who has been made emotionally disturbed by the home environment that resulted in the incest. The only healthy one in the trio is the unborn child. That would not be the one I would seek to eliminate, My Lord.

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The central issue then, should not be whether we can abort all pregnant sexual assault victims, but rather an exploration of the things we can change in ourselves, and through community education, to support such women through their pregnancies. The "abortion is the best solution" approach can only serve to encourage the belief that sexual assault is something for which the victim must bear the shame...a sin to be carefully concealed.

Mahkorn, Sandra, M.D., former rape counsellor, "Pregnancy and Sexual Assault," *The Psychological Aspects of Abortion*, pages 66, 68, University Publications of America, Washington, D.C., 1979.

Psychological support, especially from the woman's family and friends, is enormously important. They should stand by her and say clearly that, no matter what the circumstances, there should never be any embarrassment about bringing a child into the world. There should never be anything but pride in that.

Meehan, Mary, "Accepting the Unjust," *National Catholic Register*, April 18, 1982.

Will abortion of the innocent product of a rape return the mother to an unviolated, un-assaulted state? Will abortion apprehend the rapist? Will abortion restore the raped woman's peace of mind? In a sense, abortion of the unborn baby produced by the rape is just as violent an act as the rape itself.

Koop, C. Everett, M.D., former U.S. Surgeon General, *The Right to Live, The Right to Die*, page 62, Life Cycle Books, Toronto, 1980.

Abortion is to rape and incest what morphine is to pain – a superficially appealing, temporarily relieving, woefully inadequate response to something serious. The immediate benefits only mask the deeper wounds, which can fester to the point of great injury. A physician would never "treat" his patient only with morphine unless his was a hopeless case. To "treat" rape and incest pregnancies with abortion is a way of saying these women are hopeless cases – violated, tainted, damaged goods, for whom abortion is a way to scrub away the "scarlet letter."

Uddo, Basile, Professor of Law, Loyola School of Law, "Pregnancy Due to Rape and Incest," *Restoring the Right to Life: The Human Amendment*, page 188, Brigham Young University Press, Provo, Utah, 1984.

...in fact, just as with rape, there is no psychiatric evidence, nor even any theory which argues that abortion of an incestuous pregnancy is therapeutic for the victim...it is only more convenient for everyone else...The problem the pregnant incest victim faces is not the pregnancy, it is the psychological pain of incest. Again, as with rape, it is the discrimination and superstitions of those around her which make the pregnancy difficult, not the pregnancy itself. Unlike the case of rape, most incest pregnancies are actually desired, at least at a subconscious level, in order to expose the incest.

Reardon, David C., *Aborted Women, Silent No More*, pages 199, 202, Crossway Books, Westchester, Illinois, 1987.

ABORTION AND EUGENICS

Prenatal Screening

Medical science is becoming more adept at detecting disabilities of the baby in the womb, and many conditions can be treated in utero. However, the diagnostic tests which detect handicaps are often used as an indication for abortion. In addition to eliminating disabled children, false test results lead to the death of perfectly healthy children.

The possibility of giving birth to a child with a physical or mental disability is commonly accepted as reason for abortion. In "A Public Health Physician Views Abortion" (Child and Family, vol. 7, 1968), Dr. Herbert Ratner comments on the practice of abortion for eugenic reasons:

Permitting an abortion because of the possibility of a defect represents a radical departure from the entire tradition of medicine. It permits a physician to decide, on the basis of his estimate of a defect, who is to live and who is to die. It indicates the beginning of a brand new end of medicine. To the perfective, preventative and curative ends, we can now add exterminative medicine.

Amniocentesis

It is now common for pregnant women over the age of 35 to have a test called "amniocentesis." This involves taking fluid from the amniotic cavity and analyzing the cells contained in the fluids for defects and disability.

Amniocentesis is usually performed 16 weeks after the mother's last menstrual period and the results are not available for two to four weeks. Abortion because of abnormality detected in the foetus takes place no earlier than 18 weeks, and usually take place at a gestational age of 20 weeks.

An article by Dr. Joyce Chamberlain highlights the rarely acknowledged fact that amniocentesis is itself dangerous to both mother and child. The article, entitled "The Risk of Amniocentesis" (The Lancet, December 16, 1978) reports the findings of the Medical Research Council Working Party on Amniocentesis. The working party compared 2,428 women who had amniocentesis in the first half of their pregnancies with the same number of women who did not. For those who had amniocentesis, the rate of fetal loss was 2.6 percent. For those who did not have amniocentesis, the rate of fetal

loss was 1.1 percent. Furthermore, there seemed to be a similar increase of certain abnormalities such as abruptio placenta, premature rupture of the membrane, and postpartum haemorrhage later in the pregnancy

Chorionic Villi Sampling

Chorionic Villi Sampling involves a narrow tube being passed through the uterus to the chorion, the outer sac surrounding the foetus. A small sample of the floating tendrils of the chorion, the villi, can be sucked into the tube and analyzed for information about the existence of Down Syndrome and inherited disorders such as haemophilia, muscular dystrophy, cystic fibrosis, sickle cell disease, and thalassemia. Chorionic Villi Sampling cannot be performed after eleven weeks as the chorion develops into the placenta and the villi disperse. The procedure is less accurate than amniocentesis.

Alphafetoprotein (AFP)

One of the chemicals used as a measure to indicate abnormalities in preborn children is alphafetoprotein. There are two main tests: one of the amniotic fluid, and the other of the mother's blood.

Amniotic fluid is obtained at about the sixteenth week of pregnancy and tested to measure the level of alphafetoprotein (AFP). Elevated levels are found where babies have open neural tube defects, namely spina bifida and anencephaly. A low level of AFP indicates other conditions, most commonly Down Syndrome.

A simpler and safer test (maternal serum AFP) can be made by measuring the AFP level in blood taken from the mother's veins at sixteen to eighteen weeks of pregnancy. A positive result, i.e., one indicating abnormality, is usually followed by a second blood test and possibly by ultrasound, and finally by amniocentesis.

As the only purpose of these tests is to identify the handicapped child, abortion almost always follows.

Ultrasound Screening

The perfection of ultrasound screening has advanced to the point that high resolution scanning in the first trimester is now available and even routine in some areas.

An article of June 1998 in the British Medical Journal discusses the use of this technology and the, “ethical and psychological issues” that it may represent (BMJ. “First Trimester Ultrasound Screening,” 12/8/98; 317:694-695).

The screening can reveal, very early in pregnancy, both chromosomal and structural abnormalities. Its use was normally reserved for high-risk pregnancies, but it is increasingly becoming routine. Since such testing is often used as an indicator for abortion, to identify and kill disabled children. Its use presents ethical and moral dilemmas for expectant mothers and for medical staff.

Furthermore, inaccurate test results can lead to the death of healthy children. More light was shone on the seriousness of this situation during the 1999 scandal at Alberta’s Foothills hospital. In early 1999, *Alberta Report* magazine broke a story about Foothills hospital leaving babies to die following attempts to abort them by way of a late-term abortion procedure.

Shirley Popadiuk, Foothills’ public manager for acute care, acknowledged that about 40 of these late-term “genetic abortions” were performed through 1998. Officials at the hospital claimed that late-term children were only aborted at the facility if tests demonstrated them to be physically malformed.

Investigations, however, found that some of the babies being aborted showed no signs of physical abnormality, indicating misdiagnosis of the unborn child. If errors can take place in testing on late-term unborn children, there is likely to be an even greater risk of error the earlier the tests take place.

Should an abnormality be detected, an abortion recommended and that path taken, the article ponders what the psychological morbidity will be upon the mother and upon present and future siblings of the aborted child.

How does such advanced technology impact upon a mother who discovers very early on, that there is a serious disability affecting her child? Some women may not want to know. Excellent staff training and patient counseling

must be available and the expectant mother must be aware of the possibility of false positives and false negatives and that she can decide not to undergo these investigations at all.

Selective Feticide

Dr. Malcolm N. Beck, a practising child psychiatrist in Charlottetown, P.E.I., describes eugenic abortions as "selective feticide." He states:

It involves a deliberate, systematic search for those who may be unfit in mind or body, the primary intent being to terminate fetal life if such is found.

Dr. Beck makes a distinction between abortion as a matter of reproductive choice and selective feticide which usually involves the destruction of a planned, wanted child.

In a 1990 article in the Canadian Medical Association Journal, ("Eugenic Abortion: an ethical critique," 143 (3), pages 81-83) Dr. Beck states:

[Selective feticide] is fraught with technical problems and clinical complications and may have severe psychological effects on the mother...It has ethical implications for physicians and some broader social implications. In addition it may adversely affect the social identity of the medical profession.

Dr. Beck describes the human cost of eugenic abortion as very high, stating that the number of cases of disabled children aborted due to these prenatal procedures is almost identical to the number of normal children aborted.

Artificial Sex Selection

Through amniocentesis a doctor can determine the sex of the fetus and the parents may use that information for sex selection. Some parents may seek this information so that they can abort the preborn if it is of the "wrong sex."

In India, where sex selection is used to abort undesired females, the practice was banned in January 1996. Nevertheless, recent media reports indicate that the practice remains prevalent in that country. In 1999 the media reported on the comments of the General-Secretary of the Indian Medical Association, Prem Aggarwal, who said that the use of ultrasound technology in India is leading to an increase in the abortion of female fetuses, threatening India's demographic patterns.

Demographic trends in China, with the growing imbalance between male and female children, is also being blamed by many on a thriving practice of selectively aborting female children.

There have also been a number of cases documented in the United States. In Canada, in 1999, when Health Minister Allan Rock proposed banning sex selection abortions, many people opposed the measure even while stating that in principle they opposed abortion for such a reason. There is no way of knowing how many abortions are sought because of the sex of the child, but we know it does happen in both developed and developing countries.

ABORTION AND EUGENICS

Supporting References

The ease with which destruction of life is advocated for those considered either socially useless or socially disturbing, instead of educational or ameliorative measures, may be the first danger sign of loss of creativity in thinking, which is the hallmark of a democratic society.

Alexander, Leo, M.D., "Medical Science Under Dictatorship," New England Journal of Medicine, July 14, 1949.

...handicaps and unhappiness do not necessarily go hand in hand. Some of the unhappiest children I have known have been perfectly normal physically and many handicapped youngsters have cheerfully accepted difficulties I think I would find hard to bear.

Koop, C. Everett, M.D., former U.S. Surgeon General, testimony before the U.S. Senate Subcommittee on Family and Human Services, April 1983.

The frustrations of handicapped children appear to be no greater than those experienced by perfectly normal children. To this fact I can attest. My professional life has been spent largely with children who are less than one would consider totally normal and I have considered it a privilege to be involved with extending the life of these youngsters. In the thousands of such circumstances in which I have participated, I have never had a parent ask me why I tried so hard to save the life of their defective child. Nor have I ever had an old patient ask me why I worked so hard to save his or her life. Some of these children are now thirty-five years old. Nor has a parent ever expressed to me the wish that his child had not been saved.

Koop, C. Everett, M.D., *The Right to Live, The Right to Die*, page 62, Life Cycle Books, Toronto, 1980.

We tend to forget how hard it has been for civilization to triumph over the impulse to get rid of inconvenient people. And how many categories of inconvenient people there are to think about once taboos let down...

"From Abortion to Infanticide," Editorial, *The Washington Times*, May 18, 1982.

[sex-selection] may... "liberate women out of this world..."

Jefferson, Mildred, M.D., quoted in "Women: The Next Endangered Species?" Lynch, Pat K., Mademoiselle, May, 1977, page 34.

Thirty-nine percent of the six thousand women of childbearing age surveyed would choose the sex of their child if they had the chance.

Ryder, Norman B., Westoff, Charles F., National Fertility Study, 1970, Office of Population Research, Princeton University.

India has banned abortions of healthy female fetuses, an attempt at eliminating the widespread practice of aborting female fetuses in this male-dominated culture...There are no national statistics available on female infanticide or abortion of female fetuses, but the disproportionate number of males in India show it is a widespread practice.

Roy, Ranjan, Associated Press, India, January 9, 1996.

ABORTION MYTHS

Abortion and Child Abuse

Readily available abortion does not curtail child abuse. While it is true that many pregnant women reject their pregnancies and react with feelings of resentment, frustration and depression, these feelings (due to hormonal changes) are normal in early pregnancy and usually pass as the pregnancy progresses. Unfortunately, many women, while going through a period of depression, are offered an abortion, rather than counselling and support.

It would appear that far from decreasing the incidence of child abuse, liberalized abortion increases abuse against children. Studying the correlation between abortion and child abuse, Canadian psychiatrist Philip Ney reported that the rate of increase in child abuse in Canada parallels the rate of increase in abortions: British Columbia and Ontario have both the highest rates of abortion and the highest rates of child abuse; Newfoundland, P.E.I. and New Brunswick have low abortion rates and low rates of child abuse (P. Ney, "The Relationship Between Abortion and Child Abuse," Canadian Journal of Psychiatry 24:610, 1979).

"Wanted" or "Unwanted"

The majority of abusive parents "wanted" their children at the time of conception. In a seven-year study of battered children conducted by Edward Lenoski, M.D., of the University of Southern California School of Medicine, it was determined that over 90 percent of these children had been "wanted" during the pregnancy. Mothers of these children began wearing maternity clothes earlier than most expectant mothers, and fathers named their sons after themselves 24 percent of the time. In other words, abused children were not "unwanted" pregnancies. (Lenoski, E.F., "Translating Injury Data into Preventive Health Care Services, Physical Child Abuse," University of Southern California, 1976, and in Lenoski, E., Heartbeat, vol. 3, no. 4, December, 1980)

Illegal Abortions

One of the most common arguments raised by abortion advocates is that "legal" abortions save countless women from resorting to "illegal" abortions. The most often cited report on this was published in 1970 by the Royal College of Obstetrics and Gynaecology and constituted a summary of opinions of the consultant obstetricians of England. It said:

Our figures show...that despite a sharp rise in the number of therapeutic (legal) abortions from 1968-1969 there was not, unfortunately, significant change in the number of cases of spontaneous (criminal) abortions requiring admissions to hospital...the fact that legalization of abortion has not so far materially reduced the number of spontaneous abortions or the deaths from abortions of all kinds is not surprising. It confirms the experience of most countries and was forecast by the College's 1966 statement.

In "Induced Abortion, A Documented Report," (Minnesota Citizens Concerned for Life Inc., Owatonna, Minnesota, 1973), Drs. Hilgers and Sherin from the Mayo Clinic surveyed 21 scientific reports from 10 countries. Passage of permissive abortion laws had "no effect" on the criminal abortion rate in eight countries; in two, it actually increased with liberal abortion laws.

There are many reasons why legalization does not stop illegal abortions. Fear of disclosure, of someone finding out, is one of them. Pride or shame is another. Extramarital pregnancy surely prompts some women to seek abortion where it is off the record.

Legal Abortion is Safe Abortion

Abortion advocates argue that legal means safe, and that by abolishing legal abortions, we would be leading women "to the slaughter." Legal or otherwise, abortion has its inherent risks, and these risks can be severe.

One of the ways abortion advocates use the illegal-abortion argument to promote abortion is to falsify the numbers of women who died from illegal abortion prior to the legalization of abortion. They argue that if abortion is once again made illegal, hundreds of thousands of women will once again die at their own hands or at the hands of "back-alley butchers."

In his book "Aborting America," (Life Cycle Books, Toronto, 1979) former abortionist Dr. Bernard Nathanson, a co-founder of the National Abortion Rights Action League, comments on the fabrication of statistics:

How many deaths were we talking about when abortion was illegal? In N.A.R.A.L., we generally emphasized the frame of the individual case, not the mass statistics, but when we spoke of the latter it was always 5,000 to 10,000 deaths a year. I confess that I knew the figures were totally false and I suppose the others did too if they stopped to think of it. But in the "morality" of our revolution, it was a useful figure, widely accepted, so why go out of our way to correct it with honest statistics? The overriding concern was to get the laws eliminated, and everything within reason that had to be done was permissible.

In reality, a chart made by the National Center for Health Statistics (U.S.) showed 1,400 deaths from abortion in 1941. After invention of penicillin to treat infections which caused most of these deaths, by 1946, less than 300 women died from abortion. In 1972, the year before the U.S. Supreme Court legalized abortion, 39 women died from abortion. This chart included all abortion-related deaths, both legal and illegal. Since the Roe v. Wade decision legalizing abortion in the U.S., the number of deaths from abortion continues to drop, though there are now more deaths from legal abortions.

The second most common argument used by abortion advocates, that making abortion illegal once again would send women to back-alley butchers, was discredited by a Chicago study which showed what actually took place in that city's so-called safe, legal, abortion clinics.

In 1978, The Chicago Sun Times and the Better Government Association conducted an investigation to determine whether women having clinic abortions were receiving safe, competent care. Working undercover in six clinics, their representatives witnessed in four out of six clinics:

- *haphazard, unsterile and illegal medical procedures and conditions*
- *incompetent and unqualified doctors*
- *abortions performed on women who were not pregnant*
- *massive infections*
- *severe internal damage (some so severe that all reproductive organs had to be removed)*

- *two-minute abortions (average is usually 10-15 minutes elsewhere)*
- *some doctors in such a hurry they didn't wait for pain-killing medications to take hold*
- *failure to order critical post-operative pathological reports*
- *dangerously shoddy record-keeping*
- *counsellors who were paid not to counsel, but to "sell" abortions*
- *deceived, maimed, crippled women and at least twelve deaths in Illinois clinics*
- *abortions performed on girls who were as young as ten years*
- *a multi-million dollar business in abortion*

The Chicago Sun Times concluded that, "legal free-standing abortion clinics legalized highly profitable and very dangerous backroom abortions."

Abortion and Crime Reduction

Another abortion myth that has been given increased exposure in recent years by Henry Morgentaler is that abortion reduces crime. Firstly, this assertion is predicated on the fact that abortion itself is not a crime. Secondly, this assumption is based on a theory of crime that itself is far from universally accepted.

This myth gained new exposure in 1999 because of a report by Americans Steven Levitt and John Donohue, suggesting that the declining crime rate in the United States in the '80s and '90s might have something to do with the fact that abortion was legalized in the early '70s. Morgentaler utilized this report and has been strongly advancing this claim in Canada since then. On May 22, 1999 in the *National Post*, he wrote (in part): "[I am] pointing out that the availability of [abortion], and the fact that millions of women in North America have exercised it for over a generation now, has resulted in fewer unwanted and abused children, a decrease in crime and most probably a decrease in emotional and mental illness as well."

The argument is that there is a statistical predisposition of the children of poor, minority and teenage mothers to eventually become criminals, and that the disproportionate use of abortion by those same mothers brought a reduction in crime. This theory is related to the argument that abortion should be available because "every child should be a wanted child" – the assumption

being that wanted children will receive the love and nurture necessary for healthy upbringing. In the *Vancouver Sun* in 1995, Morgentaler wrote that "among those young men likely to commit offences there are fewer who carry an inner rage and vengeance in their hearts from having been abused or cruelly treated as children."

Refuting Levitt and John Donohue's work, Steve Sailer in the *National Post* (Aug. 24, 1999), writes that, in fact, "according to FBI statistics, the murder rate in 1993 for 14- to 17-year-olds (born in the high abortion years of 1975-1979) was a horrifying 3.6 times higher than that of the kids who were the same age in 1984 (who were born in the pre-legalization years of 1966-1970). In dramatic contrast, over the same time span the murder rate for those 25 and over (all born before legalization) dropped 6 percent."

In Canada, Statistics Canada reports that violent crime has risen 77 percent among youth over the last ten years, most notably amongst adolescent girls 12 to 17 years of age (up 127 percent, from 2.1 per 1000 population in 1988 to 4.7 in 1998), as reported in LifeSite News (Jan. 18, 2000). The crime rate among boys has risen by 65 percent, from 8 per 1000 population in 1988 to 13.1 in 1998.

Medically Necessary

One of the prevalent myths surrounding abortion is that it is a medically necessary procedure. Even from the pro-abortion perspective, the only time that an abortion could be argued as being medically necessary would be if the pregnancy put the physical health of the mother at risk. The fallacy of this assumption is discussed in section 5:1 above.

This is an important point in and of itself, and also because Canada's federal government claims that abortion is medically necessary to justify its use of taxpayer dollars to fund the procedure. Federal health ministers repeatedly claim that they have no choice but to fund abortions under the Canada Health Act. Yet, the CHA only requires the government funding of "medically necessary" procedures.

This is just as important in light of claims made during debate on the legalisation of abortion. During the debate on the Omnibus Bill (Bill C-150 which changed the law on abortion, cf. Chapter 10) in April 1969, Member of

Parliament Doctor P.B. Rynard (PC, Simcoe North) asked whether or not abortions would be paid for, "out of medicare hospitalization?" Justice Minister John Turner's answer was, "Oh, no." (Hansard, April 28, 1969, p.8078 as quoted by Alphonse de Valk in "Morality and Law in Canadian Politics," 1974, p.120) .

Later in the debate, when questioned about the word, "health" in the proposed law, Justice Minister John Turner said, "Health is incapable of definition and this will be left to the good professional judgment of medical practitioners to decide." (Hansard, April 29, 1969, p.8124 as quoted by Alphonse de Valk, in "Morality and Law in Canadian Politics," 1974, p.121).

The federal government transfers millions of dollars to the provinces for health services. It has repeatedly used its funding power to put pressure on provinces to pay for abortion services. It has threatened to withhold some of the money it gives to provinces if they considered rolling back their funding of abortion. Most recently, Health Minister Allan Rock, immediately following the 2001 federal election, threatened financial penalties against Manitoba, New Brunswick and Prince Edward Island if they didn't expand their funding of abortion.

These provinces already provided full funding for abortions performed in hospitals. Mr. Rock was urging them to also fully fund abortions performed in private clinics such as those owned by leading abortionist Henry Morgentaler. Ironically, this support for the operation of private "clinics" came at the same time that he was speaking out against the legitimacy of private clinics offering other medical services such as MRI scans to paying customers.

In fact, Garry Breitkreuz (CA–Yorkton-Melville) submitted an Access to Information request in 2001 seeking documentation from Health Canada for Mr. Rock's (and before him, former Health Minister Diane Marleau's) claim that abortion is medically necessary. Mr. Breitkreuz received a response which he made public shortly thereafter during debate on his own Private Member's Motion, M-228, seeking the redefinition of human life in Canadian law to include unborn children.

On March 22, 2001, he told the House of Commons, "On March 8 Health Canada responded by saying: 'I regret to inform you that after a thorough

search of all likely record holdings, departmental officials have confirmed that they have no records relevant to your request.' That is amazing. More than 100,000 unborn babies lose their right to live every year and the Department of Health does not have one document that says abortions are even medically necessary."

In each province where the people have been surveyed on whether or not they want taxpayer dollars to fund abortion, the majority have said, "No." This has been the case in Alberta, Saskatchewan, Ontario and New Brunswick.

Overpopulation

The current concern regarding overpopulation reflects a resurrection of the 19th century theorizing of Rev. Thomas Robert Malthus, an economist and cleric. He had developed a pessimistic view of the impact of human population on the earth, determining that people, given the freedom to propagate as they wished, would overtake the means of subsistence. The result, in his view, was war, epidemics and other tragedies that reduce the human population to a more manageable size.

These concerns reappeared in our day shortly after the Second World War, and have been identified as the primary justification behind global strategies to advance abortion rights and access to contraception (including forced sterilization and secret experimentation on women in under-developed countries). In 1952 the International Planned Parenthood Federation was founded in Bombay, India. In the same year the Population Council was founded in New York by John D. Rockefeller III. Since then, scores of other organizations have been founded around the world to address the issue either directly or indirectly.

Governments have kept up with the trend, setting up departments and agencies to address the issues of population growth, almost without exception predicated upon the idea that "overpopulation" is a reality and a threat. Some even treat the perceived threat as a matter of national security. In a 1967 article in *Science* magazine ("Population Policy: Will Current Programs Succeed?" vol. 158, November 1967), author Kingsley Davis noted that initially governments considered "fertility control" to be too controversial to attract sufficient public support. "These reservations had disappeared by the

mid-1960s," he notes, "in the face of an increasingly hysterical campaign to arouse fear of population growth ..."

Critics of Malthus have long noted that his theory depends upon treating man's intellectual and creative abilities as being no better than that of animals; denying man's ability to respond effectively to the challenges of growth. One of the leading proponents of Malthusian analysis, a man who captured the interest of America's general public about the issue with his book, "The Population Bomb," is Paul Ehrlich. So confident was he of his theory that he gave dates with his early predictions for the extinction of many natural resources upon which man (at least Western man) depended for survival.

The late Julian Simon, an economist with greater optimism in man's ability to solve his problems, at least within the context of a competitive, free market environment, made a wager with Dr. Ehrlich over his claims. Dr. Simon won the wager as the dates predicted by the overpopulation guru came and went. Dr. Ehrlich has not been deterred from his beliefs; he simply readjusted the time frame for his predictions. He never, however, accepted another financial wager from Dr. Simon.

Among the concerns expressed by overpopulation theorists are territory necessary for people to live, natural resources such as timber, copper, tin and other metals, energy resources such as oil, coal and natural gas, and productive agricultural land for producing healthy food. History, however, lacks the evidence necessary to defend the ominous predictions given by overpopulation advocates.

In terms of population density, a world population of 6 billion would roughly equal the population density of the largely rural US state of Georgia. "If you allotted 1250 square feet to each person, all the people in the world would fit into the state of Texas. Try the math yourself: 7,438,152,268,800 square feet in Texas, divided by the world population of 5,860,000,000, equals 1269 square feet per person. The population density of this giant city would be somewhat more than San Francisco and less than the Bronx," wrote economist Dr. Jacqueline R. Kasun in the May/June 1998 issue of *Envoy Magazine*.

When it comes to resource depletion, economists and other researchers have made a compelling argument that in a competitive economic environment, market signals regarding supply and demand effectively (though not perfectly) lead to the technological advances necessary to permit continued growth. Sometimes this means discovering alternative sources to meet the needs that were served by a resource seen as nearing depletion; at other times it means developing technology which makes the use of a resource more efficient. In some cases, this means developing new ways to access greater amounts of the resource in an efficient manner.

Underpopulation

Controversy over the legitimacy of overpopulation theory, as important as it might be, seems to be increasingly irrelevant today because the evidence found around the world over the past few years indicates that populations are decreasing, some to such an extent that these countries, particularly in the West, are no longer demonstrating the ability to reproduce themselves in coming generations.

“United Nations figures show that the 70 countries that comprise 40 percent of the world’s population now have fertility rates too low to prevent population decline,” reported economist Dr. Jacqueline R. Kasun in the May/June 1998 issue of *Envoy Magazine*. “The rate in Asia fell from 2.4 in 1966-70 to 1.5 in 1990-95. In Latin America and the Caribbean, the rate fell from 2.75 in 1960-65 to 1.70 in 1990-95. In Europe, the rate fell to 0.16 – that is, effectively zero — in 1990-95. And the annual rate of change in world population fell from 2 percent in 1965-70 to less than 1.5 percent in 1990-05. Worldwide, the number of children the typical woman had during her lifetime (total fertility) fell from 5 in 1950-55 to less than 3 in 1990-95. (The number necessary just to “replace” the current generation is 2.1). In the more developed regions, total fertility fell from 2.77 to over 1.68 over the same period. In the less developed regions it fell from more than 6 to 3.3.”

More people in Canada, the United States and Britain are beginning to raise the alarm about population levels and trends. In 1999, Statistics Canada reported that our country had experienced “the slowest annual growth rate in 30 years” — 0.9 percent from July 1, 1998 — “and only half the rate of 1.8

percent recorded during the peak year of 1988/89.” Immigration and a drop in the birth rate of 4,800 nationwide were blamed. “Natural increase, that is the difference between births and deaths, has steadily declined as a factor in population growth since 1989/1990,” stated StatsCan.

The US Census Bureau released a report in December 1999 (“1999 US Census Bureau Statistical Abstract: Compendium for the Millennium”) indicating that Americans are no longer having enough children to replace themselves. A 1998 UN revision of its World Population Prospects includes a projection that by 2020 the total fertility rate (the average number of children born per woman) in America will decline to only 1.5. America’s population is, therefore, projected to begin declining about 2030. In March, 2000, a British report published by the Family Policy Studies Centre indicated that the fertility rate there had dropped to 1.73.

Forced Abortion

Probably no nation has more aggressively targeted “overpopulation” than communist China with its well-known one-child policy, instituted in the early 1980s. Although federal politicians play down the importance of abortion in their attempt to limit family size to one child (sometimes two for rural families), the documentation continues to mount that abortion, and even post-natal infanticide, are accepted, if not common methods of restricting family size. No convincing arguments are forthcoming, other than sex selection eugenics, for the increasingly disproportionate number of boy children, compared with girls in China.

In August 2000 the world became a witness to the horrors of infanticide in China as the result of a news report about population control authorities drowning a newborn in front of the child’s parents. The parents already had two children so the authorities ordered an abortion, having the mother “forcibly injected with a saline solution to induce labour and kill the child,” reported *The (London) Times* (Aug. 24, 2000). The baby, however, survived and the father, trying to avoid carrying out the order to kill his own child, hid him behind the hospital. Doctors soon found and rescued the child, giving him to his parents to take home. “Five officials were waiting for them in their living room. During the ensuing argument, the officials grabbed the baby, dragged it out of the

house and drowned it in a paddy field in front of its parent,” reported the *Times*.

ABORTION MYTHS

Supporting References

...Abortion is the favourite theme of the moment. The thrust of the argument is, of course, toward prevention of child battering, neglect and abuse through the prevention of children...It might be a wonderfully neat solution, if it were not quite so sweeping and simplistic, or if it were only valid.

Fontana, Vincent J., M.D., Chairman of the Mayor's Task Force on Child Abuse of New York City, *Somewhere a Child is Crying*, pages 215, 216, McMillan Publishing Company, New York, 1973.

Abortion not only increases the rates of child battering at present, it will increase the tendency to batter and abort in succeeding generations. Abortion, producing guilt both in the mother and the children who survive, increases the probability of displaced hostility, which results in so many, battered, murdered children. More importantly, by interrupting the formation of the delicate mechanism which promotes mother-infant bonding, it puts at risk millions of babies who are not aborted...We have disrupted a very delicate balance, turning parents against their own offspring. There may be no turning back.

Ney, Philip, M.D., "Abortion and Child Abuse," page 34, quoted in *Aborted Women: Silent No More*, Crossway Books, Westchester, Illinois, 1987.

There is contention that unwanted conceptions tend to have undesirable effects...the direct evidence for such relationship is almost completely lacking...It was the hope of this article to find more convincing systematic research evidence and to give some ideas of the amount of relationship and undesired effect on children. This hope has been disappointed.

Polman, E., "Unwanted Conceptions: Research on Undesirable Consequences," *Ethics Quarterly*, vol. 14, page 143, 1967.

Abused children are not basically the consequences of unwanted pregnancies.

Kotelchuck, M., "Child Abuse and Neglect," *Policy Implications*, R.H. Starr, editor, Ballinger Publishing, Cambridge, 1982.

Many maltreated children are children who were very much wanted before birth. Perhaps they were wanted for the wrong reasons...It is only after the children arrive that the doubts set in and the problems surface.

Fontana, Vincent J., M.D., *Somewhere a Child is Crying*, page 216, McMillan Publishing Company, New York, 1973.

...many women of my generation are replacing having children with having abortions, not only in a literal sense but also as a major rite of passage ..."wanted unwanted pregnancies" become attractive in the first place because of interacting and not-always conscious motives, among them:

- *a desire to know we're fertile*
- *to test the commitment of the man...*
- *abortion as a rite of passage...the fact that more women are aborting makes it more permissible, even intriguing...*
- *torn between "femininity" and "feminism" getting pregnant proves we are feminine while getting the abortion proves we are feminist...*

Savan, Leslie, "Abortion Chic: Attraction of 'Wanted-Unwanted' Pregnancies" *The Village Voice*, February 4, 1981.

Doctors who did illegal abortions would let a woman in the back door, take her money, and do the abortion. Today, the same abortionist lets her in the front door, takes her money and does the abortion in the same way...

Willke, J.C., M.D., *Abortion Questions and Answers*, page 172, Hayes Publishing Co. Ltd., Revised, 1990.

...90 percent of all illegal abortions are presently done by physicians.

Calderone, Mary, M.D., then President of Planned Parenthood, "Illegal Abortion as a Public Health Problem," *American Journal of Health*, vol. 50, page 949, July, 1960.

...If all the people in the world moved into the state of Texas... each person could be given the space available in the typical American home and all the rest of the world would be empty.

Kasun, Jacqueline R., Professor of Economics, Humboldt University, *Population and Environment: Debunking the Myths*, page 2, Population Research Institute, Vanier, Ontario, 1991.

My students are very surprised when I show them how rapidly the rate of world population growth is declining...If present declining trends continue, the less developed regions of the world will reach zero population growth well before the end of the next century.

Kasun, Jacqueline R., Professor of Economics, Humboldt University, *Population and Environment: Debunking the Myths*, page 2, Population Research Institute, Vanier, Ontario, 1991.

...Before 1970, the world population growth rate was about 2 percent annually. Since the 1970s, the world population growth rate has declined to 1.7 percent annually and it is expected to go substantially lower...Birth rates have decreased...and are expected to continue to decline...

Sassone, Robert L., *Handbook on Population*, page 51, Fifth edition, American Life League Inc., Stafford, VA, 1994.

...The pessimistic view of population as posing a constant and inevitable threat to the supply of resources finds its origin partly in the work of the early-19th century economist and cleric Rev. Thomas Robert Malthus (1766-1834)...The inevitable result, according to Malthus, is that the standard of living, or level of subsistence, can never keep pace with population. Thus, the size of population, in his view, threatens constantly to overtake the means of subsistence, only to be checked by "misery and vice." Nearly 200 hundred years of experience have proven Malthus wrong...The similarity between Malthus' pessimism and current reports which predict all kinds of catastrophe is striking. Gloomy predictions based on Malthusian logic, underestimate mankind's ability to respond competently and responsibly to his changing demographic situation.

Tychsen, Laurie, *Too Many People? Answers and Hope for the Human Family*, page 28, Greenlawn Press, South Bend, Indiana, 1986.

ALTERNATIVES TO ABORTION

Crisis Pregnancy Counselling

With the growing rate of abortions, Canadian society has become more aware of the rising numbers of women who are experiencing crisis pregnancy.

Many groups offer support dealing with essential services, such as housing, safety, financial assistance, jobs or helping women place their children for adoption or foster care. This assistance helps to relieve some of the pressure of an already stressful situation.

Agencies across Canada who support alternatives to abortion will commit the time necessary to help the mother learn the skills which she will need to raise her own child, should she choose to do so.

Birthright

Many of the groups which offer abortion alternatives operate under the charter of Birthright, an interdenominational emergency service offering a positive, confidential alternative to abortion.

Birthright began in October 1968 when a Canadian housewife, Louise Summerhill, addressed herself to the problems that face those in a distressed pregnancy who were increasingly being offered abortion as the only solution. Believing that supportive concern and care were all that many women needed to bring their babies to term, Summerhill started Birthright.

There are now 600 Birthrights around the world with approximately 200 across Canada. Birthright offers the pregnant woman the advantage of going to any of its centres, if her preference is to leave her local community during the pregnancy. Birthright supports a 1-800 crisis pregnancy number that is listed daily in local newspapers.

Maternity Homes

Maternity Homes exist in all provinces in Canada. In a pamphlet advertising the Maternity Homes of Ontario, which comprises 13 maternity homes across the province we are informed that:

Maternity Homes now work collaboratively with other agencies to provide a full range of services for pregnant women, single mothers and their children.

Maternity Homes have been a part of the social service delivery system since early in the 1900's and represent a unique service to the community.

In the past, the special needs of our clients required discreet service and historically, we have had a low profile. Fortunately social acceptance of single parents has improved. As societal change occurs Maternity Homes are responding with renewed expertise. Maternity Homes provide comprehensive care to pregnant women, young mothers and children. Services are provided to young women in crisis because of pregnancy: homeless and disadvantaged women who lack the social and vocational skills to cope independently.

Many of our clients are young mothers who require daycare and alternative school programs. We offer accommodation, life skills training, secondary school education, employment programs, health services, day care, recreational activities and emotional support to pregnant single women and single mothers. The goal of our program is to help young women gain independence and self-sufficiency. Individual services offered vary according to the local community needs of each Maternity Home.

In response to the changing needs of our clients, Maternity Homes have developed a high degree of specialized services. A professional team of child and youth counsellors, social workers, nurses and educators work together to achieve individualized goals with each client. Increasingly, Maternity Homes are focusing on the health and development of infants and children and offer a wide range of programs to promote the normal development of vulnerable children. Our professional, dedicated staff are committed to maintaining the home-like, nurturing atmosphere which is central to our tradition.

Maternity Homes collaborate within the full spectrum of service to women and children. We work in conjunction with public health services, community clinics and hospitals, youth and housing resources, Children's Aid Societies, and educational resources. Use of volunteers, community development and participation in various organizations and boards are central to our philosophy.

Adoption

Adoption is the legal means by which the child of one set of parents permanently becomes the child of another set of parents. In Canada every province has legislation regarding adoption. Statistics show that approximately 48 percent of the children placed for adoption are adopted by relatives and 52 percent are adopted by non-relatives.

The greatest demand and longest waiting list – several years – is for healthy infants. Families wanting healthy babies are turned away when they already have two children or are capable of having their own children. There are so few babies for adoption that many people are deciding to adopt older children or children with disabilities, with health problems, or of mixed races, children who previously has been unavailable, or not sought for adoptive families.

Today many women faced with an unplanned pregnancy believe they have only two options: to abort or to parent the child. Yet 20 years ago, 80 to 90 percent of single women chose to place their babies for adoption.

The Final Report of Adoption in Canada, by Kerry J. Daly, PhD, and Michael P. Sobol, PhD, states:

...The number of children born in Canada and subsequently placed in adoptive homes has declined steadily over the past decade...In 1981 approximately 5376 children were adopted. By 1990, only 2386 were placed. This represents a 47.3 percent drop in the use of domestic adoption as a means of family formation across Canada.

THE HISTORY OF ABORTION LAW AND COURT CASES IN CANADA

Early Abortion Laws

For thousands of years the killing of unborn children was prohibited in Western society. The laws against abortion go back as far as the Sumerians (2000 BC) and the Code of Hammurabi in 1728 BC. Laws protecting human life before birth have been handed down to us from those times until today by both ecclesiastical and civil courts.

In modern times, until 1803, the courts protected the preborn child when it became "animated," that is, when it could be felt moving. In 1803, because of increased medical knowledge of the development of human life in the womb, Great Britain passed *Lord Ellenborough's Act*. This Act declared abortion to be a crime and a felony at any time after conception. The preamble to the Act makes clear that it was intended to protect the life of the unborn child:

...certain...heinous Offenses, committed with intent to destroy the Lives of His Majesty's Subjects by Poison, or with intent to procure the miscarriage of Women...have been of late frequently committed: but no adequate means have been provided for the Prevention of such Offenses.

Under this 1803 Act, abortions performed before quickening were punished less severely than those performed after that point.

The *Offenses Against the Person Act* of 1837 dropped the distinction between women "quick" or not "quick" with child because quickening was then understood as "merely a change in position of the uterus, ...not evidence of animate life coming to the foetus which might justify the greater protection provided by the greater punishment."

After further reflection, the 1861 *Offenses Against the Person Act* established a uniform maximum penalty of life imprisonment for abortion, whether before or after quickening. It also provided that the pregnant woman herself, as well as the abortionist, could be held guilty of the offence.

The British *prohibitions* were the law in Canada when the Canadian Parliament created its own Criminal Code which came into force in 1893. In 1929 Britain passed the *Infant Life Preservation Act* which allowed that

abortion could be lawful if done in good faith to preserve the life of the mother. The Canadian Criminal Code reflected this change in Section 237, and allowed abortion to preserve the life of the mother.

In the late 1950s and early 1960s the media, specifically *Chatelaine* magazine and the *Globe and Mail*, with the co-operation of the Canadian Bar Association and the Canadian Medical Association, called for a more liberalized abortion law.

The Harley Committee and the Omnibus Bill

In February, 1966, the House of Commons referred the matter of revision of the abortion law to the Standing Committee on Health and Welfare under the Chairmanship of Dr. Harry Harley (Lib–Halton). The committee held hearings beginning October 3, 1967.

The Harley Committee presented an interim report to the Government of Liberal Prime Minister Lester B. Pearson on December 19, 1967, advising a revision of the abortion law in Canada.

Two days later, December 21, 1967, Justice Minister Pierre Trudeau introduced a government bill in the House of Commons, An Act to Amend the Criminal Code. The bill received first reading and became commonly known as the “Omnibus Bill” because it ran to 72 pages and 104 clauses, dealing with many aspects of criminal law, including parole, penitentiaries, combines investigations, customs, tariffs and national defense. It contained proposed changes in politically sensitive areas of criminal law such as abortion, homosexuality, drunk driving and marijuana possession.

The *Calgary Herald* reported at the time that Trudeau felt that, “These amendments would have a better chance of passing if they were included in a bigger, diverse bill with its obvious advantages of psychological inertia” (Dec. 20, 1967).

The final report of the Harley Committee was presented in the House of Commons March 13, 1968 and it recommended that an amendment to allow abortion read that abortion could be permitted only if a pregnancy, “will endanger the life or seriously and directly impair the health of the mother...”

The committee rejected the notion of abortion for socio-economic reasons (“Morality and Law in Canadian Politics,” Alphonse de Valk, 1974, p.80).

Shortly thereafter, the Liberal leadership convention was held, giving Pierre Trudeau leadership of the party. An election was then called for June 1968. The Omnibus Bill died on the Order paper, only to be re-introduced by Justice Minister John Turner on December 19, 1968 as government Bill C-150, the short title of which was, The Criminal Law Amendment Act, 1968. Changes to the Criminal Code respecting abortion were contained in Clause 18 of the bill.

Second reading of the bill began on January 23, 1969 and continued until February 26. The bill was given to the Standing Committee of Justice and Legal Affairs on March 4. This committee completed its study March 28, and C-150 was sent back to the House for third and final reading on April 16, 1969.

Réal Caouette led the Cr ditistes in a three week filibuster and abortion was debated from April 25 to May 9. The final vote came May 14, 1969. The bill was passed and Canada now had a law that allowed abortion.

Section 251 became the portion of the Criminal Code which dealt with abortion. Abortion remained a crime, but exceptions were permitted if the abortion was performed in an accredited hospital by a licensed physician after a panel of three doctors had certified that the pregnancy threatened the woman’s life or health. No definition of the word “health” was provided.

Clause 14 of Bill C-150, in order to create a situation in which abortion could be legal, and to bring the Code into line with the amendments of Clause 18, amended section 195 by adding the underlined words below to subsection 2:

(2) A person commits homicide when he causes injury to a child before or during its birth as a result of which the child dies after becoming a human being.

The legislation explained: “This amendment, which adds the underlined words, would make it clear that subsection (2) of section 195 is applicable only in respect of the death of a child that occurs after the child becomes a human being. Subsection (1) defines when a child becomes a human being and is not changed.”

Section 223. (1) states:

A child becomes a human being within the meaning of this Act when it has completely proceeded, in a living state, from the body of its mother whether or not

- (a) it has breathed,
- (b) it has an independent circulation, or
- (c) the naval string is severed.

(Later in 1970, section 195 became S. 206 as a result of Criminal Code amendments. Later still 1985 amendments turned it into S. 223.)

Another important change was made in Bill C-150 by Clause 15. The phrase, "in the act of birth" was added to Section 209.

Clause 15. Section 209 of the said Act is repealed and the following substituted therefore:

209. (1) Every one who causes the death, in the act of birth, of any child that has not become a human being, in such a manner that, if the child were a human being, he would be guilty of murder, is guilty of an indictable offence and is liable to imprisonment for life.

This addition would free from culpability someone who performed an abortion. S. 209 later became S. 238 of the Criminal Code.

Clauses 14 and 15 were clearly arranged to remove legal protection from the child before birth, so that Clause 18, the abortion amendment, could proceed unhindered.

Badgely Committee

In 1975 the government appointed a Committee on the Operation of the Abortion Law to "conduct a study to determine whether the procedure provided in the *Criminal Code* for obtaining therapeutic abortions [was] operating equitably across Canada." Known as the Badgely Committee after its chair Robin Badgely, the committee studied access to abortion in Canada. In its January 1977 report, the Badgely Committee concluded that "the

procedures set out for the operation of the Abortion Law are not working equitably across Canada."

Mitges Motion

On June 2, 1987 the Private Members' Motion of Gus Mitges (PC–Grey-Simcoe), M-37, came to a vote in the House of Commons. The motion asked government to consider amending Section 7 of the *Canadian Charter of Rights and Freedoms* to include unborn persons.

The vote was made possible by changes to the rules governing Private Members' Business. Items designated by the Private Members' Business Committee to be "votable" were supposed to be debated for five hours, following which would be a vote. Previously, Private Members' Bills designed to gain protection for preborn children had fallen prey to the tactic of "talking out," so were never voted upon. The Mitges' Motion provided an opportunity for pro-life Members of Parliament to speak on the issue of abortion and to vote for complete legal protection of preborn children. During the five hours of debate, a majority of speakers defended the rights of the preborn child. The motion was lost by a vote of 62 in favour and 89 against – a difference of only 27 votes.

The Morgentaler Decision

In January 1988, the Supreme Court of Canada, in the Morgentaler decision, struck down the existing abortion law, Section 251 of the Criminal Code, for procedural reasons related to the "security of person" clause in the *Canadian Charter of Rights and Freedoms*. Section 7 reads: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." It was argued that, for a number of reasons, including the delay it would require in procuring an abortion, Section 251 threatened women's bodily "security."

Unlike the Roe v. Wade decision in the United States, the Supreme Court of Canada did not rule that a woman has a constitutional "right" to abortion. It struck down the existing law for procedural inequities. Only one of the seven judges who The narrow ruling in Morgentaler left the door open for Parliament to amend the offending provisions and enact a new abortion law which protects human life from conception onwards.

Haidasz Bill

In May of 1988, following the Supreme Court decision leaving Canada without an abortion law, Senator Stanley Haidasz (Lib–Ontario) introduced a bill (S-16) to amend the Criminal Code to give full protection to all unborn children. The bill was seconded by Senator John MacDonald (PC–Nova Scotia). The bill died with all other legislation at the end of the Parliamentary session, but Senator Haidasz reintroduced it in the next Parliament (in 1989) as S-7. The bill would have amended section 287 of the Criminal Code to ban abortion in all cases, while permitting the medical treatment necessary to prevent the death of a mother.

1988 Government Motion

Left without an abortion law following the Supreme Court decision in Morgentaler, the government introduced a motion which would have allowed for a gestational approach to abortion. That motion and five amendments were defeated by the House of Commons in July, 1988. However, the separate votes on the six abortion law proposals revealed the strength of the pro-life voice in the House.

The government motion, and amendments introduced by Mary Collins (PC–Capilano-Howe Sound), Ken James (PC–Sarnia Lambton), Barbara Sparrow (PC–Calgary Southwest), and John Bosley (PC–Don Valley West) were all variations of either the gestational or abortion-on-demand approach to legislation. Only the amendment of Gus Mitges called for legal protection of unborn children from the time of conception.

Whereas the government motion and other amendments were overwhelmingly rejected, the Mitges amendment was narrowly defeated. The vote was 105 to 118; if just 7 MPs had switched their votes, the Mitges amendment would have passed.

The Borowski Challenge

On March 9, 1989, the Supreme Court of Canada rejected the appeal of Joe Borowski who had requested a declaration that unborn children enjoy the right to life guaranteed by Section 7 of the *Canadian Charter of Rights and Freedoms*. Borowski was challenging the validity of Section 251 of the Criminal Code which had already been struck down by the Supreme Court in

January 1988. Consequently, the judges found that Borowski's challenge raised a "hypothetical point" and refused to make a ruling on the rights of unborn children.

The *Borowski* case had been in the court system for 11 years. In September 1978, former Manitoba Highways Minister Joe Borowski brought the claim to the Saskatchewan Court of Queen's Bench in Regina arguing that exceptions allowing abortion in Section 251 of the Criminal Code contradicted the right to life provisions of the *Canadian Bill of Rights*.

From the start, the government put various obstacles in Borowski's way. First, it argued that Borowski's action should have been carried in the Federal Court of Canada, rather than in the Saskatchewan Court. Borowski fought right up to the Supreme Court of Canada, which eventually decided that the case could be heard in the Saskatchewan Court. The government's next obstacle was the argument that Borowski as an individual person did not have any "status" or "standing" in the court and, therefore, could not challenge the abortion law. But with a 7-2 majority, the Supreme Court of Canada ruled Borowski eligible to represent the unborn.

In May 1983, the *Borowski* trial in defence of the unborn child opened in Regina. Counsel for Borowski claimed that the rights of the unborn - despite not being mentioned specifically by name - are in the *Charter* already. The *Criminal Code* section permitting abortions denied these rights in at least four significant areas, he said. He cited Section 7 stipulating that "*everyone has the right to life, liberty and security of person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.*"

For six weeks internationally known medical personnel, led by Sir William Liley of New Zealand and Professor Jerome Lejeune of France, testified to the nature of the preborn child. The scientific evidence presented at the trial was uncontested, and demonstrated beyond a doubt that the preborn child is a human being deserving of the full protection of the law.

The case was dismissed by the Saskatchewan lower court and was eventually appealed to the Supreme Court of Canada. After several delays, and an attempt by the Federal Government to have the case dismissed before

the hearing, the Borowski case was heard by the Supreme Court in October 1988.

As the Morgentaler decision striking down the Criminal Code provisions relating to abortion had been rendered ten months earlier, there was no longer an abortion law in Canada at the time of the hearing. This posed a problem for the Supreme Court Justices. Although they allowed the hearing to proceed, they indicated that they felt that the case could well be moot.

In the ensuing decision, in March 1989, the Justices did not assess the scientific and medical evidence on the nature of the preborn child presented in the original trial. Their decision to reject the appeal was based solely on the mootness of the case following their January 1988 ruling striking down Section 251 of the Criminal Code.

While the judgement in Morgentaler addressed the question of a woman's right to "security of person," no judgement has ever been rendered by the Supreme Court of Canada on the Constitutional rights of the pre-born child.

Daigle Case

In July 1989, the Quebec Court of Appeal, in a 3-2 decision, upheld a permanent injunction requested by Jean-Guy Tremblay, preventing his fiancée Chantal Daigle from aborting their 20 week preborn child. Three judges turned down Daigle's appeal, supporting the Superior Court ruling that the "unborn foetus" has rights.

Mr. Justice Yves Bernier wrote:

The child that has been conceived but not born is a reality that must be taken into account...It is not an inanimate object, nor the property of anyone, but a living human entity distinct from the mother...and has the right to life and protection from those who conceived it.

Justice Bernier also recognized the rights of the father:

It is just as much his child as it is the mother's, not more, not less.

The Appeal Court Ruling was binding on all Quebec judges and could only be appealed to the Supreme Court of Canada, which was done by c Daigle's lawyer, Daniel Bedard, on her behalf on July 27, 1989.

The Supreme Court of Canada overturned the Quebec Superior Court ruling, decreeing that Tremblay's case was groundless. All nine judges ruled that a father has no right to prevent a mother killing their unborn child by abortion. They also decided that neither the Quebec Charter, nor the Quebec Civil Code provide legal protection for preborn children. Daigle had travelled to the United States to have an abortion a week before the Supreme Court ruled on her appeal on August 8, 1989.

On November 16, 1989 the Supreme Court rendered reasons for its August 8 decision in the case of Guy Tremblay v. Chantal Daigle, stating that *"the task of properly classifying a foetus in law and in science are different pursuits"* and that recognizing the preborn child as a human being in law is a *"normative task...more appropriately left to the legislature."*

Government Bill C-43

In November 1989 the federal government introduced new abortion legislation to fill the void left by the Supreme Court's decision in Morgentaler. The Justice Communiqué of November 3, 1989 stated:

The Honourable Doug Lewis, Minister of Justice and Attorney General of Canada, today introduced in the House of Commons an Act respecting abortion. The bill fulfils the Government's commitment to Canadians to bring forward new abortion legislation compatible with the decision of the Supreme Court of Canada in the Morgentaler case.

"The bill introduced today establishes that the question of abortion is a medical decision to be made between a woman and her doctor, based on health grounds," said Mr. Lewis. "The new legislation on abortion is a reasonable solution to a very difficult problem for all Canadians. It balances the rights of the woman with society's interest in the protection of the foetus."

The legislation underlines the fact that abortion is a medical act to be performed by a qualified medical practitioner. The foetus is protected since the decision must be made for health reasons. "Health" is defined as including physical, mental and psychological health. The new law comes under the Criminal Code because it is only through the Criminal law power that parliament can regulate abortion on a national basis.

While the bill does not specifically refer to other indications for having an abortion, such as eugenics, rape, incest and socio-economic welfare, these

matters could be considered in relation to a determination of a woman's "health" if they adversely affected and thereby were likely to threaten her health.

Although abortion was re-introduced into the Criminal Code, the restrictions imposed were meaningless. Abortion became solely a matter between a woman and her doctor and could be performed for the vaguest of reasons, throughout all nine months of pregnancy. Only one doctor was needed to approve the abortion and that doctor could be the abortionist.

The language of the proposed legislation inferred that non-medical practitioners might be allowed to perform abortions "under the direction of a medical practitioner," since the bill did not specify that abortions were only to be performed by a physician.

Bill C-43 passed in the House of Commons on May 29, 1990 by a slim margin of nine votes, but it was defeated by a tie vote in the Senate on January 31, 1991.

Supreme Court Decision in Sullivan/Lemay v. the Queen

In May, 1985, Mary Charlotte Sullivan and Gloria Jean Lemay were charged with criminal negligence causing death to the child of Jewel Voth, and with a second charge of criminal negligence causing bodily harm to Jewel Voth, which was later dismissed on a technicality. The charges were laid after Sullivan and Lemay, acting as midwives, attempted to assist Jewel Voth in giving birth. According to the Court, Voth was in labour for 15 hours. The Court stated:

After five hours of second stage labour the child's head emerged and no further contractions occurred. Sullivan and Lemay attempted to stimulate further contractions but were unsuccessful. Approximately twenty minutes later, Emergency Services were called and the mother was transported to hospital. Within two minutes of arrival, an intern delivered the baby using... "a basic delivery technique."

The child was born dead due to asphyxiation during the long birth process.

The Supreme Court brought down their ruling on March 21, 1991, acquitting Sullivan and Lemay on the first charge of causing the death of a child. The charge had been laid under Section 203 of the Criminal Code which states:

Every one who by criminal negligence causes death to another person is guilty of an indictable offence and is liable to imprisonment for life.

Chief Justice Latimer stated that, "The child of Jewel Voth was not a 'person' within the meaning... of the [Criminal] Code." Canada's Criminal Code Section 223 requires that a child becomes a human being only after "proceeding completely, in a living state from the mother's womb."

The Drummond Case

In 1996, Ontario woman Brenda Drummond tried to kill her unborn child by shooting it in the head with a pellet gun. She was charged with attempted murder but the case never went to trial because the judge hearing preliminary arguments did not accept those of the Crown Attorney, that is, that the unborn child does have legal rights even if it is argued that it is not a human being.

Crown Attorney John Waugh conceded in his argument that the unborn child is not legally a human being, but he cited several sections of the Criminal Code which he argued grant protection to a foetus.

Section 242, for example, makes it a crime for a pregnant woman intentionally not to seek "reasonable assistance" at the time of delivery if the baby dies. Section 223 states that a person has committed homicide if a baby is born alive, but subsequently dies due to injuries suffered while in the womb.

Despite Mr. Waugh's argument, the judge ruled against him. The Defense Attorney, Lawrence Greenspon, even argued that the child would have to have died for Section 223 to be relevant.

Ontario Court Judge Inger Hansen threw out the charge of attempted murder, insisting that she had no choice because in case law a child does not become a person with the rights of a human being until it has completely emerged from its mother. Instead, she found Brenda Drummond guilty of not providing the necessities of life to a baby and gave her a suspended sentence and 30 months' probation.

She said that a new law would have to be written to provide protection to unborn children in such instances and that such a responsibility belongs to Parliament, repeating what the courts have said in abortion-related cases

since the 1988 Morgentaler decision threw out the 1969 abortion law. To date, the federal government has not accepted this challenge or responsibility.

This case received a great deal of coverage, much of it reflecting the surprise and shock many Canadians felt when they discovered that such actions are permissible since Canadian law provides no protection for the unborn child. Many Canadians had no idea that such behaviour was legal.

The Manitoba “Glue-Sniffing” Case

Winnipeg Child and Family Services made application to the Court of Queen’s Bench of Manitoba in August, 1996 to have a 22 year-old pregnant woman placed in custody until the birth of her child. She had a long history of solvent abuse (glue-sniffing), suicide attempts, and an unstable lifestyle. She had given birth previously to three children, two of whom suffered obvious effects of the mother’s sniffing habits, and all of whom were put under permanent guardianship of the Winnipeg Social Services. She herself was described at trial as suffering from “solvent abuse with cerebellar disease and cognitive impairment”. She had chronic suicidal ideation and cerebellar degeneration. The severe effects of solvents upon unborn children were described by other witnesses to include, “central nervous system dysfunction, developmental delay, attention deficit disorder, and growth deficiency”.

The Court under Mr. Justice Perry Schulman complied and on August 13th granted custody of the mother to Child and Family Services and directed that she be treated and detained until the birth of her fourth child, due in December. This order was set aside on appeal and on June 18, 1997 the case was heard in the Supreme Court of Canada. By that time, the mother had accepted treatment voluntarily, given birth in December 1996 to a healthy baby boy and was pregnant for a fifth time. Subsequently, this fifth, apparently healthy child was born.

The case had gone beyond the care of a glue-sniffing mother and become crucial to the argument for fetal rights.

The Supreme Court Judgment, released October 31, 1997 dismissed the appeal. Seven judges ruled that, “The law of Canada does not recognize the unborn child as a legal person possessing rights. ... the only right recognized is that of the born person.” Two judges, Sopinka and Major, in dissent said,

“The ‘born alive’ rule is a legal anachronism and should be set aside.” They continued, “This common-law rule which requires a foetus to be born alive before any legal rights of personhood can accrue, is an evidentiary presumption rooted in rudimentary medical knowledge not a substantial rule of law.”

Nevertheless, the Supreme Court, in its judgment, reinforced the notion of the Manitoba Court of Appeal which had found the task of formulating, or altering law to cover situations such as this to be, “more appropriate for the legislature than the courts.” In the Supreme Court decision the judges stated, “If anything is to be done, the legislature is in a much better position to weigh the competing interests and arrive at a solution that is principled and minimally intrusive to pregnant women.”

Other Court Cases

Another case worked its way through the Canadian court system from 1996 to July 1999. The case was a lawsuit brought against a mother, Cynthia Dobson, on behalf of her five-year-old son due to a traffic accident that left the unborn boy with injuries causing cerebral palsy. It addressed the responsibilities of a pregnant woman as a driver and the duty of care she owes to anyone who might suffer an injury as a result of her negligent driving. The lawsuit was brought by the boy’s grandfather on his behalf for the purpose of winning insurance money to help pay for the expensive care the boy required.

The Supreme Court ruled against the boy, arguing that he had no legal status prior to birth. With this decision, the court concurred with its earlier ruling in the 1997 Winnipeg glue sniffing case, stating that it would be wrong to impose “a duty of care upon a pregnant woman towards her foetus.” Lower courts in New Brunswick had ruled in favour of the boy. Critics charged that, with its decision, the court considered exclusively the liberty rights of women, giving no consideration to the growing scientific evidence regarding the humanity of the foetus. Justice Peter Cory, who wrote the majority decision, did say that a child has the right to sue third parties for injuries suffered in the womb. This right is traced back to a 1933 Supreme Court decision.

The idea of “wrongful birth” has also been raised in Canadian courts by way of a few fairly recent cases. In such cases, parents sue physicians for failing to

diagnose defects in their unborn children. The parents argue that they would have procured an abortion if they had been aware of the defects, arguing that they are now stuck with the added cost and emotional burdens of raising a disabled child.

Wrongful birth “has been recognized as a viable cause of action by a 1997 Supreme Court of Canada case, *Arndt v. Smith*, noted Michael Fitz-James, a Toronto-based lawyer and editor of *Canadian Lawyer* magazine (“Wrongful birth case instructive for us all,” *Medical Post*, Feb. 2, 1999). In that case, a baby was born with congenital disabilities which were traced to the mother’s bout of chicken pox while she was pregnant. Her doctor failed to warn her about a risk of birth defects thus preventing her from making an informed decision about whether or not to seek an abortion. She sued and “met with mixed success as she advanced through the various levels of B.C. courts, until finally, at the Supreme Court, she had the new tort recognized in principle, although her case was tossed out over causation issues,” wrote Mr. Fitz-James.

“The Supreme Court of Canada has stated that, in claims for wrongful birth brought by parents, the court must decide whether a reasonable mother in the circumstances of the plaintiff would have undergone a therapeutic abortion,” wrote lawyer Sheena MacAskill in 1998 (“It Could Happen to You: Wrongful birth,” *Medical Post*, Dec. 15, 1998). “In other words, there is no uniform or standard to be applied in all cases.” Ms. MacAskill is a partner at the Toronto law firm, McCarthy, Tetrault and has successfully acted in wrongful birth, wrongful life and wrongful conception cases.

A “wrongful life” claim alleges that a doctor owed a duty of care to an unborn baby which he breached by failing to give the child’s parents the opportunity to solicit an abortion. “Canadian courts have rejected claims for ‘wrongful life’ out of hand as disclosing no actionable legal right,” says Ms. MacAskill.

ATTEMPTS AT INTRODUCING ABORTION-RELATED LEGISLATION

Bill C-43 was the last attempt by a federal government in Canada to introduce legislation to curb abortion. Ever since abortion was legalized in 1969, Members of Parliament from both the governing and the opposition parties as well as some Senators have introduced Private Members' Bills and Motions to strict and recriminalize the procedure. Several had been introduced and were waiting to be picked for debate even while Bill C-43 was making its way through the House of Commons and the Senate. In most cases these initiatives were never debated. Those which have been drawn for debate were never declared votable, but they did provide opportunities to keep the issue alive and before Parliament.

In 1989, along with the aforementioned Bill S-7 introduced in the Senate by Senator Haidasz, five pieces of legislation were introduced in the House of Commons to curb abortion.

Don Boudria (Lib–Glengarry-Prescott-Russell) introduced two Private Members' Bills, C-268 and C-277. Bill C-268 tackled the issue of abortion funding by amending the Canada Health Act. It would have enabled the federal government to penalize any province which paid for abortions that were not deemed necessary for preserving the life of the mother. Bill C-277 would have amended section 293 of the Criminal Code and repealed sections 223, 238 and 287 to ban abortion in all cases, "except where that is necessary to save the mother's life."

Ralph Ferguson (Lib–Lambton Middlesex) introduced Bill C-266, which would have defined a "foetus" as a "person," prohibiting the destruction of these unborn children. It provided for a couple of exceptions, including when the abortion was "medically authorized to save the life of the pregnant woman."

John Nunziata (Lib–York South Weston) introduced Bill C-261, which would have amended section 287 of the Criminal Code to ban abortion in all cases, while permitting medical treatment necessary to prevent the death of a mother. Tom Wappel (Lib–Scarborough West) introduced Bill C-275 to

redefine “human being” to include an “embryo” and a “foetus,” thereby extending the prohibition against killing a human being to include the killing of fetuses and embryos.

Later in 1991, with the beginning of a new session of Parliament, Mr. Wappel reintroduced his bill as C-214. Mr. Boudria reintroduced Bill C-277, which would ban abortion in all cases, except to save the life of the mother, as C-221, and Bill C-268, which would stop the federal funding of abortion, as C-222. At this time he introduced a new bill, C-220, to protect the conscience rights of health care workers being pressured into taking part in abortion procedures. Mr. Ferguson reintroduced his bill, which redefined a “foetus” as a “person,” to grant it most of the same legal protections from harm, as C-302.

Following the 1993 Federal Election

The first abortion-related initiative to be introduced after the 1993 election was Motion-91. Garry Breitkreuz (Ref–Yorkton-Melville) introduced the motion, which called on the government to hold a referendum during the subsequent election asking Canadians if they wanted the government to continue funding abortion.

Later, in February 1996, Tom Wappel reintroduced his bill to redefine “human being” to include an “embryo” and a “foetus” as C-208.

In March of that year, M-91 became the first abortion-related initiative to be drawn for debate in the House of Commons since the debate over Bill C-43 in 1989. The motion was declared non-votable by the Committee on Procedural and House Affairs and was debated for one hour on May 27, 1996. The government opposed the motion, arguing that decisions about what procedures are funded by the government under the Canada Health Act are up to the provinces. Mr. Breitkreuz noted that the federal government, through the Canada Health Act, had already chosen to control the purse strings of health care and therefore had a mechanism by which to influence the funding of abortion in the provinces.

Following the 1997 Federal Election

On November 20, 1997, Mr. Breitkreuz re-introduced his abortion defunding referendum motion, this time as M-268.

On December 2, 1998, Maurice Vellacott (Ref–Wanuskewin) introduced Bill C-461. This “conscience” legislation was designed to “ensure that health care providers working in medical facilities of various kinds will never be forced to participate against their will in procedures such as abortions or acts of euthanasia. The bill itself does not proscribe abortion or euthanasia but makes it illegal to force another person to participate in an abortion procedure or an act of euthanasia.” In the next session of Parliament, on October 14, 1999, he reintroduced the bill as C-207. It was drawn for debate and came to the floor of the House of Commons on November 18, 1999. Since it wasn’t declared votable, it received the one hour of debate afforded to non-votable Private Members’ Business.

Yvon Charbonneau, Parliamentary Secretary to the Minister of Health, spoke to the Bill on behalf of the government. He essentially dismissed it as raising an issue properly dealt with at the provincial level. This was because the issue is related to health issues. The bill, however, proposed penalties that would be governed by the Criminal Code, which places it in federal jurisdiction. Some people have asked why other mechanisms can’t be used to protect health care workers from discrimination. To this point no consensus has been achieved, however, on the effectiveness of other measures, particularly since, if they too fell within provincial jurisdiction, they would not be applied consistently throughout the country.

Mr. Vellacott introduced a new bill with the same wording after it had been debated in the House, this time as C-422.

On June 2 1999, Jim Pankiw (Ref–Saskatoon-Humbolt) introduced Bill C-515. This was legislation designed to repeal the government funding of abortion. Similar to Mr. Breitkreuz’s motion, the Bill stipulated that a referendum be held in conjunction with the next federal election, asking Canadians whether or not they wanted tax dollars to fund abortion. If a majority of Canadians said, “no,” the federal government would be obligated to penalize provinces that continued to pay for abortion by withholding a portion of the funds transferred

to the provinces to help pay for social programming. The specific referendum question would be: “Do you agree that section 13 of the Canada Health Act should be amended to provide that full cash contributions shall be paid only to provinces that do not provide funding or hospital facilities or services for medically unnecessary abortions?”

Mr. Pankiw reintroduced his bill in the next session of Parliament as C-440.

On December 15, 1999, Garry Breitkreuz introduced a motion, M-360, urging the government to bring in legislation that would redefine “human being” to include “a human foetus or embryo from the moment of conception, whether in the womb of the mother or not and whether conceived naturally or otherwise, and making any and all consequential amendments required.”

Following the 2001 Federal Election

On February 2, 2001, Mr. Breitkreuz, now a Canadian Alliance MP, reintroduced his motion on redefining a human being as M-228. The motion was debated for one hour on March 22. It had not been declared votable so no vote took place to advance the motion to another stage of debate or action in Parliament.

On February 7, Maurice Vellacott, now a Canadian Alliance MP, reintroduced his conscience legislation for health care workers as C-246.

Jim Pankiw, now a Canadian Alliance MP, has indicated to the House of Commons his intention to reintroduce his abortion defunding referendum bill, but it has yet to be given a number and introduced.

Senator Stanley Haidasz

In February 1998 Senator Stanley Haidasz (Lib–Ontario) petitioned Parliament, by way of a motion introduced in the Senate, to set up a Special Joint Committee on the Unborn (“Joint” means that it would be made up of both Senators and Members of Parliament.) The purpose of this committee was to be “to examine and report upon the feasibility of legislating in the area of fetal rights in order to provide some protection to the unborn child.”

Prior to that, in November 1997, Senator Haidasz introduced Bill S-7, “conscience” legislation “to prohibit coercion in medical procedures that offend a person’s religion or belief that human life is inviolable.” He said that this was

in response to petitions over several years from over 8,000 health care workers and hundreds of physicians. The Senate went through the formality of passing it through 2nd reading so as to bring it to the committee stage of debate. (Senator Haidasz spoke to the bill at 2nd reading.) It was sent to the Legal and Constitutional Affairs Committee and the Senator was called before the committee to speak to the bill on March 3, 1998, just one day before he went into retirement.

It is commonly believed that the expeditious treatment of the bill did not reflect the priority of the abortion issue among Senators, but rather was an expression of respect for Senator Haidasz and his desire to speak to the bill prior to his retirement. Following the Senator's retirement, the bill was put far enough down on the committee's list of priorities to keep it from further debate prior to the end of that session of Parliament.

Senator Raymond Perrault

In November 1999, Senator Raymond Perrault (LIB–British Columbia) re-introduced Senator Haidasz's conscience legislation as S-11. It received some debate at 2nd reading stage, but it did not proceed further than that. Senator Perrault now has also retired.

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CANADIAN ABORTION STATISTICS

<http://www.statcan.ca/Daily/English/020118/d020118.htm>

The Daily, Friday, January 18, 2002

Therapeutic abortions

1999

Therapeutic abortion data for 1999 were collected by the Canadian Institute for Health Information. For more information on the therapeutic abortions database, contact the Canadian Institute for Health Information (416-481-2002, ext. 3523; 416-481-2950).

For more information on long-term trends in therapeutic abortions, or to enquire about the concepts, methods or data quality of this release, contact Paula Woollam (613-951-0879) or Richard Trudeau (613-951-8782), Health Statistics Division, Statistics Canada.

Therapeutic abortions, by province of residence, and rates per 1,000 female population

	1997 ¹	1998 ¹	1999	1998 to 1999	1998	1999
	Number of abortions			% change	Rate per 1,000 women ⁽²⁾	
Total	67,550	67,785	65,627	-3.2	15.9	15.5
Newfoundland and Labrador	829	815	837	2.7	6.3	6.7
Prince Edward Island	147	147	144	-2.0	4.9	4.8
Nova Scotia	2,039	2,050	1,915	-6.6	9.7	9.1
New Brunswick	1,110	1,102	1,031	-6.4	6.5	6.1
Quebec	30,187	31,638	30,702	-3.0	19.4	18.9
Ontario	...	...	..	...	...	...
Manitoba	3,616	3,442	3,515	2.1	14.0	14.3
Saskatchewan	1,993	2,009	1,898	-5.5	9.1	8.7
Alberta	10,332	10,353	10,188	-1.6	15.1	14.7
British Columbia	15,570	15,476	14,639	-5.4	17.1	16.2
Yukon	121	150	110	-26.7	19.2	14.4
Northwest Territories ⁽³⁾	315	290	235	...	17.9	22.9
Nunavut ⁽³⁾	155	...	...	25.4
U.S. reporting	293	297	231	-22.2	...	...
Residence unknown	998	16	27	68.8	...	...

¹ Due to incomplete reporting by Ontario in 1999, all abortions performed in Ontario (including abortions performed on residents of other provinces), and abortions performed in other provinces on Ontario residents have been

excluded from this table. The total number of abortions performed in Ontario was 44,118 in 1997 and 42,503 in 1998. The total number of abortions performed in other provinces on Ontario residents was 66 in 1997, 68 in 1998 and 73 in 1999.

² Rates are calculated using female population aged 15 to 44.

³ Counts for Nunavut include abortions performed on Nunavut residents during the full 1999 calendar year. For 1997 and 1998 counts for the Northwest Territories include those for residents of what is now Nunavut.

... Figures not appropriate or not applicable.

.. Data not available.