Part I

Terms and Overview

Chapter 1

Work of the Committee

The Privy Council of the Government of Canada appointed the members of the Committee on the Operation of the Abortion Law by Orders P.C. 1975-2305, -2306 and -2307 on September 29, 1975. The members of the Committee were Denyse Fortin Caron, Marion G. Powell, and Robin F. Badgley, Chairman. The Terms of Reference set for the Committee were that it was "to conduct a study to determine whether the procedure provided in the Criminal Code for obtaining therapeutic abortions is operating equitably across Canada." The Committee was asked to "make findings on the operation of this law rather than recommendations on the underlying policy." The list of the Terms of Reference with the findings of the Committee are given in Chapter 3 of the Report.

Establishment of the Committee

The Committee started its work on November 3, 1975. At the completion of the inquiry it had held nine meetings. There were three meetings of an interdepartmental committee whose membership was drawn from the Department of Justice, the Department of National Health and Welfare, Statistics Canada of the Department of Industry, Trade and Commerce, and the Treasury Board. The interdepartmental committee provided information to the Committee which facilitated its work.

The work of the Committee was with the operation of Section 251 of the Criminal Code, Revised Statutes of Canada, 1970, Chapter C-34. For brevity this Section of the Criminal Code is referred to as the Abortion Law in this Report. Throughout the Report the Committee on the Operation of the Abortion Law is referred to as the Committee.

Collection of information

The Committee drew upon a number of sources which involved the assembling of existing information and surveys done to meet its Terms of Reference. The following sources were used in the preparation of the Report.

Government of Canada. Special tabulations dealing with induced abortion were commissioned by the Committee from Statistics Canada and two branches of the Department of National Health and Welfare (Health Economics and Statistics Division, and Health Insurance and Resources Directorate).

Provincial Attorneys General. On behalf of the Committee the Minister of Justice informed the provincial attorneys general of the scope of the Committee's work. In its review of the abortion procedure these provincial departments assisted the Committee concerning directives or guidelines sent to hospitals relating to the interpretation of the Abortion Law.

Provincial Departments of Health. The Deputy Minister of Health of the Department of National Health and Welfare wrote to provincial deputy ministers of health requesting their assistance with the Committee's inquiry. Without exception this assistance was given with a degree of cooperation which was indispensable to the research of this inquiry. The Committee acknowledges this important contribution to its work by provincial health authorities which in several instances required an extensive preparation of information and included additional sources of information which were unknown to the Committee.

Legal Research. A search of federal and provincial statutes relevant to the inquiry was undertaken by the Committee. The following statutes and regulations were reviewed:

1. *The Hospital Acts* for each province.
2. The statutes dealing with health insurance for each province and the relevant federal act.
3. *The Age of Majority Acts* for each province.
4. *The Vital Statistics Acts* for each province and the relevant federal legislation.
5. *The Child Welfare Acts* for each province.
6. Specific legislation dealing with the age of consent to medical treatment in each province.
7. *The Criminal Code of Canada.*
8. *The Civil Code of the Province of Quebec.*

Hospital Site Visits by the Committee. To obtain firsthand information from hospital administrators, medical directors, senior medical staff, and directors of nursing, the Committee visited 140 hospitals in 10 provinces and two territories. Three criteria were used in the selection of the hospitals to be visited. These were: (1) the representation of hospitals in 10 provinces and two territories; (2) within these jurisdictions a selection of hospitals on a basis of their size; and (3) the representation of hospitals with and without therapeutic abortion committees. In terms of the therapeutic abortion committee status of hospitals, there was a larger representation of hospitals which had committees which were visited because the Terms of Reference indicated that information be obtained about the operation of these committees and to determine the views of hospital personnel.

On the basis of the number of hospitals which were eligible to establish therapeutic abortion committees, and which may have done so or which did not have committees, 25.0 percent were visited by the Committee. Three hospitals declined to receive a visit from the Committee for the reason that since they had no intention of doing the abortion procedure, little would be gained from such visits. The request to visit hospitals was made through their executive directors. In each case they were asked if the Committee could meet with the chairman or a senior member of the hospital board, senior members of the hospital administration, and senior medical and nursing staff members.

These visits to hospitals across Canada provided the Committee with invaluable insights into the operation of the abortion procedure and where such committees had not been established, the reasons for this decision. Without exception all of the more than 1,000 individuals, many of whom were distinguished experts or leaders in their fields of work, were concerned about the issue of abortion. They provided the Committee with extensive information about the experience of their hospitals in interviews which on an average were between 2 and 3 hours long, but which on many occasions lasted 4 to 5 hours. In the process of obtaining its information, the Committee gained the judgment of experts in hospital administration, medicine, and nursing about different questions relating to the medical and nursing treatment of abortion patients, their optimal care, and the nature of complications associated with this surgical operation.

National Hospital Survey. Information about the experience of hospitals with therapeutic abortion committees was drawn from records maintained by Statistics Canada, site visits made by the Committee, and a national survey of all eligible general hospitals in Canada. This phase of the Committee's work involved attention to the definitions of eligibility of hospitals for the performance of therapeutic abortions and of what constituted a hospital. The first point, that of eligibility, is dealt with in some detail in the Report. Although the word "hospital" is well known, its precise and legal definition is contingent upon the range of services which it provides, its staffing, and its licensing and approval by provincial health authorities. The word has often been used inaccurately to designate what in fact are treatment clinics, military service units, or northern nursing outpost stations. Some hospitals in the nation have designated specialty functions which preclude the provision of general treatment services, which might be required for the birth of infants or the termination of pregnancies.

The Committee obtained extensive information about the operation of hospitals from federal and provincial health authorities. Prior to receiving these reports, most of which were obtained between February and March 1976 but in three cases were not available until May and July 1976, the Committee based its national hospital survey on the *Canadian Hospital Directory 1975* put out by the Canadian Hospital Association. The listing of general hospitals which was assembled from this source excluded all nursing outpost stations, most specialty hospitals (e.g., mental illness, tuberculosis), and hospitals which had 15 or fewer set-up hospital beds. The reason why small hospitals (15 beds or less) were not included was because the smallest hospital reported to have

established a therapeutic abortion committee had 17 beds. It was assumed that few of these smaller units would have the requisite staffing or facilities to establish a therapeutic abortion committee. When the more detailed information was subsequently received from provincial health authorities, none of these small hospitals which had been initially excluded were considered to be eligible to do the abortion procedure within the context of provincial guidelines. On the basis of the preliminary review, out of a total of 1,378 hospitals listed in the *Canadian Hospital Directory 1975,* 921 were selected to be included in the preliminary survey.

Two questionnaires were prepared to obtain information from hospitals with and without therapeutic abortion committees. These questionnaires were reviewed by the executive directors of three large hospitals, were pre-tested on visits by the Committee to four hospitals, and were reviewed, and revised, on the basis of this assessment, by the executive councils of the Canadian Hospital Association and the Catholic Health Association of Canada. Both of these national associations informed their membership of the Committee's inquiry. In addition, the Ontario Hospital Association in its bulletin notified hospitals and physicians in Ontario of the Terms of Reference and the scope of the Committee's work. The Canadian Council on Hospital Accreditation provided the Committee with an up-to-date listing of accredited hospitals across Canada and the basis for its review of hospital accreditation.

A total of 612 completed questionnaires was returned to the Committee, 209 from hospitals with therapeutic abortion committees and 403 from hospitals without committees. Based on information which was subsequently received from provinical health authorities in terms of provincially set requirements concerning the abortion procedure, replies were received from 77.4 percent of hospitals which were considered to be eligible in terms of these requirements to establish therapeutic abortion committees. This source of information was used in conjunction with findings from Statistics Canada and provincial health authorities in the analysis of the hospital's role in the abortion procedure.

Survey of Hospital Staff. On its site visits to hospitals with therapeutic abortion committees, the Committee requested permission to undertake a survey of hospital personnel who were involved in the treatment of abortion patients. The format of these questionnaires was pre-tested at several hospitals and revised on the basis of comments made by nurses and social workers. In the 70 hospitals in 10 provinces and the two territories which participated in this survey, the number of staff who worked with patients who obtained therapeutic abortions was estimated for each centre by hospital administrators and directors of nursing. The appropriate number of questionnaires was subsequently sent to each hospital for distribution to staff nurses and social workers who worked in the operating rooms and on the wards where these patients were treated. The questionnaires had no individual identification, they were completed anonymously and mailed directly to the Committee. The responses which were received did not constitute a random sample of hospital staff, but an informed estimate made by directors of nursing of the number of personnel in each hospital who were involved with abortion patients. Of the total number

of questionnaires which were circulated to hospital staff on this basis, 1,513 replies, or 58.5 percent, were completed and mailed to the Committee.

To determine the extent to which the work of hospital staff with abortion patients had involved problems of ethical rights and labour relations, the Committee obtained information from provincial human rights commissions about the number and the nature of applications which had been made to them directly or on behalf of hospital staff involved in the abortion procedure. The question of staff relations involving abortion was also reviewed during each hospital site visit made by the Committee with hospital administrators and directors of nursing.

National Physician Survey. This survey was undertaken to obtain information on the views and the experience of physicians with therapeutic abortion. From preliminary information received by the Committee, a trend which was later verified, it was assumed that this operation was most often done by obstetrician-gynaecologists, to a much lesser extent by family physicians, with the remainder performed by other specialists such as general surgeons. The selection of the two major disciplines which did this procedure was undertaken for the Committee by the Sales Management System, an organization which is used by the Canadian Medical Association in its mailings to physicians. Permission to use this source was obtained by the Committee from the Canadian Medical Association. This source was used for several years as the basis of *Canada Health Manpower Inventory* put out annually since the early 1970s by the Department of National Health and Welfare. This listing may underestimate the total number of physicians in Canada as it excludes an unknown number of physicians such as interns or residents who have temporary or no known addresses.

Other sources of information were considered, but these were not used because of the time constraints involved in this inquiry. These sources were the listings maintained for the licensing and the health insurance payment of physicians by each province. The sources were used by the Department of National Health and Welfare as a complementary means of estimating the supply and the distribution of physicians in its annual inventory of the supply of professional health workers. Unlike the listing given by the Sales Management System, these sources may overestimate the actual number of physicians who are in active medical practice since licensed physicians who live abroad are included as well as physicians who are engaged in non-clinical pursuits. In the *Canada Health Manpower Inventory 1975* the total number of physicians in Canada in 1974 was recorded as 36,772 by the Sales Management System and 38,640 based upon provincial sources, a 4.8 percent difference.

Because of their central role in the abortion procedure, all of the 1,217 obstetrician-gynaecologists who were listed by the Sales Management System were included in the national physician survey of the Committee. The Committee believes this total represents well the members of this medical specialty who were in active medical practice in 1976 and who were potentially accessible to women seeking therapeutic abortions. Because their number was considerably larger, but their direct involvement in the abortion operation was less extensive, a 25 percent random sample of family physicians was selected by the Sales

Management System from its records. For purposes of considering the experience of these physicians it was felt that this group of 3,956 family physicians would be representative and provide a sufficient basis for analysis.

Copies of the questionnaire were sent to the Canadian Medical Association and provincial medical associations for their information and their review. The advice of several of the executive directors of these associations was incorporated into the revised questionnaire which was mailed to physicians who were included in the survey in January-February 1976. In the letter which was sent to physicians with the enclosed questionnaire, the purpose of the inquiry was outlined. They were asked to complete and to return the questionnaire which required no personal identification.

The physicians who replied to the survey often gave additional and extensive replies; in many instances they appended signed letters stating their views. A full listing of their written comments was assembled by the Committee. In these comments about 5 percent of the physicians who replied to the survey made observations about the membership and composition of the Committee, its Terms of Reference, and the format of the questionnaire which they had been sent. In almost equal numbers the physicians who made these comments either encouraged the Committee in its work, or, conversely, felt the inquiry was inadequate and biased. Some physicians offered their personal assistance to the Committee. The Committee acknowledges with appreciation the thoughtful observations which were made by some 2,000 physicians. Some of the comments of the physicians on the survey were:

> Your questionnaire is excellent! I am very impressed. Your questions are very searching and very well designed to draw out a person's opinion and thoughts. Good luck in your fact-finding.

• • •

> None of the government's business.

• • •

> I think this is a useful Committee. I hope these results will be published. We must continue to examine and explore the issues—not avoid them.

• • •

> After you get your salaries, appoint a Royal Commission, then shelf it with the other crap.

• • •

> The Committee is approaching a difficult area very reasonably. We need more information and less emotion.

• • •

> This questionnaire is slanted and not impartial at all. With great reservation I submit this information realizing I may be giving fuel to people who can quickly shade it to their own cause.

Good questionnaire—covers most if not all the bases.

• • •

The questions that you have asked are completely irrelevant and show an existing bias and lack of understanding of the entire problem.

• • •

Send out questionnaires like this to all the doctors.

• • •

A secret ballot of all physicians in the country might reveal interesting views on this whole topic.

• • •

This questionnaire is poorly constructed. I expected Robin Badgley to do better.

• • •

I was pleased to participate in the filling out of this form. I will be interested to hear of any further developments concerning abortion and the Criminal Code. Glad to see your survey.

• • •

If you want information from me, you have to be prepared to pay for it.

• • •

1) Read the Lane Report.[1]

2) Grow up!

• • •

I wish you every success in your work. Your task is one of vast responsibility to the future of our country.

Out of the total of 5,173 physicians to whom questionnaires were sent, 138, or 2.7 percent, were returned indicating that the forwarding address was unknown, the physician had retired from active medical practice, or the intended recipient had died. Based on these returns the revised total of the number of obstetrician-gynaecologists in the survey was 1,196; for family physicians the revised sample was 3,839. The number of questionnaires returned by obstetrician-gynaecologists was 922, or 77.1 percent, and from family physicians, the 2,211 replies constituted 57.6 percent of the sample of this group.

[1] *Report of the Committee on the Working of the Abortion Act* (London: Her Majesty's Stationery Office, 1974), Volumes 1-3.

	Total Questionnaires Sent	Number of Replies	Percent Return
Obstetrician-Gynaecologists	1,196	922	77.1
Family Physicians	3,839	2,211	57.6
TOTAL	5,035	3,133	62.2

The questionnaires which had been received were coded, verified for their processing reliability, and prepared for analysis by the end of April 1976.

National Patient Survey. The Canadian Committee for Fertility Research, World Health Organization—Collaborating Centre for Clinical Research on Human Reproduction, was commissioned by the Committee to undertake a national survey of women who obtained abortions. This organization functions in cooperation with university-affiliated teaching hospitals in Canada and the World Health Organization to carry out clinical trials and research related to human fertility. The Canadian Committee for Fertility Research assumed no responsibility for the survey of abortion patients, but without its coordination and management of this survey, this study would not have been possible.

Time and financial constraints limited the extent to which a fully statistically representative sample of abortion patients could be undertaken. Such a step would have involved a full listing of the number of these patients who were treated at each hospital in Canada as well as detailed information about each hospital. While Statistics Canada has such information, it was privileged and could not be drawn upon for research sampling purposes. In the selection of the 24 hospitals in 8 provinces which were involved in this survey, the approach taken was to seek regional representation, a balance among hospitals by their size, and to provide for a mixture of hospitals which were affiliated with medical faculties and hospitals without training functions. A sufficient number of interviews were obtained to approximate the national distribution of these patients. In comparison with the 1974 information published by Statistics Canada on the distribution of therapeutic abortions, the regional distribution of patients who were included in the 1976 survey underrepresented Ontario, somewhat overrepresented Quebec, and there was a comparable distribution for other parts of Canada.

In cooperation with the Canadian Committee for Fertility Research, the Committee prepared a draft questionnaire which was pre-tested in anglophone and francophone medical centres. The revised final version of the questionnaire was sent to the hospitals which participated in the survey. The training of interviewers was done during January 1976 by two senior members of the Canadian Committee for Fertility Research who visited each centre, reviewed the project with hospital administrators and senior medical staff, and provided on-the-spot training for the interviewers who would be obtaining information from abortion patients. In most cases these interviewers were trained nurses who were familiar with general hospital procedures. The selection of the patients was broadly representative of all patients obtaining therapeutic abortions at each centre. Interviews began in February 1976 and they were

concluded on May 7, 1976. Throughout this period the questionnaires which were completed were sent on a weekly basis to the Committee's offices where they were checked, coded, keypunched, and prepared for computer analysis. These steps were completed by the end of May 1976.

A total of 4,912 interviews were obtained with women obtaining therapeutic abortions in 24 hospitals. Of this number, 4,754 questionnaires had complete information upon which the survey findings were based. This number of patients represented approximately one-third of all therapeutic abortions which were obtained in Canada during the time when the survey was in progress. On the basis of previous surveys of this kind in Canada, or those studies which have been done abroad, the Committee believes that the size and comprehensiveness of this part of its general inquiry was unique in these respects. The Committee acknowledges with appreciation the assistance which was given by the women who took part in this study.

National Population Survey. The Canadian Institute of Public Opinion which conducts the Gallup public opinion polls in Canada was commissioned by the Committee to undertake a national population survey on the knowledge and experience of persons about induced abortion. At the completion of its regular interviews on other topics, over a four-month period Institute interviewers gave 4,189 adults in the survey a questionnaire on abortion. The respondents were asked to complete it in privacy, to seal it in an unidentified envelope, and to return it to the interviewer. In addition to the usual adult population of 18 years and older which is surveyed by the Canadian Institute of Public Opinion, a sample of 554 teenagers between the ages of 15 and 17 years was included. A total of 3,574 adults who were contacted (85.3 percent) completed the questions relating to abortion. The combined total of teenagers and adults was 4,128 individuals.

The design of the sample used by the Canadian Institute of Public Opinion was based on selected population characteristics reported in the 1971 Census. The women and men who answered questions in the national population survey about their knowledge and experience with abortion were generally representative of the Canadian population. There was no marked variation by the regions of the country or the size of the communities where these individuals lived compared to the distribution of the Canadian people. Slightly more women (3.9 percent) were included in this survey than the proportion of all women in Canada and somewhat more persons (6.0 percent) between 30 and 49 years were included, with proportionately fewer individuals (6.4 percent) who were 50 years or older.

The Institute estimates on the basis of its usual sampling procedures that there is less than a 5 percent variation in the accuracy of its findings as these relate to the Canadian population. Put another way, the findings obtained by the Institute usually reflect with considerable accuracy what the total population thinks about or is doing relative to a particular issue. Because the usual monthly sample drawn by the Institute includes men and women and the Committee was concerned to obtain information directly from a representative number of women about their views and experience with abortion, the national

population survey on abortion was undertaken for four consecutive months in the first half of 1976.

Out-of-Country Abortion Services. In the late 1950s and the early 1960s some Canadian women obtained abortions in a number of countries. Reports received by the Committee indicated that a majority of women who took this course in recent years went to the United States and to a lesser extent to the United Kingdom. The Committee obtained information on these trends from the central statistical agencies dealing with abortion statistics in the United Kingdom and the United States. The Committee acknowledges the assistance of: The Department of Health and Social Security, United Kingdom; Abortion Surveillance Branch, Center for Disease Control, United States Department of Health, Education, and Welfare.

The Alan Guttmacher Institute of New York City has compiled a listing of 2,271 abortion centres in the United States. A copy of this listing was provided to the Committee as the basis for its survey of services in the United States which were or might have been used by Canadian women. This listing was validated by the addresses of some centres used by Canadian women in the United States which were given to the Committee by a number of Canadian physicians and referral agencies in this country. From these sources an amalgamated listing was established of 228 agencies in the United States which (1) were known to treat Canadian patients seeking an abortion, and (2) which it was felt because of their proximity to the Canadian border might provide these services. A questionnaire dealing with the work of each centre about the total number of abortions which were done, the number of Canadian women who had been served, and where in Canada they came from was sent to the 228 centres in 10 states, most of which were located along the international boundary. A total of 128 agencies (56.1 percent) which were contacted in the United States provided the Committee with information.

The Committee relied upon three additional sources of information about the number and the characteristics of Canadian women who went to the United States to obtain induced abortions. In the national population survey, women were asked if they had had an abortion and where this operation had been done. The research staff of the Committee visited 40 centres in seven states and obtained firsthand information about the operation and the services of these abortion programs. At eight of these centres which were located in five states, questionnaires were completed by 237 Canadian women who obtained abortions in the United States between March and April of 1976.

These sources of information, when considered together, gave a picture of the general trends which were taking place. But because the search for such information was not always welcomed by these patients, the agencies involved in Canada and the United States, and in turn its collection reflected upon the accuracy and adequacy of the tabulation of these trends by official statistical sources, a more complete and feasible documentation remains to be done.

Voluntary Associations. The Committee was assisted in its inquiry by the counsel and the information given by several national and provincial voluntary associations. It was indicated that the Terms of Reference which had

been set for the Committee gave it a fact-finding mandate and the inquiry was asked to "make findings on the operation of this law rather than recommendations on the underlying policy". Several of the executive directors and the members of the councils of these associations provided the Committee with information about research or studies which it was felt would be relevant to the inquiry. On occasion these associations informed their membership about the establishment of the Committee, its Terms of Reference, and indicated that the Committee would accept information related to its work. As a result of these efforts the Committee obtained information from a sizeable number of provincial and local agencies and interested groups and had correspondence directly with hundreds of Canadians.

The Committee obtained information on the family planning and abortion counselling services of 369 local community associations, public health units, and welfare agencies about their programs, their staffing, and their services. The listing of these agencies was obtained from national associations, provincial government sources, and a search of telephone directories of cities and large towns across Canada. Since there was little prior knowledge by the Committee of the extent to which these agencies did or did not undertake these activities, the total listing to which inquiries were sent was not a sample. For this to have been done, a full tabulation would have had to be established, a step which was not feasible within the limits of this inquiry. Some agencies involved in this field were reluctant to provide information to the Committee. Of the total of 369 agencies from which partial or more detailed information was obtained, 100 were agencies directly involved in some aspect of family planning, planned parenthood, or abortion counselling activities, 134 were educational institutions such as college or university health services, and 135 were provincial or municipal health units.

Information on the services provided for pregnant women was obtained from 123 agencies consisting of 84 Children's Aid societies and 39 maternity homes. With the cooperation of the directors of these agencies information was obtained from 203 women in seven provinces who used these services. The participation of these agencies and the women who gave information is acknowledged by the Committee.

Confidentiality of information

Existing administrative records, occasional surveys, and other available sources do not provide a comprehensive view of the experiences with induced abortion of Canadian women, physicians, and hospitals. Because much of this information is limited in its scope, it does not represent well how this issue is seen or what is done about it. A problem facing any inquiry into this question is how to get representative and complete information on this socially sensitive issue. At the start of its work the Committee found that while many women, physicians, and hospital personnel were willing to provide detailed information about their experience with induced abortion, almost none were willing to do so if there was a risk of personal identification. In this situation the Committee

was faced with the problem of ensuring that the findings which it got were valid and representative, yet at the same time to find a means of ensuring the confidentiality of the information which was obtained. Because of the nature of its study, special precautions were taken in the handling of confidential information, steps which proved to be necessary because of some undue interest in the Committee's work. The premises of the Committee were twice broken into. On other occasions physicians and lawyers alleging to represent the Committee sought to obtain information about therapeutic abortions from hospitals and some surveys were done purportedly on the Committee's behalf.

In the contract negotiated by the federal Department of Supply and Services on behalf of the Committee with the Canadian Committee for Fertility Research which undertook the hospital patient survey, it was stipulated that:

> No statistical analysis will be undertaken at the time of the study or subsequent to the study which will permit the individual identification of patients, physicians, other health personnel, or health institutions.
>
> The research information to be obtained from patients will be based on the principle of informed consent. No information will be obtained for the research study which has not been voluntarily provided by an informant.
>
> The research information obtained will be subject to the ethical review procedures followed in the health institutions within which the information is obtained.

These procedures were followed in each of the hospitals which participated in the survey. Prior to their participation, each patient was read the following statement:

> The Canadian Committee for Fertility Research and the Committee on the Operation of the Abortion Law are conducting a study on therapeutic abortion. We are asking you for your kindness and cooperation in this interview.
>
> This information is useful to us in gaining an understanding about some of the problems women have in getting an abortion. Now that you are here to have a therapeutic abortion you have valuable information about how this was arranged.
>
> Your cooperation is voluntary and will not affect your application for an abortion. Your name will not appear on the interview. All reports are statistical and never reveal any one person's answer.

In their terms of appointment each member of the Committee and the persons who were employed by the Committee were sworn to consider the information which was obtained as confidential during and after the inquiry. In all its work with patients, physicians, hospitals, and other voluntary and professional organizations, this assurance was given by the Chairman concerning the information which was obtained. A further step was also taken. In each case the assurance was made that:

> When your reply has been coded for summary analysis in which (you, your hospital, your agency) will not be identified, the questionnaire reply which you return to the Committee will be destroyed.

This pledge was honoured by the Committee. Without it, the Committee had no doubt that only a partial and limited amount of information would have been obtained. The Committee considers this step to be a "necessary fact of life" when research is done which deals with matters about which little is publicly known and about which there is much anxiety, fear, and stigma. It is for this reason that there is no identification in this Report of any patient, any physician, any hospital, or any voluntary or professional association, unless that information was already in the public domain. It is also for this reason that there can be no further individual identification of any source in this Report. After the validity of each source of information was established in the judgment of the Committee, all personal or institutional identification was removed from these materials.

Staff of the Committee

During every phase of its inquiry, the Committee was assisted by a highly capable research and administrative staff. As Executive Secretary to the Committee, Deanne E. Barrie's extraordinary contribution was indispensable during every phase of this inquiry in the form of her exemplary organization and management of a complex task, her efficient coordination of many different programs, and her graciousness and kindly humour. As Senior Research Associate, R. David Smith with great ability and competence organized the several surveys undertaken by the Committee and was responsible for the coding, the verification, the computerization and the statistical analysis of the survey findings. In particular, the Committee acknowledges its deep debt to these two colleagues whose considerable contribution anchored each step of the Committee's work.

Representing the three disciplines of law, medicine, and sociology, different backgrounds, and different perspectives, none of the Committee members had worked together prior to the inquiry. The Committee was joined in its work by consultants and a research staff whose training was in nursing, social work, medicine, law, economics, sociology, population geography, and statistics. As stipulated in its Terms of Reference, the sources of information for the inquiry were assembled in six months; the Report was prepared during a four-month span. The consistent rule of work of full-time and part-time staff members involved considerable extra personal effort and frequent voluntary overtime during evenings, weekends, and statutory holidays. The Committee considers itself fortunate to have had the opportunity to work with these colleagues. Without their immeasurable diligence, much of the work of the Committee either would not have been done or what was started, accomplished. It is with sincere appreciation that the Committee acknowledges the contribution of all of its staff and research consultants.

Executive Secretary

Deanne E. Barrie

Office Staff

Ila Bossons
Adora G. Okunn
Diane B. Panneton
*June Rilett
Maureen McG. Ruickbie
Alison M. Underwood

Research Associates

Marlene C. Becker-Longdon, R.N., B.N.
Viviane T. Berneman-Ship, M.A.
*Lois M. Green, M.Sc.
*Elizabeth Hurd, B.A.
*Kenneth D. Smith, LL.B.
R. David Smith, M.A.
*Harris S. Wineberg, LL.B.

Research Consultants

*R. Glen Beck, Ph.D.
*Stanley C. Best, M.D., F.R.C.P.(C.)
*Carl D'Arcy, Ph.D.
*Richard W. Osborn, Ph.D.
*C. A. Woolever, M.D., F.R.C.S.(C.)

*Part-time

Chapter 2

Abortion in Canada

The procedures set out for the operation of the Abortion Law are not working equitably across Canada. In almost every aspect dealing with induced abortion which was reviewed by the Committee, there was considerable confusion, unclear standards or social inequity involved with this procedure. In addition to the terms of the law, a variety of provincial regulations govern the establishment of hospital therapeutic abortion committees and there is a diverse interpretation of the indications for this procedure by hospital boards and the medical profession. These factors have led to: sharp disparities in the distribution and the accessibility of therapeutic abortion services; a continuous exodus of Canadian women to the United States to obtain this operation; and delays in women obtaining induced abortions in Canada.

The roots of these social disparities go well beyond the Abortion Law itself. They reflect how Canadian society has dealt with a socially sensitive issue involving much stigma and fear. These disparities cannot be easily or effectively resolved by any law until there is a more widespread openness about the issue coupled with a deepened sense of social responsibility about a procedure which has involved several hundred thousand Canadian women in recent years, a number increased several fold when their partners and families who are involved are also included. While the Abortion Law is specific in setting out the procedures to be followed, its definition of guidelines is broad enough to accommodate the breadth of the needs and the experiences of people across the nation. It is not the law that has led to the inequities in its operation or to the sharp disparities in how therapeutic abortions are obtained by women within cities, regions, or provinces. It is the Canadian people, their health institutions and the medical profession, who are responsible for this situation. The social cost has been the tolerance of widespread and entrenched social inequity for the women involved in the abortion procedure, and an unreasonable professional burden on some physicians and some hospitals.

To understand the abortion situation, it is necessary to look more broadly at what this issue means to Canadians. The Canadian way of life has experienced some major changes in recent years which have affected the basic contours of the population, changes which are reflected in how many children parents want, in sexual behaviour and the patterns of contraceptive use. As the

country was transformed from an agrarian society to a highly industrialized state, different social expectations and a higher economic standard of living led to fundamental changes in what people do, what they want out of life, and how they have seen the issue of induced abortion. While in these respects there have been changes from the ways of the past, little consensus has emerged about the present situation or the steps to be taken in the future.

Because abortion can be fired into a divisive issue, the public has been blind to what is actually happening. It has avoided seeking effective and direct ways to accommodate profoundly different outlooks. One attitude has been "Leave well enough alone. Perhaps it will go away." This outlook has been countered by people holding different perspectives who have said, "Here are our facts. This is what must be done." Between these two outlooks there is a range of deeply held, but not always easily articulated, concerns which cut across regions, religious faiths, political affiliations, the primary language which is spoken, or the other social circumstances of individuals. On the one hand these views represent an emphasis on safeguarding the life and the physical health of a mother, and on the other hand a concern with the total social circumstances of a woman and the situation of her family. At its core each of these two perspectives, both of which are held by many Canadians, involves a different way of seeing the meaning of life, the nature of human respect, the functions of parenthood and the family, and the changing role of women in Canadian society.

Abortion is an issue which most people would rather avoid—the women who are involved, the health professions, and the public. But it is here. It will continue to be here. Only its dimensions may change. Because concern with abortion cuts deeply into moral principles and professional ethics, it is a charged emotive issue. It will remain so with there being no easy resolution. Like other profound issues which involve the principles of life and death, abortion is an issue which, while they would rather avoid it, concerns many people. For all women who are capable of becoming pregnant, abortion is one critical option to be considered. For the sizeable number of women who have taken this course, there has been much stigma and stress which have left a durable residue of concern, much uncertainty about its long-term effects on their health, and a persistent fear that their anonymity will be breached.

Most people across Canada from whom information was obtained did not wish to see abortion removed from the Criminal Code. Having said this, however, many people wanted changes made in how the law itself was being implemented and the conditions under which abortions may be obtained. There was limited support among the medical profession for the hospital therapeutic abortion committee system, a procedure which it was felt was not working equitably. Likewise, there was no extensive support among physicians for any other option.

While women seeking therapeutic abortions take time to reach this difficult personal decision, and in some cases wait until their pregnancies are well advanced, the major factor contributing to the delay by most women obtaining abortions in Canadian hospitals occurred after an initial consultation

had been made with a physician. An average interval of eight weeks between the initial medical consultation and the performance of the abortion procedure not only extended considerably the length of gestation, but it increased the risk of associated health complications.

Because some women could not meet the requirements of hospital therapeutic abortion committees, did not wish to do so, or were not referred to hospitals with committees by their physicians, a number of women either went to the United States or carried their pregnancies to term. There is little detailed information about the Canadian women who each year obtain abortions in the United States, why they leave Canada, from what part of the country they come, or the quality of the care which they receive abroad. For every five women who obtained an abortion in Canada, at least one woman left the country for this purpose. What is indicated by the findings obtained by the Committee is that a means needs to be established in conjunction with health authorities in the United States which while based on the principle of informed consent and protecting the anonymity of these women, can list their numbers, determine the quality and the safety of the services which are provided, and more fully document their reasons for not having this procedure done in Canada.

Most physicians either promptly assist their patients or immediately indicate to them their reluctance to do so. But the terms of the Abortion Law do not work equitably because some physicians do not handle the issue of abortion in a straightforward manner with their patients. In many cases the physician's position on the abortion issue is usually not known beforehand by women seeking induced abortions. As is the case with hospitals, few physicians relish the idea of being closely identified with the abortion procedure. From the perspective of the patient, it is often a matter of chance whether the physician who is initially contacted tries to facilitate her request for an abortion, or whether the steps taken by a physician serve to delay an application being made on her behalf to a hospital's therapeutic abortion committee. In this situation many patients get the medical "merry-go-round" treatment. This sequence of events is costly to the public purse, heightens the level of stress among patients, and extends the length of their pregnancies for many women.

There has been no major published review in Canada by the medical profession of the standards of medical care which are involved in the therapeutic abortion procedure, by whom it should be done, what consultations may be indicated, what types of hospital facilities and services are required, and under what circumstances first and second-trimester abortions can be done with safety. On its site visits to 140 hospitals across the country, many physicians whom the Committee met indicated that first-trimester abortion operations involving no complications can be done as out-patient procedures, but it is more usual in Canada to hospitalize these patients for several days. There is no agreement on the staffing, the facilities and the procedures which are required for the higher risk second-trimester abortions. In short, what constitutes the minimal facilities and staffing as well as what is involved in the optimal treatment of women obtaining induced abortions has not been clearly set out. Considering the great variability of the procedures which were followed, the

range of treatment received by these patients, and the implications for health costs, such a review outlining the standards of care is indicated with its results being made widely known.

While there was much concern among physicians about the definition of health, there was little uniformity in how this concept was interpreted. Unlike other health conditions about which there is usually agreement that the state of good health involves a person's physical, mental, and social well-being, there was no such consensus when this concept concerned induced abortion. Specific definitions of health which would apply only to induced abortion, but not to other health conditions, were on occasion recommended. There has been no sustained or firm effort in Canada to develop an explicit and operational definition of health, or to apply such a concept directly to the operation of induced abortion. In the absence of such a definition, each physician and each hospital reaches an individual decision on this matter. How the concept of health is variably defined leads to considerable inequity in the distribution and the accessibility of the abortion procedure.

By virtue of Canada's membership in the United Nations and its recognition of the Constitution of that international body's affiliate, the World Health Organization, this nation has gone on record as having acknowledged a definition of health which stipulates: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The *Constitution of the World Health Organization* further states: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

The principles set out in the *Constitution of the World Health Organization* which have been acknowledged by Canada's membership in that organization have sometimes been given lip service, or considered as ideals to be endorsed in principle, but felt to be unattainable in practice. The Government of Canada, several provincial governments and the Canadian Medical Association recognize, but have not formally endorsed the principles of the World Health Organization's concept of health. In the absence of other formally endorsed statements, this definition can be considered one basis for the interpretation of the word "health" in the Abortion Law.

The explicit terms of the Abortion Law were not well known to the public, women seeking abortions in Canada, the medical profession, or hospital boards. Many of the public believed it was illegal under any circumstances to obtain an induced abortion in Canada, a view which was also held by some patients who went to the United States for this operation. A large number of physicians attributed to the Abortion Law a specific length of gestation when the procedure could be done where none is indicated in its terms. Some of the hospital administrators and most of the members of hospital boards whom the Committee met on its visits to hospitals across Canada did not have a firsthand knowledge of the law, but acted in accord with what they felt it stipulated.

On the basis of their interpretation of the Abortion Law, most hospitals doing this procedure had developed a number of preconditions to be met by

patients prior to their applications being reviewed by therapeutic abortion committees. These committees in turn relied upon an assortment of guidelines which were used in the review of abortion applications. One hospital committee might approve all such applications, while often in the same city another hospital committee on essentially the same stated grounds would turn down virtually all submissions. In each case the decision was based on various definitions of health and what was seen to constitute danger to a woman's health. While these different procedures may have well served institutional purposes, their consequences for women seeking induced abortion meant that some, as it were by the luck of the draw, had their applications speedily reviewed, while others who were in similar circumstances experienced considerable delay or had their applications rejected. The preconditions used by the hospitals included all or only one or two requirements such as: prior consultations by one, two or three physicians; a social service review; a residency requirement; tests for congenital deformities; contraceptive counselling; the consent of a spouse or partner; length of gestation; or interviews with patients by members of the therapeutic abortion committee.

There have been few formal grievances raised by hospital staff about their participation or refusal to participate in the abortion procedure. In only two instances it is known that such complaints have been reviewed by provincial human rights commissions. However, 1 out of 13 nurses from whom information was obtained said they knew of one or more colleagues who had left their positions because of assignments involving the abortion procedure. Most nurses, like most physicians, look upon the abortion procedure with distaste; their participation in this procedure is based on a sense of professional obligation and responsibility. In this situation grievances are seldom formally voiced. In most hospitals where the abortion procedure is done, the options for submitting grievances are available in the form of union contracts, staff associations, or formal grievance procedures. While "conscience clauses" have not been written into union contracts concerning the non-participation of hospital staff in treatments or procedures to which they may be opposed on moral grounds, many hospital administrations act upon this principle in the assignment of work duties among their staff.

With several notable exceptions, in general there were one or two large hospitals in each region which performed most of an area's therapeutic abortions. The major exceptions involved some half dozen major cities and more extensively, several sizeable regions. Women who lived in the catchment areas of the regional hospitals with committees usually had a more prompt and direct access to abortion services when applications on their behalf were submitted. This was not the case for women who lived in smaller centres or rural areas who had no direct access to these services when they sought them out. In this respect the distribution of physicians had little to do with the establishment or the non-establishment of hospital therapeutic abortion committees.

The Abortion Law allows for the review of the operation of the therapeutic abortion procedure by provincial health authorities. There have been no detailed reviews by the provinces of the composition of therapeutic abortion

committees, the preconditions set for the submission of applications, the guidelines which are used to review applications, the decisions which have been made, or the nature and the extent of the health complications associated with induced abortion compared to spontaneous and other abortions or childbirth.

The requirements of the Abortion Law stipulate that the abortion procedure may only be done in hospitals which are approved by provincial health authorities or which are accredited by the Canadian Council on Hospital Accreditation. Both the definitions of "approved" and "accredited" hospital status encompass a broad span of facilities, services, and staffing. In some instances hospitals of eight beds with a medical staff of two physicians are accredited. There is no uniformity in the provincial requirements involving the approval of hospitals for the establishment of therapeutic abortion committees. The requirements for the rated bed capacity of hospitals which are eligible to establish therapeutic abortion committees vary from an undesignated number to 50 and 100 beds. The requirements for the size of the medical staff set by the provinces range between 3, 6 and 10 physicians. Other provincial preconditions include: the requirement of the appointment of medical specialists; specific types of facilities; the organization of a medical staff which holds 10 annual meetings; a medical audit committee; or the provision of family planning counselling for abortion patients. Hospitals with therapeutic abortion committees in some instances were not observing these provincial regulations.

By virtue of their small size or specialty functions, a number of hospitals in Canada were ineligible to do the abortion procedure. The requirements set by provincial health authorities were also a major factor which made a sizeable number of *general* hospitals in Canada ineligible to establish hospital therapeutic abortion committees. When these requirements were coupled with the established medical custom that the abortion procedure was usually done by obstetrician-gynaecologists, the number of hospitals eligible to do the abortion procedure was effectively reduced to 2 out of every 5 hospitals in the nation. The various requirements were responsible for many of the discrepancies in the distribution and the accessibility of the therapeutic abortion procedure. Half of the eligible general hospitals had established therapeutic abortion committees. While the volume of induced abortions will likely remain at least at its present level during the next several years, it is apparent that a substantial number of hospital boards and physicians want no part of this procedure. They are unlikely to change this firmly held position. The principle of free choice is deeply embodied in the Canadian way of life. This fact applies equally to the provision of health services. No patient, no physician, and no hospital can be forced except under unusual circumtances into doing procedures which are against their principles.

One out of five women who had an abortion operation paid extra medical fee charges. In some instances the performance of the abortion operation was contingent upon the payment of these extra fee charges. These charges were not evenly distributed among all abortion patients, but affected most of those women who were young, were less well educated, or were newcomers to Canada. In some provinces the collection of these extra payments was not in accord with provincial health insurance regulations.

The requirements involving the age of young women or their marital status relating to the consent for medical treatment as this applied to the abortion procedure often varied between hospitals in the same city, among hospitals within a province, and between different provinces. In seven provinces and the two territories the age of majority is used as the age of consent for medical treatment. In three provinces where a lower age of consent for medical treatment has been established, there is much ambiguity about the legal meaning of these statutes or regulations. For the physicians involved there was an unresolved dilemma about the legality of performing an abortion procedure without parental consent as permitted under provincial legislation for females who were under the age of majority but over 14 years in Quebec and under the age of majority and over 16 years in Ontario and British Columbia. In terms of the consent for medical treatment, the age range among the provinces was between 14 to 19 years. Variations in the legal age of majority and for consent to treatment affect the availability of the abortion procedure across the country. The requirements, often set unilaterally by hospitals, in the absence of statutory authority, for the consent of a current or separated marriage partner for the procedures of abortion and sterilization cause difficulties for some women seeking these services.

With few exceptions, notable by its absence among hospitals with therapeutic abortion committees, was there any routine review of the Abortion Law by new members of hospital boards, new members of hospital therapeutic abortion committees, and on occasion, by recently appointed hospital administrators. In this respect at the level of community hospitals, the management and the surveillance of the therapeutic abortion procedure has been ineffective and lacked direction. This situation has developed because of the socially sensitive nature of the abortion procedure. No hospital as a public institution wishes to be seen as an abortion centre or to be known to provide exemplary care for abortion patients. Unlike other aspects of hospital work which are often matters of public pride, the social profile of the abortion procedure in hospitals was kept as low as possible. In many instances the work of hospital therapeutic abortion committees was not routinely reviewed by hospital boards, or if this was done, it was given cursory attention. Some hospital adminstrators did not inform their boards fully on this matter, and for their part, most hospital board members asked few questions about the abortion procedure. Most hospital board members were laymen who had little time to spend on this voluntary work or to review full agendas. In other respects the work of hospital therapeutic abortion committees was often a closely guarded professional secret, one seldom divulged fully at medical staff meetings or openly discussed among other hospital personnel. It was within this context that the preconditions for the submission of abortion applications and the guidelines which were used for their review were assumed to be developed and followed in the public interest.

Many of the women who obtained abortions in Canada or who went to the United States for this procedure were young and had a better than average level of education. In contrast with women who had not had induced abortions, these women on an average were more sexually active and less often used effective contraceptive methods. For a substantial number of the women who

had induced abortions and who had been using more effective birth control measures at the time of coitus, their reason for seeking an abortion represented a contraceptive failure. One of the central findings of this inquiry was the lack of accurate information that Canadians had about contraception and the precautions which were necessary in the use of birth control measures. As with abortion, family planning has been an issue of some public concern, but in terms of the allocation of public effort and resources, it has been only modestly supported. More money is spent on paying for the treatment and the care of women who have induced abortions than on ways of seeking a reduction in their numbers and in providing more effective programs of family planning and sex education. Existing sex education courses in schools, the work of public health programs or the efforts of voluntary associations, when considered together, have had little impact on the population as a whole. In each instance they have reached a small and select group of individuals. In the case of women who had induced abortions, there was virtually no difference in the use of contraceptive methods between women who had had sex education and contraceptive counselling and the use of such measures by women who had not had such instruction. New and different approaches are indicated if a greater level of effectiveness is to be achieved.

In one province where information was available on a before-and-after basis, the use of hospital and medical services among women who had induced abortions was comparable to the health care experience of women who had childbirth, and was considerably lower than the use of these services by women who had spontaneous and other abortions. Women who had induced abortions had relatively few gynaecological problems during the year after their abortion operations. Their level of mental health, as measured by the reasons why they used medical services, was comparable to women who had spontaneous and other abortions and surgical sterilization, but the experience of these three groups in this respect was double the rate of the women who had deliveries. It is unknown what the long-term physical and social consequences of induced abortion may be for the health of the women who have this operation.

The rate of reported health complications associated with induced abortions in Canadian hospitals varied inversely with the volume of this procedure which was done by hospitals. Hospitals which did the fewest abortions had higher complication rates than hospitals which did the largest number of induced abortions. There were fewer risks for patients at hospitals which had developed considerable specialization in doing this procedure. When this situation has occurred in the treatment of other health conditions in Canada, it has on occasion been resolved by the establishment of special treatment centres such as for the treatment of cancer, mental illness, or tuberculosis. For a number of reasons this trend toward the specialization of abortion treatment services has already partly evolved, although it has not been formally recognized by hospitals or provincial health authorities. Two positive trends since 1970 have been the reduction in the volume of illegally obtained abortions as well as a sharp decrease in the number of deaths and complications stemming from illegal abortions resulting in the treatment of these women in hospital.

In terms of the information compiled on induced abortion, spontaneous and other abortions, and childbirth by health insurance, vital statistics and

special register sources, little analysis has been published about the occurrence, the distribution, or the health complications associated with these pregnancy-related conditions. The way the existing classification system is used requires extensive review, in particular, dealing with the codification of abortions listed as *not specified as induced or spontaneous*. By definition, these abortions are neither spontaneous miscarriages nor induced terminations of pregnancy. But between 1970 and 1973 there were nine abortions in this catch-all category for every ten reported therapeutic abortions. The occurrence of these *other* abortions varied by the size of hospital, their type of ownership, and whether therapeutic abortion committees had or had not been established. It is wholly unreasonable to believe that these variations occurred because of natural causes, or their uneven occurrence was purely a matter of chance.

Much of the information which is collected is neither fully analyzed nor made publicly available. Such information is required to determine the scope of regional and local variations in the occurrence of all categories of abortion and the nature and extent of immediate and long-term complications associated with all types of abortion, childbirth, surgical sterilization and unwanted pregnancies. Such information is available; its continuous and prompt analysis is readily feasible and called for.

No society finds it easy to deal with the issue of abortion. Why it occurs to the extent it does and how it affects some women more than others are measures of rapidly changing and different ways of life. A dilemma involved in the operation of the Abortion Law—whether it remains as it is or is changed one way or another—is that the central features of Canadian society which it encompasses will not readily change. The abortion situation is one where two different circumstances exist together—a substantial number of women seeking this operation, and a sizeable proportion of the medical profession and a large number of hospital boards which on moral and professional grounds will not participate in this procedure. Each of these two facts is equally durable. The steps which are evolving toward an accommodation in the form of specialized treatment centres have not been broadly recognized nor has there been an official endorsement of this emerging process.

The options are few concerning induced abortion. There is no evidence that its volume is decreasing. To the contrary, its reported incidence has increased in recent years. Believing or wishing it were otherwise will not change it. The critical social choices are between two sensitive issues, induced abortion and family planning. In the Committee's judgment, the evidence is conclusive. When effective contraceptive means are appropriately used, the chances of conception occurring are sharply reduced, if not eliminated, for most women. The extent of induced abortions in the future can be expected to remain the same as at the present time, and its occurrence may gradually rise, unless there are effective changes made in the contraceptive practices of Canadians, particularly among high risk groups. Made in the context of known family planning and population policies, these changes may be brought about by increased efforts through research to find more effective and acceptable methods of contraception and by coordinated family planning programs for public education and health promotion. There is no surety that such steps will

be fully effective. Without taking them, there is virtually no likelihood that the volume of induced abortions will be reduced, or even contained at its present level. The results of this inquiry indicate clearly the need for greater public effort and more resources to be allocated by all levels of government and voluntary associations for the support of family planning programs. Combined with this effort, ways which are acceptable in the context of Canadian society must be found to reduce the considerable social inequities which are now associated with obtaining therapeutic abortions in Canada and which result in so many Canadian women going to the United States for this purpose.

The social cost of justice is the attaining of reasonable equality of all persons before the law. In its social consequences this is not the case for the operation of the Abortion Law. The accumulative effects of how this law has been interpreted by provincial health authorities, hospital boards, and the medical profession have created a situation of much inequity for women seeking and obtaining therapeutic abortions. Unless steps are taken to achieve a greater degree of social equity, the current disparities in the operation of the Abortion Law will continue to exist in the future. If a reasonable degree of social equity is to be achieved, that decision for its full attainment rests with the Canadian people. This is the central critical choice to be made about the abortion issue, one which in its resolution will require considerable courage and will be a measure of what is just in the Canadian way of life.

Chapter 3
Terms of Reference and Summary of Findings

As defined by its Terms of Reference, the Committee was given a fact-finding mandate to determine if the procedure set out in the Abortion Law was working equitably. The Committee was instructed to make no recommendations on the policy underlying the Abortion Law. While many sources provided information to the Committee, the use of this information and the conclusions drawn about the findings in the Report are the responsibility of the Committee.

The Terms of Reference together with a summary of the findings, which are provided in more detail in Part II of the Report, are given here as well as other findings related to the occurrence of induced abortion.

1. **The Committee on the Operation of the Abortion Law is to conduct a study to determine whether the procedure provided in the Criminal Code for obtaining therapeutic abortions is operating equitably across Canada.**

2. **The Committee is asked to make findings on the operation of this law rather than recommendations on the underlying policy. It will examine the following matters, among others:**

   (a) **The availability by location and type of institution of the procedure provided in the Criminal Code;**

The total number of induced abortions obtained by Canadian women in 1974 consisted of: (1) therapeutic abortions done in Canadian hospitals; (2) illegal abortions obtained in Canada; (3) induced abortions obtained in the United States; and (4) "assisted" abortions classified under other listings. The Committee estimated that the number of induced abortions which were not obtained under the procedures set out in the Abortion Law was 45.1 percent higher than the reported number of therapeutic abortions for 1974. For every five live births in Canada in 1974, it is estimated that there was one induced abortion. (Chapter 4).

Provincial requirements for the establishment of therapeutic abortion committees exempted 317 *general* hospitals, or 35.0 percent of all general hospitals in Canada. A total of 259 *specialty* treatment hospitals, or 19.2

percent of all hospitals in Canada, did not have therapeutic abortion committees. A total of 72 *private specialty* hospitals were ineligible to establish therapeutic abortion committees. Of 14 *private general* hospitals, six did not meet provincial requirements for this procedure, two hospitals had therapeutic abortion committees, and six which met designated medical staff and facility requirements did not have committees. Of 96 non-military hospital facilities operated by the Government of Canada, four eligible hospitals had established these committees. In terms of all civilian hospitals (1,348) in Canada in 1976, 20.1 percent had established a therapeutic abortion committee. If only those general hospitals which met hospital practices and provincial requirements and were not exempt in terms of their special treatment facilities are considered, then of these 559 hospitals, 271 hospitals, or 48.5 percent, had established therapeutic abortion committees, while 288 hospitals, or 51.5 percent, did not have these committees. (Chapter 5).

Coupled with the decisions of obstetrician-gynaecologists, half of whom in eight provinces did not do the abortion procedure in 1974-75, the combined effects of the distribution of eligible hospitals, the location of hospitals with therapeutic abortion committees, the use of residency and patient quota requirements, the provincial distribution of obstetrician-gynaecologists, and the fact that the abortion procedure was done primarily by this medical specialty resulted in sharp regional disparities in the accessibility of the abortion procedure. The relative accessibility of these resources was related to one or more of three outcomes. These were: (1) the length of time between an initial medical consultation by a woman and when the abortion operation was done in a Canadian hospital; (2) the number of abortions done in Canadian hospitals compared to the number of Canadian women going to the United States for this purpose; and (3) changes in the volume of illegitimate births in a region. Where there were fewer hospitals with therapeutic abortion committees, where the distribution of these hospitals was concentrated in a few large centres, and where there were proportionately more hospitals with committees which did no induced abortions, then there were fewer reported abortions done in these regions. (Chapter 6).

What this means is that the procedure provided in the Criminal Code for obtaining therapeutic abortion is in practice illusory for many Canadian women.

2. (b) The timeliness with which this procedure makes an abortion available in light of what is desirable for the safety of the applicant;

There was no uniformity across the nation involving the standards of medical care relating to the quality of services or the requisite facilities required to undertake the abortion procedure in general hospitals. Hospitals which would be permitted to establish therapeutic abortion committees in some provinces would not be allowed to do so in other provinces. Most of the requirements did not specify the services and facilities required for the abortion procedure. (Chapter 5).

One direct consequence of the amended Abortion Law was the sharp reduction of illegal abortions among teenagers and young women. The number

of deaths of women in Canada resulting from attempted self-induced or criminal abortions, which averaged 12.3 each year between 1958 and 1969, dropped to 1.8 deaths annually from 1970 to 1974. In 1970 there were five maternal deaths due to illegal abortion in Canada, one in 1971, one in 1972, none in 1973, and two in 1974. (Chapter 4).

The incidence of complications associated with therapeutic abortion declined as the total number of these operations done in Canadian hospitals increased between 1969 and 1974. The decline in the *other* (unspecified) rate from 1.6 in 1972 to 0.1 in 1974 more than accounted for the total drop in the incidence of all of the rates combined for the recorded listing of complications during this period. (Chapter 13). Three methods, surgical dilatation and curettage, suction dilatation and curettage, and menstrual extraction, accounted for 86.8 percent of procedures used in therapeutic abortion operations. They resulted in 39.5 percent of the initial complications associated with induced abortions. The saline procedure which was used for 8.6 percent of the therapeutic abortions accounted for half (50.7 percent) of the reported associated complications. This method, used in connection with second-trimester abortions, indicates the risks associated with the increased length of gestation. (Chapter 13). Well-equipped, and more extensively staffed institutions whose number included many university-affiliated teaching hospitals, had the lowest rate of complications (2.9 per 100 abortions), while hospitals which did the fewest abortion procedures had a rate which was almost double (5.6 per 100 abortions). The hospitals performing the largest number of abortions had the lowest complication rate in spite of performing a larger number of abortions in the later stages of gestation. (Chapter 13).

What these trends mean is that the number and types of complications associated with therapeutic abortions might be reduced by: a decrease in the number of unwanted conceptions; the development and the broader use of safer induction techniques; the performing of all therapeutic abortions at an earlier stage of gestation; and, concentrating the performance of the abortion procedure into specialized units with a full range of required equipment and facilities and staffed by experienced and especially trained nursing and medical personnel. More comprehensive and complete information is required about the as yet unknown long-term physical effects of the induction methods which are now being used and about the emotional and social problems which may precede and follow unwanted pregnancy and abortion. Minimal attention is now paid to finding ways to improve the utilization of the techniques which are available for contraception and early induction, or to finding more acceptable methods for these purposes. (Chapter 13).

2. (c) The criteria being applied by therapeutic abortion committees.

How danger to the health of a woman seeking an induced abortion was judged varied from the estimation that in no instance was this operation justified, a variety of intermediate interpretations, to the broadest possible definition which allowed an abortion to be done when it was requested by a woman. Based on these different understandings of the concept of health, a number of requirements were set for patients seeking this procedure and a wide

range of guidelines were used in the review of applications for induced abortions. Hospitals with therapeutic abortion committees had on an average four requirements to be met by women prior to their applications being reviewed (e.g., consent, length of gestation, residency or quota requirements, social service review). If equity means the quality of being equal or impartial, then the criteria (requirements and guidelines) used by hospital therapeutic abortion committees across Canada were inequitable in their application and their consequences for induced abortion patients. (Chapter 11).

3. In particular the following questions are to be answered if possible:

(1) Is the procedure not available for any of the following reasons?

(a) There are not enough doctors in the area to form a committee;

For the nation, 2 out of 5 Canadians did not live in communities served by hospitals eligible to establish therapeutic abortion committees. (Chapter 6). Of the 1,348 civilian hospitals in operation in 1976, at least 331 hospitals had less than four physicians on their medical staff. In terms of the distribution of physicians, 24.6 percent of hospitals in Canada did not have a medical staff which was large enough to establish a therapeutic abortion committee and to perform the abortion procedure. (Chapter 5).

3. (1) (b) The views of doctors with respect to abortion do not permit them either to assist in an application to a therapeutic abortion committee or to sit on a committee;

Among the doctors in the national physician survey, when their personal attributes such as age, sex, religion, primary language, type of specialty training or where they worked in Canada were considered together, there was no relationship to the range of indications upon which they would support or reject a woman's request for a therapeutic abortion. The issue of therapeutic abortion for these physicians was one which cut across all social backgrounds and types of medical practice experience. (Chapter 9).

Almost half of the physicians felt that induced abortion lowered the value of human life. Physicians holding this view worked in virtually every hospital in Canada. When they constituted a majority of the medical staff of eligible hospitals without committees, their views significantly determined a hospital's position on the abortion procedure. (Chapter 6). Conversely, almost half of the physicians (for whom information was available) who worked in hospitals without therapeutic abortion committees said they would be prepared to serve on these committees, if they were established at their hospitals. (Chapter 9).

3. (1) (c) The views of hospital boards or administrators with respect to abortion dictate their refusal to permit the formation of a committee;

The decision of two-thirds of the eligible hospitals which had not established therapeutic abortion committees was based on the grounds of religious morals and professional ethics. Accounting for a quarter of eligible hospitals without committees, the position of those institutions which were owned by or

affiliated with religious denominations was clearly set forth. There were no circumstances in the foreseeable future under which most of these hospitals would be prepared to establish committees or be indirectly associated with the abortion procedure. Put bluntly, as it was by the boards, the administrators and the staff of these hospitals to the Committee, these hospitals wanted no part of induced abortion. Rather than have any involvement in this procedure, most of the boards of these hospitals would seek to change their ownership, close their hospitals, or transfer their services to other patient treatment programs.

3. (1) (d) Hospitals cannot obtain accreditation by the Canadian Council on Hospital Accreditation or approval by the provincial minister of health owing to inadequate facilities.

In 1976, a total of 251 accredited *general* hospitals had established therapeutic abortion committees, while 19 non-accredited *general* hospitals were approved by provincial health authorities to do the abortion procedure. One *specialty* hospital had established a committee. In 1976, half of the accredited general hospitals in Canada had established therapeutic abortion committees. (Chapter 5). There was no indication that a failure to obtain accreditation was involved in the decision not to establish therapeutic abortion committees. (Chapter 6).

3. (2) Are the applicants for abortion being discouraged from obtaining legal abortions in Canada because delays in obtaining medical examinations, decisions by therapeutic abortion committees, and termination of pregancies where approval has been given, increase the risks to a point which applicants find unacceptable?

On an average, women took 2.8 weeks after they first suspected they had become pregnant to visit a physician. After this contact had been made there was an average interval of 8.0 weeks until the induced abortion operation was done, which resulted from direct delays in how physicians and hospitals dealt with these patients. Among women who had been pregnant 16 weeks or longer when they had an induced abortion, 1 out of 5 of these women said there was no therapeutic abortion committee at the hospital in the community where they lived. Among the small group of women who had induced abortions whose previous applications had not been approved by a hospital therapeutic abortion committee, 1 out of 4 had been pregnant for 16 weeks or longer. While 5.2 percent of patients said the physician whom they initially contacted did not refer them to another physician, 1 out of 5 of these patients subsequently had abortions when they had been pregnant for 16 weeks or longer. Among the 1 out of 10 patients who had difficulties in arranging a hospital appointment, 1 out of 5 subsequently had an induced abortion when they had been pregnant 16 weeks or longer. Three out of four of the women who had an induced abortion done between 13 to 15 weeks of gestation had initially consulted a physician at least eight weeks earlier. An equal proportion of women who had their abortions when they had been pregnant 16 weeks or longer had also seen a physician some two months prior to the abortion operation. (Chapter 7).

One out of 200 physicians in the national physician survey reported the actual average length of time (8.0 weeks) between when a woman initially consulted a physician and when the therapeutic abortion operation was performed. (Chapter 9).

3. (3) Do therapeutic abortion committees require the consent of the father or, in the case of an unmarried minor, the consent of a parent?

Since the "therapeutic abortion exception" in the Abortion Law does not specify any age of consent, a minor of any age who is not otherwise legally incapable may give a valid consent to the procedure for the purposes of the criminal law. Since the "therapeutic abortion exception" in the Abortion Law does not seek to infringe upon provincial jurisdiction over the matter of consent to medical care and treatment, the uncertainties in the laws of the provinces have been allowed to affect the consent requirements of hospitals.

While there was considerable variation in the practices of hospitals with therapeutic abortion committees across the country, most of these hospitals required the consent of a parent or guardian to a therapeutic abortion on an unmarried minor. In provinces where the age of consent to medical treatment was lower than the age of majority, a substantial number of hospitals continued to use the age of majority as a standard for consent. Although there is no known legal requirement for the consent of the father to a therapeutic abortion, more than two-thirds of the hospitals surveyed by the Committee which did the abortion procedure required the consent of the husband. A few hospitals required the consent of a husband from whom the woman was separated or divorced and the consent of the father where the woman had never been married. (Chapter 10).

3. (4) To what extent is the condition of danger to mental health being interpreted too liberally or in an overly-restrictive manner, and is the likelihood or certainty of defect in the foetus being accepted as sufficient indication for abortion?

If the definition of mental health is restricted to psychiatric disorders associated with physical conditions, psychoses, or long-term neuroses, then few abortion patients had these conditions. (Chapter 11). The medical profession was deeply divided on this question. Overall, 43.9 percent of the physicians said that mental health as an indication for induced abortion was being interpreted too liberally, 37.5 percent endorsed the present situation, and 14.9 percent felt that mental health in this context was interpreted too restrictively. (Chapter 9).

In 9 out of 10 hospitals in the national hospital survey the possibility of deformity or congenital malformation of the foetus was considered in the review of a pregnant woman's medical history. Pregnancy resulting from rape or incest was a consideration given high priority by therapeutic abortion committees, most of which (8 out of 10) considered their occurrence as valid reasons for the approval of a therapeutic abortion. (Chapter 11).

3. (5) To what extent has permitting the pregnancy to continue affected the woman or her family in cases where the woman would have preferred an abortion but did not obtain one?

Based on the reported use of health services, women who had had therapeutic abortions appeared generally to be in good health. In a before-and-after study, during the year following their operation, these women made slightly less use of hospital services and had fewer consultations with physicians than women who had had deliveries or spontaneous and other abortions. In terms of the hospital and medical services which they obtained, the level of mental health of women who had induced abortions was comparable to women who had spontaneous and other abortions or who had been sterilized. These three groups of women (induced abortions, spontaneous and other abortions, sterilization) subsequently consulted physicians, on an average, twice as often for reasons related to mental health than women who had term deliveries. (Chapter 13).

In the national population survey of 4,128 individuals, women were asked about their experience with childbirth and abortion. A substantially higher proportion of single mothers were poor. Fewer poor women who were single or married had had induced abortions. In contrast, more middle-income women had had induced abortions and fewer of these women and those females with still higher incomes were unmarried mothers. (Chapter 7). Among a small group of women who were carrying their pregnancies to term, 1 out of 4 had at one time considered having an induced abortion, but they had not taken this course because of a lack of accessible services for therapeutic abortion or because of delays which had been involved in applications submitted on their behalf to hospitals with therapeutic abortion committees. (Chapter 7).

3. (6) What types of women are successful and what types not successful in obtaining legal abortions in Canada?

In comparison with women who had not had abortions (national population survey), women who had induced abortions were younger, more were single, and in general they had a higher level of education. (Chapter 14). Between 1970 and 1973 the number of illegitimate births and therapeutic abortions equalled one-fifth of the number of the deliveries during this period. The *rate of change* in illegitimacy was one factor which was associated with the relative accessibility to the abortion procedure in Canadian hospitals. Single mothers in comparison to women who had induced abortions tended to have less education and lower incomes. (Chapter 7).

When the number of women who did not have an abortion after obtaining approval from a hospital committee are considered with the women who initially had wanted to become pregnant and subsequently decided to seek an abortion, then 1 out of 6 women changed their decisions one way or another about having an induced abortion. Women who had induced abortions were on an average more sexually active than women who had not had this operation. (Chapter 14).

3. (7) Are hospital employees required to participate in therapeutic abortion procedures regardless of their views with respect to abortion?

Most of the hospitals in the national hospital staff survey reported they had had no recent problems involving the recruitment of staff for abortion

services. In 1 out of 4 of these hospitals, prior to the employing of staff, a description was given of the services without other options being made available and 1 out of 6 did not employ staff who felt they could not provide care to all patients. Based on the stated hiring practices of some hospitals, their employment procedures relating to the abortion procedure may not be in accord with the codes of provincial human rights commissions. (Chapter 12).

About one-third of the nurses were not prepared to leave their current positions which involved them in some aspect of the abortion procedure, but they would have preferred, if they had the choice, not to do this type of work. One out of thirteen of the nurses who worked in 41 of 70 hospitals said they knew of one or more colleagues who had made a formal grievance related to the abortion procedure. For most of the nurses who may have had complaints about their participation in the abortion procedures, union contracts, staff associations, or provincial human rights commissions provided a means for conciliation in resolving their concerns. This recourse was seldom taken. (Chapter 12).

3. (8) To what extent are abortions which are being performed in conformity with the present law seen to be the result of a failure of, or ignorance of proper family planning?

Among sexually active women in the national population survey, slightly less than one-fifth did not use any form of contraception. More of these females who never used contraceptive means were young, single, and had an elementary and high school education. Seven out of eight women (84.8 percent) who were seeking an induced abortion had used one or more methods of contraception. Their unwanted pregnancies were accounted for by factors other than their ignorance of family planning. (Chapter 14).

In almost equal numbers, women who were having induced abortions who had had sex education used the same types of contraception as the women who had had no such instruction in schools.The findings for these women do not lend support for the adequacy of current contraceptive and family life education programs undertaken at schools across Canada. (Chapter 14).

The type of contraception used by many of the patients who had abortions in Canadian hospitals in 1976 (national patient survey) differed from the contraceptive practices of women in the national population survey who had not had abortions and of women who had previously had abortions. Less than 1 out of 5 (18.0 percent) of the patients used oral contraceptives, which contrasted with the 44.0 percent of women in the national population survey who had not had abortions, and the 47.0 percent of women who had previously had abortions. In contrast with the two groups of women in the national population survey, the patients who had had abortions in 1976 (national patient survey) used: the diaphragm twice as often; their partners had used the withdrawal method 2.4 times more often; the rhythm method about three times more often; vaginal spermicides five times more often; and their partners had used condoms above four times more often. By having coitus under these circumstances, the chances of an unexpected, and for many, an unwanted

pregnancy were sharply raised. This fact stands out starkly as a major factor contributing to the number of induced abortions across Canada. By not using contraception, or by not knowing how to use the means which were tried, many Canadian women and men took chances which had profound implications for themselves and for society. (Chapter 14).

A substantial number of women and men across Canada have had no formal instruction about contraception. The physician was seen by many Canadians (national population survey) as the major source of contraceptive advice. All other resources including those operated by schools, churches, community agencies and public health departments were seldom cited as the sources of contraceptive information. Notable by its absence was the role of the mass media—newspapers, radio, and television. (Chapter 14).

In its work abroad Canada has helped to initiate on a cooperative basis with other nations the components of an exemplary comprehensive family planning program. This endeavour stands in sharp contrast to the efforts which have been undertaken in this country. The research work to date in Canada has been fragmentary; most of the relevant questions have not been studied. (Chapter 15). More money from the public purse was spent on providing treatment services and facilities for abortion patients than on the public effort to undertake effective preventive measures. In the broad terms of per capita expenditures it was estimated that $0.58 was spent by each Canadian in 1974 to pay for the costs of therapeutic abortions and $1.61 for the immediate costs associated with childbirth. At the same time from designated expenditures, $0.24 per capita was spent on federal and provincial family planning measures. (Chapter 15).

3. (9) How many Canadians are seeking therapeutic abortions outside the country, and, if this can be determined, for what reasons?

The Committee estimates that 9,627 Canadian women obtained induced abortions in 1975 in the United States. Relatively few Canadian women went to other countries for this purpose. (Chapter 4). At several of the commercial agencies clients who were referred to the United States were routinely told that obtaining an abortion was illegal in Canada and misinformation was given about the actual costs involved. These commercial abortion referral agencies existed opportunistically, at a stiff price for their clients. There was reasonable doubt about the propriety of their work. They existed because there was a demand for their services which was not otherwise being met. (Chapter 15).

Among a small group of women who had abortions in the United States from whom information was obtained, 7 out of 8 would have preferred to have had an abortion in Canada, if they had known or had been told this option was available. Over half of these women said that their physicians felt they had little chance of getting an abortion in Canada, were morally opposed to assisting them, or were unwilling to refer them to a hospital where this procedure was done in Canada. (Chapter 7). The ratio of the number of Canadian women going to the United States for induced abortions to the number of women using Canadian hospitals for this purpose, varied directly with: (1) the number of hospitals with therapeutic abortion committees in a

region; and (2) the proportion of those hospitals with such committees which did the abortion procedure. (Chapter 6).

Related findings

Abortions not Specified as Induced or Spontaneous. The system used to classify different types of abortions (*International Classification of Disease*) contains a "catch-all" category intended to list abortions which are neither induced nor spontaneous. Abortions in this category accounted for 113,533 reported abortions between 1970 and 1973, a number almost equal to the 124,129 reported therapeutic abortions done in Canadian hospitals during the same period. In general, provinces with lower rates for *induced abortions* had substantially higher rates for *spontaneous abortions and other abortions*. The rates of spontaneous and other abortions also varied substantially by: (1) the size of hospitals; (2) whether hospitals had established or had not established therapeutic abortion committees; and (3) the type of ownership of hospitals without committees. Religious hospitals, most of which on stated moral principles were opposed to induced abortion, had the lowest ratio per 1,000 live births of spontaneous and other abortions. (Chapter 4).

Disposition of Hospital Charts. In comparison with the special arrangements made by 3 out of 4 of the hospitals for the records and minutes of therapeutic abortion committees, one-third of these hospitals took comparable precautions involving the handling and the storage of the charts of induced abortion patients. Few hospitals with therapeutic abortion committees had established either special guidelines governing the accessibility to the charts of induced abortion patients by staff or for their use for research purposes. Dual standards obtain in this regard. Comparable access is unknown to the Committee to have been given for research involving the review of the work of therapeutic abortion committees or for the analysis of the decisions reached by these committees on abortion applications. (Chapter 11).

Extra-billing of Medical Fees. When the expected and the actual rates of the extra-billing by physicians of abortion patients are compared, on a national average women who had this operation were extra-billed more often than might be expected in 5 out of 8 provinces and this situation likely occurred in a sixth province. The conclusion that there are no financial deterrents to obtaining health services was not valid for the 1 out of 5 of the 4,754 women who had therapeutic abortions in eight provinces in 1976. The combined consequences of either the largest fee charges or the most extensive extra-billing involved abortion patients who were the most socially vulnerable: young women; newcomers to Canada; and the least well educated. (Chapter 15).

Knowledge of the Abortion Law. Some six years after the federal abortion legislation was amended to allow induced abortions to be obtained under stipulated circumstances, 2 out of 3 persons in the 1976 national population survey did not know it was legal under any circumstances to obtain a therapeutic abortion. Over half of the women and the men did not know what

the situation was in their communities regarding the accessibility of abortion services. (Chapter 6). While the Abortion Law sets no limits when an induced abortion may be done in terms of the length of a pregnancy, 3 out of 4 physicians in the national physician survey agreed with what they felt the law said on this point. Nine out of ten physicians reported the number of weeks which they said the Abortion Law stipulated about the length of a pregnancy when an induced abortion could be performed. (Chapter 9).

Opinion of the Abortion Law. About 1 out of 10 women and men said that an induced abortion should never be performed. More individuals, but still a minority, held the opposite viewpoint. Among the individuals in the national population survey, 1 out of 6 women and 1 out of 4 men said that an induced abortion should be performed whenever such a request was made by a woman. Taken together, these two contrasting viewpoints were held by about 1 out of 4 women and 1 out of 3 men. Three-quarters of the women and two-thirds of the men did not endorse either of these two positions. They either had no opinion on this issue or they felt that this operation should be performed under specific circumstances related to the impact of an unwanted pregnancy on a woman's life or her health. (Chapter 11).

Over half of the physicians wanted therapeutic abortion to be removed from the Criminal Code, and a third favoured the present arrangement. When they were asked where first-trimester abortions should be performed, two-thirds of the physicians endorsed a hospital day-surgery unit, followed by in-hospital patient service. One-fifth said this procedure could be effectively handled in a community clinic, and less than 1 out of 10 said this operation should be done in a physician's office. (Chapter 9).

Optimal Professional Care. On the basis of the national patient survey and reports of women who had therapeutic abortions, an appraisal of how the optimal professional care of women who obtain induced abortions can be provided is indicated, an appraisal which takes into account their views, and the concerns of the physicians and nurses who serve them. (Chapters 7 and 8).

Population Policy. The national crude birth rate has declined between 1960 to the present time. Between 1970 and 1974, it dropped from 17.5 to 15.4 per 1,000 persons. The number of female sterilizations was 244,963 and the number of reported induced abortions was 124,129 between 1970 and 1973. The recent changes affecting induced abortions accelerated, but only partly contributed to the broader population trends. (Chapter 4).

For the nation as a whole, information about sexual behaviour, contraceptive use, the volume of induced abortions, and the sterilization of women and men, when coupled with changing external migration trends (immigration, emigration) constitute a necessary basis for: the establishing of basic social indicators for the health of Canadians; the supply and demand of public services; and the changing shape of the economy. Information on these trends is a necessary cornerstone to the consideration of national (or regional) population policies. (Chapter 14).

Related Health Costs. Between 1973 and 1974, the average hospital and medical care costs for the treatment of each woman having a therapeutic abortion dropped from $284.17 to $270.76. The range in these costs between the 10 provinces was between $195.45 and $320.00, or a variation in direct reported health costs of 61.1 percent. There was no apparent association between different provincial complication rates and the average length of hospital stay of patients who had therapeutic abortions, the proportion who were treated on an out-patient or in-patient basis, or the average health costs which were paid for the medical and hospital services which were required by this procedure. (Chapter 15).

Repeat Induced Abortions. There are indications that the proportion of women having repeat induced abortions may be sharply increasing. The women who had been previously pregnant and had prior abortions differed from the majority of the women in the national patient survey More of these women were single, on an average they had a higher level of education, more were working outside the home and fewer had previous live births. (Chapter 14).

Sterilization and Induced Abortion. The typical woman having an abortion who was also to be sterilized concurrently had an elementary school level of education, spent most of her time at home, was over 30 years of age and had two or more children. The level of education of women having induced abortions was inversely related to the occurrence of sterilization, involving 17.7 percent of females with an elementary school level of education, 9.4 percent who have attended high school and 6.2 percent who had been to college or university. (Chaper 14).

The implications in the findings from the national physician survey suggest that more physicians in the future than at present may be prepared to advise patients to have a sterilization operation. This trend may be indicated by the higher proportion of young physicians who were prepared to advise their patients along these lines. (Chapter 9).

Tabulation of Therapeutic Abortions. A total of 42 reported therapeutic abortions were done in hospitals without therapeutic abortion committees in four provinces in 1974. Two different systems are used in the classificatior of induced and other types of abortions at the national level. These systems lead to much confusion and inaccuracy in the classification of all categories of abortions. The discrepancy is great between the actual and the potential use of existing sources of information about all types of abortion and their associated health complications. (Chapter 4).

4. The Committee will consult periodically with an inter-departmental committee consisting of representatives of the Department of Justice, the Department of National Health and Welfare, the Treasury Board Secretariat and Statistics Canada which are to provide the Committee members with all relevant information available within the government.

Three meetings of the inter-departmental committee were held.

5. **The study is to be completed within six months from the time of establishment of the Committee.**

The research work of the Committee was completed within six months of the date (November 3, 1975) it was established. The Report of the Committee was prepared during the following four months.

6. **The results of the study will be made public and will be tabled in the House for debate.**