hasn't been a lot of high quality research. But the word is now starting to get out."

"These are people getting opioids legally, from a physician. It's a significant problem," he adds, estimating that as many as one million of the eight million Americans using prescription opioids are now medically addicted — and perhaps twice that amount if the Geisinger study is accurate.

It's slowly forcing some painful soul searching in pain management circles, Von Korff says.

An educational video produced by Physicians for Responsible Opioid Prescribing includes information from a drug manufacturer asserting that "the rate of addiction amongst pain patients who are treated by doctors is much less than 1%" (www.responsibleopioidprescribing.org/educational/index.html).

But that estimate "was a gross misinterpretation, not just by the manufacturer ... but by the so-called thought leaders who were in positions of eminence, and some of our professional organizations and the pain management community who allowed that myth to perpetuate itself by misinterpretation of those data," charges Nathaniel Katz, director of the Center for Opioid Research at the Massachusetts General Hospital, in Boston, Massachusetts.

Dhalla says there's no compelling reason to believe that medically induced addiction rates in Canada are dramatically different from those found in the US.

But Canadian data are sparse and inexact, says Rehm, who nearly a decade ago estimated that the number of illicit prescription drug users in Canada was between 300 000 and 900 000 (*Can J Public Health* 2009;100[2]:104-8)

As many as 200 000 Canadians are currently addicted to painkillers, Rehm estimates, adding that he's equally discouraged that evidence-based best practices for treatment of medically induced addiction do not exist.

The doubling in the number of Ontarians seeking treatment for prescription opioid abuse since 2005 and the tripling in the number of patients now undergoing methadone treatment are indicators of troubles to come, he adds. "And we need to keep in mind that addiction to prescription opioids is a chronic relapsing disease." — Paul Christopher Webster, Toronto, Ont.

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Sex-selective abortions: no simple solution

While American legislators contemplate criminalizing sex-selective abortion, experts say the experience of other nations which have tried to impose such a prohibition indicates that it is difficult to enforce and easy to skirt.

Nevertheless, United States Congressman Trent Franks (Arizona–Republican) is pushing to outlaw abortion for the purpose of sex or race selection. If passed, the Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act of 2011 will see health professionals who perform or accept funding for the taboo terminations face unspecified fines and imprisonment for up to five years. Anyone who coerces or transports a woman into the States to abort a fetus based on its race or gender will also be subject to penalty, although women who undergo the procedure are exempted from prosecution (www.opencongress.org/bill/112-h3541/text).

Franks says the need for a prohibition against sex selection is evident in the findings of a 2008 National Academy of Sciences report, which indicated that there has been a recent uptick in "son-biased sex ratios" among Asian immigrants to the United States, suggesting significant "sex selection, most likely at the prenatal stage" (www.pnas.org/content/105/15/5681.full). He also asserts that the ban is needed for race selection because minority babies are aborted at five times the rate of white babies.

"I hope that this bill will catalyze an awareness where people will begin to recognize the humanity of the victims and the inhumanity of what's being done to them," he says.

Similar policies have been enacted in the last three decades to offset dire gender imbalances in India, China and South Korea, among other countries. But these strategies — which include restricting access to sex-selective abortion and banning sex detection tests — have been difficult to enforce and have had limited efficacy.

Opponents argue that such legislative approaches are unnecessary and ineffective.

Such policies are being used to "create insidious new obstacles to reproductive healthcare" and "do not in any way address the serious and complex concerns raised by the practice of sex selection," Sujatha Jesudason, executive director of Generations Ahead, stated in the pro-choice organization's official *Statement opposing sex selection bill* (www.generations-ahead.org/files-for-download/success-stories/Statement_12_5_11.pdf). "This bill means just one thing for every woman: the highest and most intrusive of scrutiny of the reason she seeks an abortion."

Franks does not take issue with the assertion that there is a "bigger agenda" behind the bill. "I do hope that someday children of all sexes and races will be protected from abortion on demand," he admits.

But he believes sex-selective abortion is a unique opportunity for advocates on both sides of the abortion debate to find common ground. "We may not agree on abortion, but at least we can say as a society that we're not going to abort children based on the fact that they're the wrong colour, or that they're a girl or boy."

Criminalizing the practice, however, may not be the best way to achieve that objective. The imbalance in India's male-to-female sex ratio at birth has steadily worsened since the country introduced its ban on sex-selective abortion in 2003, following a ban on

sex detection testing in 1994. Between three and six million such abortions were performed in India in the 2000s, compared to between one and four million in the 1990s and up to two million in 1980s (*Lancet* 2011;377:1921-28).

The number of girls "missing" at birth in China has similarly increased since it outlawed sex-selective abortion in 1994, according the United Nations Population Fund (www.unfpa.org/gender/docs/studies/china.pdf).

In those countries, illegal clinics have often sprung up in response to local demand and attempts to crackdown on those or seize ultrasound equipment have been largely unsuccessful, either because of corruption or indifference to enforcement. Few providers have been charged or convicted under such laws to date (*Reprod Health Matters* 2008;16:90-98).

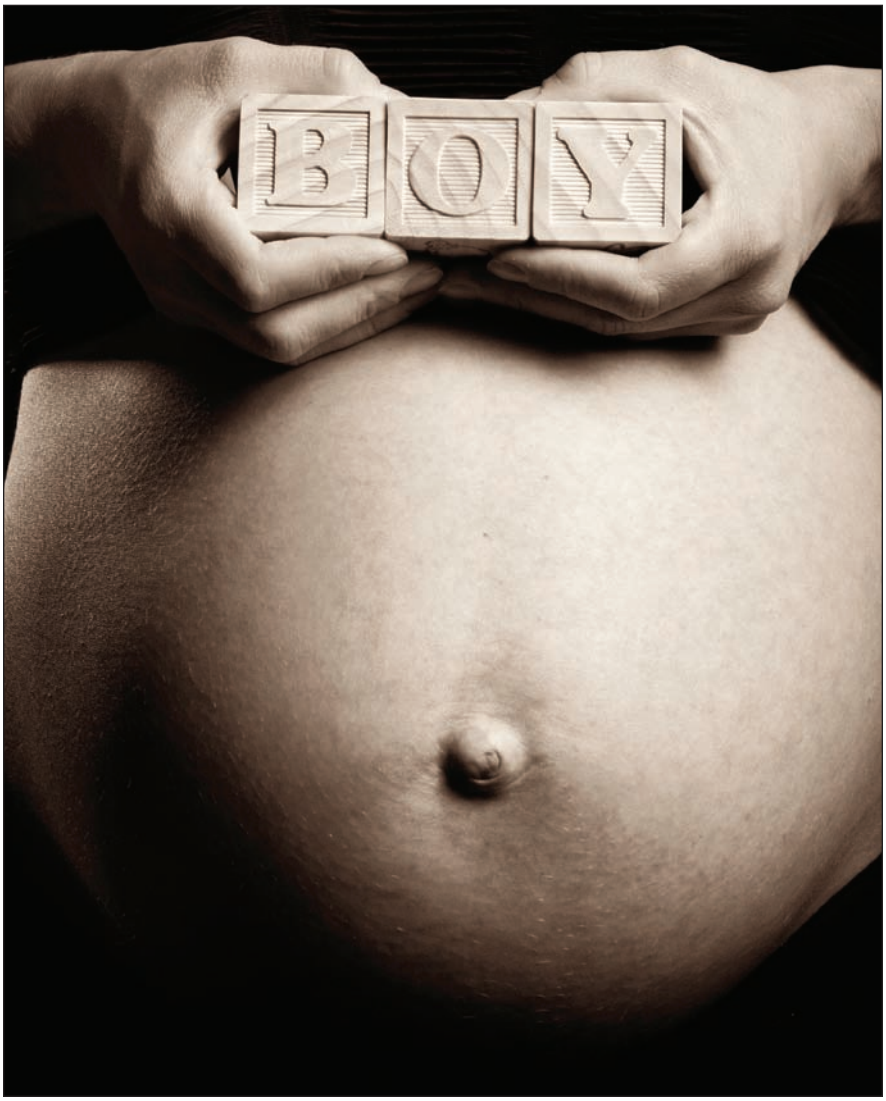
The legal sanctions are difficult to enforce because ultrasounds and abortions are typically done at separate clinics, or in the private sector, which is largely unregulated (*Asia Pac Popul J* 2001;16:109-24).

Even in the public sector, poor salaries for doctors, underfunding of hospitals and dependence on user fees have led some providers and clinics to offer the illegal services (*Reprod Health Matters* 2008;16:90-98).

Enforcement is also difficult, according to the United Nations Population Fund, because communicating the sex of a fetus can be done discreetly, even without words, making it "extremely difficult" to catch offenders (www.unfpa.org/gender/docs/studies/summaries/regional_analysis.pdf).

But the extent to which such factors would be significant in the US or Canada is uncertain, given their strong regulation of the medical community and overwhelming public censure of sex selection, says Gwen Landolt, national vice president of REAL Women of Canada, a women's organization based in Ottawa, Ontario.

As well, Franks acknowledges, "people who are so dramatically committed to aborting a little girl could simply lie" as to their reasons for requesting the termination of a pregnancy. "But it's also true that sometimes the law is a teacher," he adds. "There's something about the law saying that this is something as a society that we collectively agree is wrong that begins to cause people to look at their own conscience in that regard."



Several countries that have prohibited sex-selective abortions have found that the law is difficult to enforce and that people determined to have boys find ways of skirting the law.

Pro-choice advocates counter that the root causes of sexism and gender bias that drive son preference will not be addressed by limiting women's access to reproductive health care.

"To the contrary, abortion bans, mandatory reporting requirements, and harsh penalties on providers only further marginalize women who are already disempowered," NARAL Pro-Choice America president Nancy Keenan testified before the US House of Representatives Committee on the Judiciary Subcommittee on the Constitution in December 2011 (www.prochoiceamerica.org/assets/download-files/hr3541-testimony.pdf)

"Further, in order to protect themselves against the law's harsh penalties, including jail time and loss of all federal funds, the bill could compel providers to single out women of color for greater scrutiny. To avoid increased legal and financial liability, providers and reproductive-health centers may even cease providing abortion care to entire groups they perceive to be most 'at risk' for such practices, thereby diminishing access for women of color and immigrant women to necessary medical care," she added.

Opponents of sex selection abortions also argue that the prohibitions on the practice result in limitations on other abortions.

For example, the city of Guiyang in China introduced severe restrictions on termination of pregnancy after 14 weeks and women now need a special letter of authorization from local authorities before they can obtain an abortion (*Reprod Health Matters* 2008; 16:90-98).

It's also become commonplace for providers in India to self-restrict their practices to the first trimester in order to ensure they can't be accused of providing sex-selective abortions (*Econ Polit Wkly* 2004;39:5044-52).

South Korea is the only country that has achieved a reduction in imbalanced sex ratios at least in part because of sex selection prohibitions. But the reduction in discrimination is also in part the product of social and economic change, as well as a "Love Your Daughters" media campaign, according to the United Nations Population Fund (www.unfpa.org/gender/docs/studies/summaries/regional_analysis.pdf).

Franks argues that relying on targeted public awareness and education campaigns, without prohibiting sex-selective abortion, is the equivalent of endorsing the practice.

And waiting for broad social change won't provide immediate protection for a woman currently being coerced into aborting a female fetus, he adds. "[Criminalizing sex-selective abortion] would give her the private right of action to defend herself against this coercion. If there's anything uglier than aborting a child because of its color or sex, it would be being forced to do that." — Lauren Vogel, *CMAJ*

***CMAJ* 2012. DOI:10.1503/cmaj.109-4097**

Second of a two-part series.

Part I: **Sex selection migrates to Canada** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4091).

Utility, stability and a digital presence

The first person Dr. John Fletcher shared the good news with was a flight attendant. Sitting alone in the international departures lounge of an airport, en route to his sister-in-law's wedding, he had no friends or family nearby when he received the call offering him the job as *CMAJ*'s new Editor-in-Chief.

"I felt excited and a sense of responsibility, in equal measure. This is a big job," says Fletcher, a native of Cheshire, England, who received his medical degree from the University of Cambridge in the United Kingdom and a master's degree in public health from Harvard University in Cambridge, Massachusetts.

He takes over the leadership of the journal from Dr. Rajendra Kale, interim Editor-in-Chief since Oct. 1, 2011 (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4025). Fletcher was chosen as the 17th Editor-in-chief (there have also been two interim Editors-in-chief) by an eight-member selection committee appointed to find a replacement for former Editor-in-Chief Dr. Paul Hébert. Before accepting a position as deputy editor (research) at *CMAJ* three years ago, Fletcher worked for seven years as an editor at *BMJ*.

"We are very pleased that John Fletcher has taken on this key role," CMA President Dr. John Haggie stated in a press release. "His wide experi-

Roger Collier

"I felt excited and a sense of responsibility, in equal measure. This is a big job," says newly appointed *CMAJ* Editor-in-Chief Dr. John Fletcher.