

## Chapter 6

# Distribution and Availability

Several related concepts are involved in the analysis of the abortion procedure.<sup>1</sup> The need for abortion services is determined by the number of women who seek to terminate their pregnancy. The need and the demand for services are not synonymous. The distribution of the abortion procedure relates to its allotment among eligible hospitals. The availability of the abortion procedure is the extent to which it is at the disposal or within the reach of women seeking an abortion. The availability of the abortion procedure involves the distribution of eligible hospitals with committees, the volume of abortions which are done, the pattern of medical practice which may influence when and where the procedure is done and how the individuals involved at every stage view the accessibility of the services which are provided.

The Terms of Reference required that the Committee review “the availability by location and type of institution of the procedure provided in the Criminal Code.” The Committee was also enjoined to inquire whether (1) “There are not enough doctors in the area to form a committee”; (2) “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”; and (3) “The views of hospital boards or administrators with respect to abortion dictate their refusal to permit the formation of a committee”. In determining the scope of the abortion procedure in terms of its distribution and availability, information on the decisions of eligible hospitals without committees was obtained from site visits to hospitals made by the Committee and the national hospital survey done by this inquiry.

### Distribution of eligible hospitals

The number of women who live in communities served by eligible hospitals is an index of the relative availability of the induced abortion procedure.<sup>2</sup> This

<sup>1</sup> The concepts of need and demand are used here on the basis of their meaning in the analysis of health care services, and not from a basis of their economic or moral implications.

<sup>2</sup> Definition of an eligible hospital is given in Chapter 5. Of 559 eligible hospitals in 1976, 271 had established therapeutic abortion committees and 288 hospitals did not have committees.

measure provides only a general measure of availability. It is not a direct index of the demand for induced abortion, but looks at the location of eligible hospitals with and without committees in terms of the number of people living in rural counties, towns or cities based on the 1971 population census. How many Canadians did not live in a community where an eligible hospital was located can also be determined. Like other medical and surgical care which requires hospital-based treatment, where women seek and obtain an induced abortion can vary for personal reasons or be related to the availability of medical specialists and hospital facilities. What this measure indicates in gross terms are the proportion of Canadian women who, if they were seeking approval for this procedure from the therapeutic abortion committee of a hospital, could have had an abortion application reviewed in the community where they lived, or whether because such a service was not available, they would have had to go to another community.

There are four categories of communities where women lived in terms of this measure of distribution. These are: (1) communities with a *single* eligible hospital which had a therapeutic abortion committee; (2) *joint* hospital communities which usually were larger towns and cities where both hospitals with and without committees were located; (3) communities which had eligible hospitals which had not established committees; and (4) the proportion of the population living in towns and cities where there were no hospitals which were eligible to establish committees. Communities with a single eligible hospital with a committee were available to 13.4 percent of Canadian women. The distribution of these hospitals, as well as of larger cities in which hospitals with and without committees were located, reflected regional differences in the concentration of the population in metropolitan areas and the proportionate distribution of the hospitals with committees. Eligible hospitals which had not established committees were located in centres representing 5.7 percent of Canadian women. There was no marked regional distribution among these hospitals. If all centres with eligible hospitals were grouped together (eligible hospitals with and without committees), these hospitals served 60.7 percent of women in Canada and 39.3 percent of the female population was not served by eligible hospitals.

With two exceptions (Nova Scotia and Saskatchewan) there was a marked east-to-west trend in the proportion of the Canadian population served directly by eligible hospitals in the communities where they lived. On an average about two-thirds of the people living in the Maritimes (with the exception of Nova Scotia) did not have an eligible hospital in the community where they lived. For Nova Scotia, Quebec and Saskatchewan, about half of the population lived in communities with eligible hospitals. For Ontario and three western provinces (with the exception of Saskatchewan), two-thirds of the population lived in centres with eligible hospitals. In these respects the accessibility to eligible hospitals of the average person who lived in the Maritimes and in western Canada were reversed.

The provincial and the regional distribution of hospitals with therapeutic abortion committees and the proportion of the population who were served by these hospitals closely paralleled the general distribution of eligible hospitals.

TABLE 6.1

## POPULATION SERVED BY ELIGIBLE GENERAL HOSPITALS\*

Province	Communities with Single Hospitals With Committees %	Communities with Hospitals: With/Without Committees %	Total Population Served by Committee Hospitals %	Communities with Eligible Hospitals Without Committees %	Total Population Not Served By Committee Hospitals %	Total Population Not Served by Eligible Hospitals %
Newfoundland .....	6.7	16.3	23.0	10.1	77.0	66.9
Prince Edward Island .....	8.0	17.0	25.0	6.3	75.0	68.7
Nova Scotia .....	11.4	33.2	44.6	10.0	55.4	45.4
New Brunswick .....	4.1	27.6	31.7	8.1	68.3	60.2
Quebec .....	3.6	40.9	44.5	9.2	55.5	46.3
Ontario .....	24.3	40.9	65.2	2.6	34.8	32.2
Manitoba .....	5.9	54.2	60.1	9.7	39.9	30.2
Saskatchewan .....	10.9	35.2	46.1	3.9	53.9	50.0
Alberta .....	7.3	54.2	61.5	7.0	38.5	31.5
British Columbia .....	15.4	48.9	64.3	2.1	35.7	33.6
Yukon, North West Territories .....	32.6	—	32.6	8.9	67.4	58.5
CANADA .....	13.4	41.6	55.0	5.7	45.0	39.3

\* Based on 1971 Census and 1976 distribution of hospitals.

Where, as in the Maritimes, there were relatively fewer people living in communities in which an eligible hospital was located, there was also less direct accessibility to hospitals which had established therapeutic abortion committees. The reverse situation was true in western Canada. In that part of the country where on an average 2 out of 3 persons lived in communities which had eligible hospitals, almost equal proportions of the population were served by hospitals which had established therapeutic abortion committees. On the basis of these findings, the Committee concludes that one important element in the distribution of hospitals with therapeutic abortion committees was the relative distribution and direct accessibility to all eligible hospitals which served the population. Where the direct accessibility to all eligible hospitals was high, there was also a greater accessibility to hospitals with therapeutic abortion committees. In these respects women living in eastern Canada had on an average a level of accessibility to the abortion procedure which was half of that for women who lived in western Canada.

## Hospitals with committees

Nineteen hospitals had established therapeutic abortion committees when the amendments to the Abortion Law went into effect on August 26, 1969. An additional 31 hospitals had established committees by the end of 1969. This number rose to 143 hospitals in 1970 and included 271 hospitals in 1976. The trends in the volume of abortions done during this period were: (1) the proportion of hospitals with committees doing no abortions declined from 22.0 percent to 17.0 percent; (2) an increase in the number of hospitals doing the abortion procedure, but the number of abortions done by hospitals in the intermediate range (under 100 abortions per year) decreased from 46.0 percent to 11.0 percent; and (3) a sharp increase in the proportion of the total abortions for the country which were done by a small number of hospitals (70.0 percent).

There were 31 hospitals with committees (21.7 percent of hospitals with committees) which did no abortions in 1970. In 1974, the latest year at the time of this inquiry that detailed information was available from Statistics Canada, the number of hospitals with committees doing no abortions had risen to 46. They represented 17.4 percent of hospitals with committees. There were no hospitals with committees which did no abortions in 1974 in Prince Edward Island, Saskatchewan, Alberta, the Yukon and the Northwest Territories. In Newfoundland, Nova Scotia, New Brunswick, Saskatchewan and Alberta, there was a decrease from 15 hospitals with committees doing no abortions in 1970 to 5 hospitals in 1974. In Quebec, Ontario, Manitoba, and Saskatchewan the number of hospitals with committees rose from 76 in 1970 to 156 in 1974, or by 205.3 percent, and during the same period the number of hospitals with committees which did no abortions increased from 17 to 36, or by 211.8 percent. The number and the proportion of hospitals with committees doing no abortions in each province in 1974 was:

	Number	Percent
Newfoundland .....	1	16.6
Prince Edward Island .....	—	—
Nova Scotia .....	1	8.3
New Brunswick .....	3	37.5
Quebec .....	12	44.4
Ontario .....	21	19.0
Manitoba .....	3	33.3
Saskatchewan .....	—	—
Alberta .....	—	—
British Columbia .....	5	9.3
Yukon and Northwest Territories .....	—	—

The distribution of hospitals with committees doing no abortions was not uniform for the country, constituting over a third of eligible hospitals with committees in Manitoba (33.3 percent), New Brunswick (37.5 percent), and Quebec (44.4 percent). Proportionately more hospitals with committees in eastern Canada than in western Canada did no induced abortions. Of the 265 hospitals with committees in 1974, 219 hospitals did all of the abortions. The factors accounting for hospitals with committees doing no abortions, or from year to year doing relatively few abortions, were related to the demand for abortion by patients, the process of pre-screening of abortion requests by physicians prior to an application being submitted to a hospital's therapeutic abortion committee, and the nature of the guidelines used by the committees in their review of abortion applications.

The number of hospitals with committees in which the abortion procedure was done increased from 112 hospitals in 1970 to 219 hospitals in 1974. Hospitals doing under 50 abortions in 1970 accounted for 66.0 percent of all hospitals with committees. They did 27.0 percent of the total number of abortions for the country. By 1974, hospitals doing under 50 abortions each year represented 41.0 percent of eligible hospitals with committees and did 5.0 percent of total abortions. A proportionate shift occurred during this period for hospitals doing between 51 to 100 abortions annually. Representing 10.0 percent of hospitals in 1970, these hospitals did 29.0 percent of abortions, while by 1974, 23.0 percent of hospitals doing between 51 to 100 abortions accounted for 15.0 percent of the abortions done that year in hospitals in Canada.

The major trend between 1970 and 1974 was the increase in a small number of hospitals which did a majority of the abortions in Canada. In 1970, seven hospitals (4.9 percent) did 54.0 percent of reported abortions done in Canada. Three hospitals that year accounted for 38.0 percent of the number of abortions. By 1974, 73 hospitals, or 27.5 percent of hospitals with committees, did 89.0 percent of reported abortions. A total of 33 hospitals (12.5 percent) of hospitals with committees which did over 400 abortions each year accounted for 70.0 percent of the abortions in 1974. While there were more hospitals in 1974 doing a larger number of abortions, a small number of hospitals which had established committees in 1969 and 1970 continued to do a substantial number of abortions. Fifteen hospitals which accounted for 51.6 percent of the abortions in 1970 did 40.1 percent of the total number of abortions in 1974.

The trend of a few hospitals in each province doing a majority of the abortions was consistent across Canada.

*Newfoundland.* The communities in which the hospitals with committees were located had 23.0 percent of the 1971 provincial population. Two hospitals with committees which were in cities representing 21.3 percent of the provincial population did 95.6 percent of abortions in 1974 and 98.0 percent in 1975. Three of the remaining hospitals with committees did 2.0 percent.

*Prince Edward Island.* The two hospitals which did all of the abortion procedures (100.0 percent) were located in communities representing 25.0 percent of the provincial population.

*Nova Scotia.* Located in cities where 18.5 percent of the province lived, three hospitals with committees did 82.1 percent of the abortions in 1974. Eight hospitals doing 91.8 percent of the abortions were in communities where 26.9 percent of the provincial population lived.

*New Brunswick.* Two hospitals with therapeutic abortion committees which did 80.9 percent of all induced abortions in 1974 were located in two cities representing 28.8 percent of the population. Five hospitals which did 95.2 percent of all the province's induced abortions in 1974 were located in centres which had 31.2 percent of the provincial population.

*Quebec.* Two cities in the province of Quebec did 100.0 percent of the reported abortions done in hospitals in 1974. Twelve hospitals in one city, representing 32.5 percent of the provincial population, did 99.4 percent of abortions in 1974. The population of the two cities in which hospitals with committees did all reported abortions in 1974 had 33.8 percent of the provincial population.

*Ontario.* The 110 hospitals with committees were located in towns and cities representing 65.2 percent of the provincial population. One large city with 27.1 percent of the provincial population did 44.5 percent of all reported abortions in 1974. On an accumulative basis, two cities which had 31.1 percent of the provincial population did 56.9 percent of abortions, three cities with 34.1 percent of the population did 56.9 percent of abortions, and four cities with 34.9 percent of the population did 65.6 percent of the abortions. Twenty-one hospitals with committees in Ontario did no abortions in 1974; nine hospitals did an average of two abortions each year. The remaining 72 hospitals with committees did 118 abortions in 1974.

*Manitoba.* Three hospitals in a major metropolitan area representing 54.1 percent of the provincial population did 95.5 percent of abortions in 1974. Four hospitals in two cities whose combined population was 57.3 percent of the provincial total did 99.0 percent of the abortions.

*Saskatchewan.* Three hospitals in two cities in which 28.8 percent of the Saskatchewan population lived did 82.9 percent of the provincial total of abortions in 1974. Five hospitals in three Saskatchewan cities with 35.4 percent of the provincial population did 96.0 percent of the abortions in 1974.

*Alberta.* Deviating from the national pattern, six hospitals in two cities representing 51.7 percent of the provincial population did 40.2 percent of the abortions in 1974. The national trend emerged when the number of abortions done in eight hospitals in four cities were grouped together. The cities where

these hospitals were located had 56.0 percent of the Alberta population and they did 95.6 percent of the reported abortions in 1974.

*British Columbia.* Representing a broader dispersion of hospitals throughout the province doing more abortions, 10 hospitals in two metropolitan areas with 49.9 percent of the population of British Columbia did 74.0 percent of the abortions in 1974. Thirteen hospitals in five cities where 53.5 percent of the population lived did 83.7 percent of abortions in 1974.

*Yukon and Northwest Territories.* The two hospitals with committees which did all of the abortions (100.0 percent) in 1974 were located in centres representing 32.6 percent of the population of the Yukon and Northwest Territories.

Information was not available at the time of the inquiry on the total number of abortions done in Canada in 1975. Replies received directly from hospitals in 1976 indicated that where abortions had been done by hospitals in 1975 the relative numbers had not changed from the pattern of distribution in 1974. Statistics Canada provided information on the residence of women seeking an abortion and the location of the hospitals where this procedure had been done in 1974 for New Brunswick, Quebec, Saskatchewan and British Columbia. The residence of women obtaining an induced abortion was only available for abortion procedures done on an *in-hospital* basis, i.e., patients who had been admitted to an overnight or longer stay in hospital. All abortions done on an ambulatory or day-care basis were not included. For these reasons this information was not comparable to the total number of abortions done by these hospitals relative to the population served by these hospitals.

Of the 440 reported induced abortions done in hospitals in New Brunswick in 1974, 55.2 percent were done on an in-patient hospital basis. While almost three out of four of these patients (73.9 percent) had the abortion procedure done in a local hospital in the community where they lived, women in four communities accounted for 71.8 percent of all in-patient abortions. More than 1 out of 5 of the women (21.0 percent) who lived in seven regions of New Brunswick had their operations done at a local hospital on an in-patient basis.

Based on Statistics Canada information on the number of women who obtained induced abortions and, who were admitted to hospital in Quebec in 1974, these patients accounted for 65.4 percent of all reported induced abortions for the province during that year. The remainder, or 34.6 percent, represented induced abortions which had been performed on a day-care surgery, or on an out-patient basis. Out of the total of 2,795 women for whom information was available about where they lived and where they had had their induced abortions in Quebec hospitals, 76.3 percent lived in a metropolitan area and had this operation done at a local hospital. The induced abortion procedure was done on an in-hospital basis during 1974 in 5 out of 59 census districts in Quebec with the total for four districts being 19 operations. None of the 623 women, or 22.3 percent of all in-hospital patients who had induced abortions, who lived in 54 regions of the province had this operation done at local hospitals where they lived.

Of a total of 1,411 induced abortions reported by Statistics Canada which were done in Saskatchewan hospitals in 1974, 893, or 63.3 percent, were on an

in-patient basis. Of these abortions done on an in-patient basis, 51.2 percent of the women had this operation done at a local hospital, while 48.8 percent went to hospitals in other centres. If the abortion patients living in three of the larger cities are not considered, 12.2 percent of women living elsewhere in the province had their abortions done in local hospitals, while 87.8 percent of such patients went to larger centres for this operation.

Representing 44.9 percent of the 10,024 induced abortions in 1974 in British Columbia, there were 4,501 abortions which had been done on an in-patient basis. Information on the residence of patients was not available from Statistics Canada on 55.1 percent of the abortions which were done on an ambulatory or day-care basis. Reflecting the distribution of the population and hospitals with therapeutic abortion committees, 89.7 percent of women in British Columbia in 1974 who had an abortion on an in-patient basis had this procedure performed at a local hospital. The remainder, or 10.3 percent of in-hospital abortion patients, left the centres where they lived to have an abortion. If patients living in four of the larger cities in British Columbia are not considered, then 67.5 percent of women living in other parts of the province had an abortion on an in-patient basis at local hospitals and 32.5 percent went to other communities for this procedure.

**The hospitals in each province which did the majority of abortions were located in major cities or metropolitan areas. In addition to doing the abortion procedure for women in these communities, these hospitals were the main referral sources for women coming from rural areas with no hospitals, those centres with hospitals which were not eligible to do abortions, communities with eligible hospitals without committees, and places whose hospitals with committees did no abortions.**

## Eligible hospitals without committees

The distribution of hospitals which perform the abortion procedure is determined by the decisions of hospital boards to establish or not to establish committees. If other requirements are met, the decision to establish or not to establish a committee is vested with the board of an approved or accredited hospital. The Abortion Law stipulates that a therapeutic abortion committee may be "appointed by the board of that hospital for the purpose of considering and determining questions relating to termination of pregnancy within that hospital." The Terms of Reference set for the Committee required it to determine if the "views of hospital boards or administrators with respect to abortion dictate their refusal to permit the formation of a committee." Because each hospital retains its autonomy in this matter, several factors account for the decisions by 288 eligible hospitals not to establish therapeutic abortion committees.

*Decisions of Hospital Boards.* Five categories of reasons were given by hospitals for not establishing therapeutic abortion committees.<sup>3</sup>

<sup>3</sup> Based on replies from eligible hospitals in the national hospital survey.



	Percent
1. professional ethics of medical and nursing staff .....	39.4
2. religious denomination ownership and/or affiliation of hospital .....	23.7
3. avoidance of conflict .....	15.9
4. no demand for abortion .....	7.9
5. inadequate facilities and specialization of medical staff .....	6.5
6. other .....	6.6

*Professional Ethics.* Many examples were reported of doctors who would refuse to become members of therapeutic abortion committees if these committees were appointed by hospital boards, and of doctors and nurses who on ethical and professional grounds would take no part in the treatment of abortion patients. These views of the medical and nursing staff were frequently endorsed by hospital boards. When they were not, board members recognized the dilemma of establishing a non-functioning committee which would be strongly opposed by doctors and nurses. When the reverse situation occurred where a board decided not to establish a committee, but members of the medical staff were in favour of doing so, this situation was almost invariably resolved by physicians acknowledging a hospital's position on induced abortion when they were given hospital admitting privileges. Their option was clearcut. In their work in the hospital either they accepted the board's decision, or they could seek patient admitting privileges elsewhere. Examples of the opinions involving the professional ethics of medical and nursing staff members are drawn from replies to the national hospital survey undertaken by the Committee.

Under the present circumstances, there is no longer any medical indication to justify therapeutic abortion (i.e., a direct attack on the foetus) to protect the life or physical health of the mother.

. . .

We are not concerned with the Abortion Law; we just do not believe in this as a modality of treatment.

. . .

There seems to be confusion related to therapeutic abortions. The true therapeutic abortion procedure is rarely necessary; however, if you mean for convenience, this is a very expensive means of birth control for irresponsible people.

. . .

Is sterilization mandatory following a therapeutic abortion? Do we solve *social* ills by this means? Should not poverty and ignorance be treated directly, thus preventing the conception of these unwanted children?

Abortion is a homicide. Some very strict laws must control it. It must not be used as a contraceptive measure. To accept free abortion is equal to recognizing euthanasia. The legislator, to be logical with himself, cannot abolish capital punishment for recognized criminals and, at the same time, accept the systematic murder of future citizens capable of rebuilding the nation.

. . .

Abortion on demand is not a birth control measure. There will be circumstances when there is great trauma to the individual through having a child, but usually mental and economic problems can be overcome.

. . .

Continued slaughter of the human foetus cannot but make our society less than human and when birth control measures are available I cannot see us as a nation resorting to condoning human destruction—and certainly not after a foetus has become viable.

. . .

There are cases where a therapeutic abortion would be necessary such as rape, incest etc. However, as long as facilities are available within a reasonable distance of our service area, the majority of our medical staff would be reluctant to establish a committee and/or perform abortions.

. . .

This small hospital, while it could perform this service, has been effectively stopped by the undercurrent of disapproval by many of the older nurses on the staff.

. . .

Nurses wonder how they can save life one day and destroy it the next day.

. . .

All members of our medical staff are convinced of their Pro-Life philosophy. As physicians they have sworn to protect life and not to destroy it.

. . .

In the year and a half I have been associated with this hospital, there has not been a patient presenting a medical condition that warrants therapeutic abortion.

Medical Staff do not encourage young unmarried women to resort to abortion when pregnancy occurs. Young women are encouraged to continue the pregnancy with supportive therapy, and without ill effects.

The Medical Staff do not encourage abortion as a contraceptive measure as it is not consistent with good medical practice.

• • •

We have no problems. We have three doctors. None of them are in favour of abortion.

• • •

If the law is changed, re abortions, it seems imperative that provision be made within future legislation to provide for a "conscience clause", safeguarding the rights of hospitals, doctors, and nurses not to participate in abortions.

Further, provision for a clause in the Bill of Rights should be made to provide that no discrimination or punitive action be taken against women who refuse to have an abortion or permit sterilization.

Therapeutic abortion committees should allow for the presence on the committee of medical anti-abortionists.

*Religious Denomination Ownership and/or Affiliation.* The 1975 *Canadian Hospital Directory* listed 124 general hospitals owned by religious denominations. Five denominations which provided information to the Committee listed ownership and/or affiliation in 1976 with 151 general hospitals. These were: the Pentecostal Assemblies of Canada (1); the Catholic Church of Canada (133); the Salvation Army (8); the Seventh-day Adventist Church in Canada (2); and the United Church of Canada (7). Two Jewish general hospitals owned by voluntary corporations had no formal association with a religious denomination. A total of 71 hospitals owned or affiliated with five religious denominations, or 47.0 percent, were eligible under hospital practices and provincial requirements to establish therapeutic abortion committees. Sixty of these hospitals (84.5 percent) did not have committees.

The General Executive of the Pentecostal Assemblies of Canada on March 8-12, 1976 endorsed the following principles:

- (1) *Bible Basis*—Psalm 139: 1-13 and many other Scriptures teach that human life and human personality begin at conception and continue within the mother's womb before birth; and that to deliberately destroy that life is the killing of a living person.
- (2) *The Position of the Pentecostal Assemblies of Canada.* The Pentecostal Assemblies of Canada declared its position on Abortion at the 1968 General Conference at Windsor, Ontario in Resolution #18, affirming that abortion, except on strictly therapeutic grounds, is contrary to the Word of God and the sanctity of God-given life and that such intervention calls for God's strong condemnation.

The Medico-Moral Guide of the Catholic Health Association of Canada which was approved by the Canadian Catholic Conference on April 9, 1970 states:

Art. 9. Every human being has a right to live, and every effort should be made to protect that right.

Art. 13. From the moment of conception life must be guarded with the greatest care. All deliberate action, the purpose of which is to deprive the foetus or an embryo of its life, is immoral.

Art. 14. However, medical means required to cure a grave illness in a pregnant woman, and which cannot be deferred until the foetus is viable, are allowed even though it might endanger the pregnancy in progress.

Hospitals which are members of the Catholic Health Association of Canada endorse the principles of the Medico-Moral Guide.

The Salvation Army in a *Statement on Abortion and Family Planning* issued by its Territorial Headquarters on March 25, 1975 states:

3. An unborn child is a "potential person" from the moment of conception and a "potential" member of a family and of society, with spiritual, moral, and legal rights in both spheres.
4. Based on the experience of its Women's Social Service Officers, it is best, in most instances, to try and help a woman to accept the fact of an unplanned pregnancy and subject to medical advice, to allow it to go to term, while giving all possible supportive help.
5. Abortion should be granted only on adequate medical grounds after the therapeutic abortion committee has by certificate in writing stated that in its opinion the continuation of the pregnancy of such a female person would or would be likely to endanger her health, but not for social reasons. "Health" should be interpreted as soundness of mind and body, allowing for usual feelings of guilt, anxiety, and the pressures of socio-economic conditions.

*In Salvation Army Hospitals it is required that:*

1. Where deemed advisable by the Board of Management, and approved by Territorial Headquarters, a Therapeutic Abortion Committee be properly constituted and its members formally appointed by the Board of Management.
2. Abortions will be considered necessary only when recommended by such an Abortion Committee at a properly constituted meeting with a minimum of three doctors present.
3. The Abortion Committee should have associated with it a Salvation Army Officer and a social worker.
4. Whenever possible, qualified counselling be available to the prospective mother prior to the consideration of an application by the Abortion Committee.
5. The Abortion Committee give particular consideration to such factors as the age of the mother, her medical history in the light of any previous pregnancies or abortions, the estimated age of the fetus, and the timing of the abortion procedure.

In correspondence with the Executive Offices of the Seventh-day Adventist Church in Canada, the following statement was made:

The Seventh-day Adventist Church has never enunciated, by way of resolution or policy directive, its position with respect to the surgical procedure known as

abortion. However, an examination of the practice and procedure followed in the hospitals and clinics operated by our denomination around the world does suggest a *de facto* policy which can be characterized in one word: "conservative".

This position, while not as rigid as that adopted by some communions, has nevertheless been predicated upon the fundamental issue of the preservation of the life of the mother. Through the years we have identified with the traditional posture which contemplated surgical intervention only where the life of the mother is in jeopardy or where organic pathology is confirmed.

The Twenty-fifth General Council of the United Church of Canada in its *Statement on Birth Control and Abortion* of August 1972 approved the following recommendations:

*Preamble*

As Christians we wish to affirm:

The sanctity of human life, born or unborn. That life is much more than physical existence.

We also affirm that:

The taking of human life under any circumstances is wrong and the hurting of human life under any circumstances is wrong.

2. *Abortion*

- (a) We affirm the inherent value of human life, both as immature in the foetus and as expressed in the life of the mother and related persons. The foetus is a unique though immature form of human life and therefore has inherent value.

Christians should witness to this value by insisting that abortion is always a moral issue and can only be acceptable as the lesser of two evils in each particular situation. Therefore, abortion is acceptable only in certain medical, social and economic situations.

- (b) The present law, which requires a hospital therapeutic abortion committee to authorize an abortion is unjust in principle and unworkable in practice.
- (c) We do not support "abortion on demand". We believe that prior to twelve weeks of gestation, or prior to that stage of foetal development when abortion can no longer be performed by D&C suction, abortion should be a personal matter between a woman and her doctor. After that period of time, abortion should only be performed following consultation with a second doctor. We further believe that her male partner and/or other supportive people have a responsibility to both the woman and the foetus and should be involved in the decision wherever possible.

These moral principles enunciated by the religious denominations which were owned by or were affiliated with 71 eligible general hospitals determined the decision of the hospital boards relative to the induced abortion procedure.

*Avoidance of Conflict.* The public controversy which is on occasion associated with the abortion procedure was cited as the reason why therapeutic

abortion committees had not been established by 1 out of 6 eligible hospitals (15.9 percent). In reaching this decision some hospitals felt this was the prevailing opinion in the communities which they served. Recognizing the divided views of a community on induced abortion, hospital boards and administration in other instances were reluctant to spark a local controversy. As one administrator put it, "Why start a fight when by doing nothing we can keep the lid on." The publicized incidents involving the picketing of hospitals or the campaigns to elect board members holding known views on abortion were seen as divisive episodes which should be avoided.

The intensity of public opinion, in particular in some smaller communities, and the lack of anonymity for patients and doctors if abortions were to be done were given as the reasons why a number of smaller eligible hospitals did not have committees. For some of these eligible hospitals without committees which were located in smaller centres, patients seeking an abortion were routinely referred to larger cities where it was felt they would retain their anonymity and receive prompt treatment.

These informal safety-valve arrangements were seen as a means of resolving potential conflict among local doctors, staff nurses and the people served by a hospital.

Medical staff does not wish this hospital to become an "abortion mill" as it would benefit very few local residents and, if sufficient volume was present, could cause curtailment of other elective surgery.

. . .

In this small community of less than 25,000 people, the Right to Life group is very vocal. It intimidates local physicians with phone calls in the middle of the night. Hence, so few physicians are willing to perform the operation, that patients are referred to larger metropolitan centres. Referrals are also made to protect the anonymity of the patient.

. . .

Abortion Committees and abortions in general may be difficult to achieve in small hospitals and communities due to the personal involvement and relationship commonly found in smaller areas.

. . .

In a small community such as ours there is no possible way the Hospital Board or the Medical Staff of this Hospital would approve the procedure of therapeutic abortions. I as administrator also back the Board and the Medical Staff decision.

. . .

Easy and rapid availability of abortion services in \_\_\_\_\_ only 120 miles from \_\_\_\_\_, the small caseload and the social implications of performing abortions in a small community detract from creating an abortion service at this hospital.

The social and religious views of our region and our Board of Directors have not allowed us in previous years to offer the service of a real Therapeutic Abortion Committee to the population. However, even with the secularization of our Board of Directors and a sure evolution of our community, I do not think we can imagine, in the following years, a Therapeutic Abortion Committee with a notion of health which would be similar to the one of the World Health Organization. Indeed, it appears to us, as a community, that such a liberal point of view is an open door to the era of abortion on demand.

In a more positive manner, our medical staff will shortly be proposing to the Board of Directors of our hospital, the establishment of an abortion committee which would really be for therapeutic purposes.

One must doubtlessly keep from sliding into the easiness of abortion on demand, which is surely not a contraceptive method. The medical profession of our community believes in the opportunity of establishing a Therapeutic Abortion Committee, since it answers a need recognized by everyone even if it appears limited.

. . .

There is a lack of facilities for abortion in this area due to anti-abortion feelings of church-affiliated hospitals.

. . .

Our hospital does not perform any abortions. This decision was taken jointly by the Board of Directors and the Council of Physicians and Dentists. The persons susceptible of getting an abortion in accordance with the law are referred directly to a hospital in \_\_\_\_\_ .

Distance is no obstacle and mostly the hospitals there are well provided with qualified personnel and equipment allowing a precise diagnosis and an adequate decision in accordance with the law.

. . .

We do not feel it necessary to have every hospital in a given area do abortions and would prefer to see this service offered as a free-standing facility. If the service were offered here, we would not wish to see all staff of any category forced to participate.

. . .

At the present time all patients who might require an abortion (for reasons specified) the medical staff report them to the city and we are not involved in any way.

*No Demand for Abortion.* A small number of eligible hospitals without committees (7.9 percent) reported that therapeutic abortion committees had not been established because there had been no requests to do this procedure. For many hospitals with committees, there was an extensive "pre-screening" by physicians of patients before an application for an abortion was sent for review to a hospital's committee. While a hospital's position on the abortion procedure

may not be well known by the people in the community, most local family physicians and obstetrician-gynaecologists knew if a committee had been established, and often what guidelines had been adopted for the review of applications made for abortion. The statement that there had been no demand for abortion, or no requests had been received, may indicate that no women in a community had sought an abortion. This position may also reflect a hospital's known position on abortion, with abortion patients being referred elsewhere for this reason.

No requests have been brought to our attention. We presume the needs are not there yet.

. . .

We believe, in view of the small demand for therapeutic abortion and the difficulties involved in establishing a committee, that we can continue to refer our patients to hospital centres which provide these services.

. . .

The need in this community for abortions has not been made known to the hospital. However there appears to be a great need for the dissemination of family planning information to people especially those in low socio-economic groups who do not readily make themselves available to attend planned lectures, seminars, etc. The use of a mobile distribution of information system sent to communities on a regular basis might be of advantage. The use of clinics, seminars, public lectures should continue as widely as possible as education in and general acceptance of means of preventing pregnancy appears to be most important.

. . .

Up to this point there has been no interest indicated regarding the establishment of a committee.

*Inadequate Facilities.* Inadequate facilities and the specialization of medical staff were cited by 6.5 percent of the eligible hospitals without committees as reasons why committees had not been established. When this was the case, these reasons were more often a rationale based on ethical and professional convictions that a hospital should not establish a committee. In terms of hospital practices and provincial requirements, these hospitals had the facilities and services which were required to do the abortion procedure.

It was believed non-relevant for our hospital to start the necessary wheels while we do not have the necessary diagnostic equipment and while the cases presented are rare and the members of such a committee consequently, could not acquire the motivation and experience necessary to make a correct assessment.

. . .

The Board and Medical Staff of this Hospital, after full consideration and discussion, agreed *not* to set up an Abortion Committee. The performance of



abortion was *not* considered to be a desirable role for a small Community Hospital. The additional demand on the facilities of this Hospital for this purpose is believed to be achievable only at the expense of other present demands on its services.

. . .

The hospital does not have an obstetrical service. The gynaecology which is practised is highly specialized infertility endocrinology. The necessity of forming a Therapeutic Abortion Committee has never been perceived clearly, because of the orientation of the department of gynaecology as well as of the population served.

. . .

At this stage in time, we cannot accommodate extra procedures in our hospital as we already have a shortage of beds.

In addition some of the Medical Staff are opposed to the procedure of therapeutic abortion and the Board's view is negative regarding this subject.

## Ownership of hospitals

Hospitals are owned by voluntary (lay) corporations, private corporations, religious orders or corporations and government (municipal, provincial and federal). The selection of members of the hospital board may be by: the nomination of new members by the current members of a board; the appointment of members by municipal, district or provincial governments; the election from the membership of a voluntary non-profit association; or it may represent a combination of these procedures. In terms of direct public accountability based on ownership and the selection of board members, hospitals range from being closed or self-perpetuating corporations, a combination of appointment and selective public representation, to the direct selection of members in county or municipal elections. With the exception of Quebec, this mosaic of ownership and the various means of the selection of board members characterizes the administration of hospitals across Canada. With the *Act Respecting Health Services and Social Services* (S.Q. 1971, c.48) there was a reorganization of the Quebec hospitals in 1971 which involved uniform standards for the election or appointment, the term of office, and the composition of hospital boards in Quebec.

The ownership of a hospital and how the members of its board were selected determine in large part the decision which was taken on the abortion procedure. The boards of hospitals owned by government, religious denominations, or which are university hospitals for instance may receive considerable public pressure about the abortion issue. But because members of the boards of these hospitals are appointed, their position on the abortion issue is not directly accountable to the public nor may it be in accord with the views of their hospital staff or the public whom it is intended to serve. This situation obtains

equally for hospitals with committees and eligible hospitals without committees. In contrast, those hospitals whose boards are elected from the membership of a community association or by means of civic elections may more directly represent the views on abortion of a particular community.

For a majority of community hospitals which were visited by the Committee, the paid-up membership in the hospital association or corporation was often less than 100 individuals, on occasion consisting of fewer than 30 to 40 members. The reported attendance at annual association or corporation meetings was of the same order. Annual subscription dues ranged from \$1 to \$100. Life membership in an association or a corporation was often given upon the receipt of a sizeable charitable donation. In a number of community hospitals across Canada, special campaigns dealing with the abortion procedure have resulted in a sharp increase in the membership of some hospital associations. When this situation has occurred, there has been a change on occasion in a particular hospital's policy on the abortion procedure. Invariably when these local pressures have occurred, the boards and administrators who were involved were concerned that the hospital as a public institution was being used as a means to extend the interests of special groups.

The ownership of the 271 hospitals with therapeutic abortion committees included 186 owned by community associations; 11 owned by religious denominations; 48 owned by municipalities; 9 operated by provincial governments; and 3 run by the federal government. The remainder had some form of dual ownership (e.g., community associations—religious, community association—municipal, or religious—provincial government). Among hospitals which were eligible to establish therapeutic abortion committees, proportionately more hospitals owned by community associations and the federal government had established committees, followed in order by municipal hospitals, provincial hospitals, and hospitals owned by religious denominations.

Unlike the hospitals which for various reasons were ineligible to establish committees, **the decision of a majority (63.1 percent) of the eligible hospitals which had not established committees was based on religious morals and professional ethics.** The position of those institutions owned by religious denominations was clearly set forth and in each case generally adhered to publicly stated moral principles. There were no circumstances in the foreseeable future under which 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. Expressing a view which was widely held by the boards and administrators of these hospitals, two senior administrators of religious hospitals said:

A change of ownership and staffing of this hospital would be necessary. The corporation would have no alternative but to withdraw from providing hospital services if it was required that therapeutic abortions be performed in this hospital.

. . .

It is our belief that the primary function of our Government leaders is to legally protect every human person. We would go further to say that the Government should be even more concerned in defending the innocent, the weak and the helpless. The United Nations spoke loud and clear on this matter in the preamble to the *Declaration of the Rights of a Child* which in part states, "... the child by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth".

We are appalled and have we not reason to be when statistics (CHA News, number 12, 1975) show us that a total of 48,136 legal abortions were performed in our Canadian hospitals—a rate of 14 per 100 live births. *Is this what legal protection of the individual human person is all about? Are therapeutic abortion committees so essential in our hospitals? What happens in a Pro-Life hospital where there is no therapeutic abortion committee and a woman's life is at stake because of her pregnancy?* Answer: When a situation such as this happens there is no need to refer to a therapeutic abortion committee for approval to save a person's life. In a Catholic hospital, the Medico-Moral Code, approved by the Catholic Conference for Catholic Hospitals in Ottawa on April 9, 1970, Article 13 and 14 would be referred to. It states: "From the moment of conception life must be regarded with the greatest care. All deliberate medical action, the purpose of which is to deprive the foetus or an embryo of its life, is immoral. *However, medical means required to cure a grave illness in a pregnant woman and which cannot be deferred until the foetus is viable, are allowed even though it might endanger the pregnancy in progress*". The above statement leads us to believe that the total care of the pregnant woman is in safe hands in the Pro-Life Hospital where a therapeutic abortion committee and direct abortion procedures are prohibited. For Government to force hospitals to establish therapeutic abortion committees would be a violation of Civil Rights because the law clearly states that it is discretionary rather than mandatory to set up such committees. If the mother's life was not safely guarded we would see the reason for Government to be alarmed but this is far from being the case in our Pro-Life hospital.

As the number of hospitals owned by religious denominations has declined in recent years, their operation has been taken over by community associations and by municipal and provincial governments. Before their transfer of ownership to *community associations*, 16 eligible hospitals without committees had been owned by religious denominations. Among the eligible hospitals without committees which were owned by *municipal* and *provincial governments*, 16 hospitals had been previously owned by religious denominations (2 municipal, 14 provincial). The religious traditions on which these 32 hospitals had been established continued to be respected in most of these hospitals by board members, administrators, and the members of the medical and nursing staff.

There was no instance known to the Committee of any level of government (municipal, provincial, federal) instructing a hospital to establish or not to establish a therapeutic abortion committee. The selection of board members of municipal hospitals was by election or the appointment of aldermen or well known community leaders. Once elected or appointed, the decision on the establishment of a committee was reached by a majority decision of the hospital board. The situation was somewhat similar for most hospitals owned by provincial governments. The appointment of members of hospital boards

operated by the provinces was usually made on the recommendation of a provincial minister of health or the decision of the provincial cabinet. In some instances other special arrangements were made. Frequently incorporated under a separate legislative act, the nomination of board members to these hospitals was made on the basis of seeking distinguished individuals representing a broad cross-section of the population and often on a basis of preserving a hospital's traditions before its operation was assumed by government. Although no provincial government had issued a directive on the abortion procedure to hospitals which it directly or jointly operated, the decision on abortion reached by the boards of provincially operated hospitals were determined directly by who was appointed or was not appointed to these positions.

In the case of federal hospitals with committees, the decision had been reached after a review by each hospital's medical staff and, depending on where the hospital was located, by the Regional Director of the Medical Services Branch of the Department of National Health and Welfare.

The position of a majority of eligible community associations and municipal hospitals without committees, while not stated as directly as it was for religious hospitals, was comparable in its consequences. Most of the hospitals in this category upheld the view that induced abortion was a breach of professional ethics for members of the medical and nursing staff. The issue of abortion was seen to transcend an individual's affiliation with a particular religious denomination. Dating back to the Hippocratic Oath taken in the past by doctors which stipulated "and especially I will not aid a woman to procure abortion", the principle of preserving life has been an ethic embodied in the training and practice of the health professions. *The Lejeune Statement* drawn up by geneticist Jerome Lejeune was circulated toward the end of 1973 to physicians in Quebec and there was a mailing to physicians elsewhere in Canada in June, 1974. This statement, endorsed by some 5,000 physicians (3,000 in Quebec, 2,000 in other provinces) concluded:

From the moment of fertilization, that is from the earliest moment of biologic existence, the developing human being is alive, and entirely distinct from the mother who provides nourishment and protection.

From fertilization to old age, it is the same living human being who grows, develops, matures and eventually dies. This particular human being with his or her characteristics is unique and therefore irreplaceable.

Just as medicine is at the service of life when it is failing so too it should service life from its beginning. It should have absolute respect for human life regardless of age, illness, disability or degree of dependence.

When confronted with tragic situations, it is the duty of the doctor to do everything possible to help both the mother and her child. The deliberate killing of an unborn human to solve social, economic or eugenic problems is directly contradictory to the role of the doctor.

The Code of Ethics endorsed by the Canadian Medical Association is required as a pledge of each physician who is on the medical staff of an accredited hospital.<sup>4</sup> While this Code has no statement relating to abortion, its

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<sup>4</sup> Canadian Council on Hospital Accreditation, *Guide to Hospital Accreditation*, Toronto, 1972, page 24.

imperatives for the responsibilities to patients of An Ethical Physician stipulate that the physician:

will on the patient's request, assist him by supplying the information required to enable the patient to receive any benefits to which the patient may be entitled;

shall except in an emergency, have the right to refuse to accept a patient;

will allow death to occur with dignity and comfort when death of the body appears to be inevitable.

The differences in the two codes fall outside the scope of this inquiry. Based on these statements of professional ethics and when support of these codes was combined with religious principles, it is evident that a substantial number of doctors believed that human life begins at the time of conception. It was their professional duty, as they saw it, to preserve life at all costs. In the national survey of physicians, 42.3 percent of the doctors disagreed or strongly disagreed that abortion was a human right.

**Almost half of the doctors (47.7 percent) felt that 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 at eligible hospitals without committees, their views significantly determined a hospital's position on the abortion procedure.** The situation in one small hospital with an active medical staff of five physicians was an example of what occurred in many other hospitals in this category. Recognizing a potential rift between the hospital board and the members of the medical and nursing staff over the abortion procedure, until shortly before a site visit by the Committee, the administrator had not previously tabled this item on the agenda of board meetings. The members of this municipal board were elected at general civic elections every two years. The Chairman of the Board felt that the hospital as a public institution had an obligation to establish a therapeutic abortion committee. He believed that women seeking an abortion in this community should not be referred to a large urban hospital some 100 miles away. Most of the senior hospital staff, including the administrator and the director of nursing, rejected this view. There was a consensus among 4 of the 5 physicians who represented three religious denominations that the abortion procedure breached their professional and religious ethics. They would not serve on a therapeutic abortion committee if one had been established by the hospital board. Patients seeking an abortion in this community either were referred for counsel to the single physician on staff who held different views, or less often, directly to hospitals in other centres. All of the physicians on the medical staff were held in high respect by members of the board. All had practiced in the community for a number of years. Not wishing a confrontation, the Chairman of the Board concluded that under present circumstances there was no way this hospital could or would establish a committee. If this were to be done in the future, the appointment of a committee would only result when a gradual changeover took place, with the current physicians being replaced by doctors holding different views.

## Public knowledge of induced abortion

Before taking part in the national population survey, the individuals who were interviewed were read a statement by the interviewers. The respondent was asked to participate in the survey, to answer some questions put directly by the interviewer, and to complete certain replies in privacy which related to their personal experiences. These replies were returned to the interviewers in unmarked sealed envelopes. In the opening statement which was read to persons in the survey, a therapeutic or induced abortion was defined as: "When we use the word 'abortion', we mean one which is brought about by a woman seeking it, not one which occurs spontaneously."

The individuals in the national population survey were asked if obtaining an abortion in Canada was legal or illegal. Almost half of the women and men in the survey said that obtaining an induced abortion was illegal under any circumstances, while slightly over a third said that it was legal to have this procedure done. Their answers were:

	Legal	Illegal	Don't Know	Total
	percent			
Women .....	35.9	47.3	16.8	100.0
Men.....	37.5	50.3	12.2	100.0

Where persons lived in Canada and their social circumstances were related to whether they felt obtaining an abortion was legal or illegal. In regions where there were higher rates of therapeutic abortions than the national average such as in British Columbia and Ontario, more women and men said that it was legal to obtain an induced abortion. Where the reported rates for therapeutic abortions were lower in the country, fewer people in these regions such as in the Maritimes or Quebec said this was the case. There was no variation in these responses by the size of the community where people lived. More young adults than either persons who were much younger or older said induced abortions could be legally obtained. **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.** This lack of knowledge which varied by the circumstances of individuals did not preclude some persons from having definite views on what they thought the law was about, whether it was too liberal or too restrictive, or about the circumstances under which a therapeutic abortion might be obtained.

There were marked differences in the knowledge of the law by a person's level of education, religious affiliation, and whether English or French was the language which was usually spoken. Over double the proportion of women and men who had college and university training than individuals with an elementary school education said it was legal to obtain an induced abortion. There

was also a difference between anglophone and francophone Canadians, with almost three times as many anglophone women (45.9 percent) as francophone women (16.9 percent) saying it was legal to obtain an abortion. Slightly less than half of women and men who were Protestants compared to about a third of individuals who were Catholics replied that getting an induced abortion was legal.

Among the women and men who said that obtaining an induced abortion was illegal in Canada, 15.6 percent said that the abortion legislation was too liberal, while 34.7 percent held the opposite viewpoint. There was little variation across the country among those persons who said obtaining an induced abortion was illegal and at the same time felt the law was too liberal in its terms. This was not the case among persons who said it was illegal to get this operation and at the same time felt that the current legislation was too restrictive. While about a third of individuals in the Maritimes (34.1 percent) and Quebec (33.2 percent) held these views, almost half (45.0 percent) of the persons in British Columbia who said getting this operation was illegal said that the law was too restrictive. In terms of whether English or French was the usual language which was spoken, the replies of both groups were somewhat comparable. While saying getting an induced abortion was illegal, 13.4 percent of anglophone individuals and 17.2 percent of francophone individuals felt the current legislation was too liberal. Conversely, 38.8 percent of anglophone individuals and 31.5 percent of francophone individuals said getting an abortion was illegal and the law was too restrictive.

In a question which dealt more explicitly with how the decision was reached to obtain an induced abortion in Canada, 25.0 percent of women and 27.2 percent of men said that this procedure required the approval of a hospital committee of physicians. One out of ten women (9.0 percent) said this decision was made by a woman herself, 19.2 percent by a woman and her doctor, and 10.5 percent by a woman and two physicians.

The extent to which the accessibility of services can be seen and measured involves several components which may or may not be congruent. These aspects of accessibility are: (1) the actual existence of appropriate personnel or facilities; (2) how the decisions of the staff who are responsible for these resources are made and on what basis; (3) how close the individuals to be served are to these resources; and (4) the subjective evaluation by the people who need the services concerning their availability. While in terms of the actual proximity or availability of services a person's opinion of their accessibility may be inaccurate, this fact is nonetheless important to know about as on the basis of this opinion an individual may decide if the services are to be used or if other options are to be tried. People who may not need a particular service may feel that these services are adequate or an unnecessary public expense, while persons who are concerned about the matter may seek the extension of these resources and call for their fuller public support. From this perspective there is no firm measure of the accessibility of services for it is a constantly changing judgment which varies with a person's situation at a particular time.

The women and men in the national population survey were asked in their opinion whether accessibility to services for induced abortion where they lived

was too easy, appropriate, or too difficult. The major fact emerging from the answers given to this question was that **over half of the women (55.0 percent) and the men (56.6 percent) did not know what the situation was in their communities regarding the accessibility of abortion services.** These individuals either did not know or were undecided on this issue. They chose not to make a definite judgment.

If the women and men who were undecided on this point are grouped together with a smaller number of individuals who felt that the present distribution of abortion services was adequate, then 3 out of 4 women and men held these views. **Less than 1 out of 10 persons in the national population survey felt that the treatment services for induced abortion were too easily accessible, while slightly more, 1 out of 6 persons, said that such services were too difficult to obtain for women who sought out these services.**

	Too Accessible	Present Level of Accessibility is Appropriate	Too In-accessible	Don't Know	Total
	percent				
Women .....	11.2	17.7	16.1	55.0	100.0
Men .....	7.7	17.3	18.4	56.6	100.0

Individuals in the national population survey were also asked: "If you know someone who had an abortion, what single source was most often used by these people?" The response categories for this question were: (1) hospital where they lived; (2) hospital outside the community but in the same province; (3) hospital outside the province but in Canada; (4) other sources where they lived; (5) other sources outside the community but in the same province; (6) other sources outside the province but in Canada; (7) a hospital or clinic in the United States; and (8) other sources.

Three out of four Canadians in the national survey either did not know anyone who had had an abortion (71.6 percent) or did not know where abortions were performed (5.9 percent). Of the 22.5 percent of individuals who knew someone who had had an induced abortion, half (51.0 percent) said this procedure had been done in a local hospital, and a fifth (19.7 percent) reported that the abortion which they knew about either had been done at another provincial hospital or in a hospital elsewhere in Canada, 17.3 percent said the abortion had been done in the United States, and 12.0 percent reported they knew of illegal abortions which had been procured in Canada.

Those provinces which had more hospitals with committees and a broader geographical distribution of these hospitals than other provinces had a higher proportion of respondents who knew about induced abortions which had been done at a local hospital or another hospital in the province or in Canada. The provinces in which a substantial majority of abortions were reported to have been done in a Canadian hospital were: British Columbia (87.1 percent), Nova Scotia (85.8 percent), Saskatchewan (83.3 percent), Alberta (79.0 percent), and Ontario (74.5 percent). Relatively fewer women living in these provinces



than elsewhere were reported to have had illegal abortions or to have gone to the United States to have this procedure done. In contrast, fewer women were reported to have had induced abortions done in local hospitals in Newfoundland, New Brunswick, Quebec, and Manitoba, and in these four provinces a larger number of abortions were reported either to have been done illegally or had been obtained in the United States. The proportion of women reported to have had an induced abortion done at local hospitals was 27.3 percent in New Brunswick, 24.7 percent in Quebec, 35.0 percent in Manitoba, and 50.0 percent in Newfoundland. The number of illegal abortions cited by respondents varied across the country, with the largest proportions reported in Newfoundland (18.8 percent), Quebec (19.3 percent), Manitoba (25.0 percent), and Saskatchewan (16.7 percent). With the exception of Saskatchewan, a number of women from each of the other provinces were reported to have gone to the United States to obtain an abortion. The proportions of women by province whom individuals knew who had left the country for this procedure were: 34.7 percent in Quebec; 27.3 percent in New Brunswick; 18.7 percent in Newfoundland; 16.1 percent in Ontario; and 15.0 percent in Manitoba, with the proportions being lower for other provinces.

TABLE 6.2  
OPINIONS OF POPULATION WHERE INDUCED ABORTIONS ARE DONE BY  
PROVINCE, 1976\*

NATIONAL POPULATION SURVEY

Province	Location Where Induced Abortions Done				Total
	Hospital in Community	Other Hospital in Canada	Non Hospital Sources	United States	
			percent		
Newfoundland .....	50.0	12.5	18.8	18.7	100.0
Nova Scotia .....	42.9	42.9	3.5	10.7	100.0
New Brunswick .....	27.3	39.3	6.1	27.3	100.0
Quebec .....	24.7	21.3	19.3	34.7	100.0
Ontario .....	56.6	17.9	9.4	16.1	100.0
Manitoba .....	35.0	25.0	25.0	15.0	100.0
Saskatchewan .....	66.7	16.6	16.7	—	100.0
Alberta .....	63.2	15.8	10.5	10.5	100.0
British Columbia .....	73.4	13.7	9.7	3.2	100.0
CANADA .....	51.0	19.7	12.0	17.3	100.0

\*This table lists information from the national population survey where women known to respondents had an abortion. Excluded from this table are: respondents who did not know women who had an abortion; respondents who knew women who had an abortion but didn't know where the abortion had been done. Information not available for Prince Edward Island.

Individuals in the national population survey were also asked: "What has been your (or your partner's) personal experience with (induced) abortion?" To this question, the replies which were anonymously completed by individuals were: (1) never been pregnant; (2) never considered it; (3) thought seriously but never did anything about it; (4) tried to bring about an abortion myself; (5) had it done but not by a doctor; (6) had it done in a doctor's office in Canada;

(7) had it done outside Canada; (8) had it done in a hospital in Canada; and (9) no partner.

The abortion experience of women varied by where they lived. With the exception of attempted self-induction, women who lived in large cities (500,000 or more individuals) had more abortions than women living in towns or rural areas. Women living in metropolitan areas represented 30.7 percent of the national population survey; 31.8 per 1,000 had considered, had tried, or had had an abortion. For a majority of the individuals (69.3 percent) in the national population survey who lived outside these large cities, there was a strong association between the size of the community and the experience with abortion. More women living in rural areas or towns of less than 1,000 inhabitants than in larger centres had seriously considered having an abortion (7.1 per 1,000) or had had an illegal abortion (4.3 per 1,000). The rate of legal abortions (in Canada and out of the country) for women living in these smaller centres was 3.2 per 1,000. As the size of the place of residence increased, there was a decline in the number of women who considered but did nothing about abortion, had tried self-induction, or had an illegal abortion. This change was matched by a larger number of women who had an abortion in a Canadian hospital or who had gone to the United States for this procedure.

What these findings indicate is that: (1) where there were fewer hospitals with therapeutic abortion committees, (2) where the distribution of these hospitals was concentrated in a few large centres, and (3) where there were proportionately more hospitals with committees which did no induced abortions, then there were fewer abortions done in these regions. Conversely, the findings indicate that where obtaining an abortion was seen to be more difficult to obtain in Canada, more Canadians said they knew of induced abortions which had been procured illegally or in the United States.

Overall, half of the women and men in the national population survey either did not comment or were satisfied with the present abortion legislation. One out of six women and 1 out of 8 men felt the law was too liberal since it made it too easy to obtain an induced abortion. In contrast, a quarter of the women and a third of the men said the law was too restrictive.

	Too Liberal	About Right	Too Restrictive	Don't Know	Total
	percent				
Women .....	16.2	24.9	26.5	32.4	100.0
Men.....	12.8	23.0	36.6	27.6	100.0

Twice as many older women and men than younger adults felt the law was too liberal while the reverse situation was true among individuals by their ages concerning those who felt the law was too restrictive. There were few major differences between Catholics and Protestants on this point although slightly more Catholic men and women felt the law was too liberal and a few more Protestants said the law was too restrictive. There was a fair degree of similarity across the country in the assessment of the Abortion Law. A few

more women in the West than in the East felt the law was too liberal, but this slight trend was counterbalanced by a few more women and men in the West who were more satisfied with the law than individuals who lived in the East. While there were no appreciable differences by which major language was spoken and how the law was seen, there was a trend that, as the amount of schooling of individuals increased, more persons with a college or university training than individuals with an elementary school education felt the law was too restrictive.

What is clear from the several surveys undertaken by the Committee is that there was a broadly held and durable concern about induced abortion. This concern went beyond how accurately people knew the law or their knowledge of the circumstances when this operation might be done. The views of the public on this issue have not always been clearly known. What has been better known are the opinions of some public spokesmen, special groups, or mass media reports. Like the tip of an iceberg, these views are highly visible, but their below-the-surface dimensions are not always known. Some of these socially visible groups have put forward categorical solutions which have been said to represent the public viewpoint about how the issue of abortion might be resolved in the public interest.

Despite some diversity in how the persons in the national population survey saw the issue of abortion, there were several consistent trends which established a sense of unity about its identity. Persons in the national population survey who held views on one or the other side of how accessible treatment services were—those individuals who said it was too easy or too difficult to obtain an abortion—were in a minority. Regardless of their social circumstances, most of the people across the country took a middle-of-the-road position.<sup>5</sup> They endorsed neither the position that an induced abortion should never be allowed, nor the decision to obtain this operation should rest solely with a woman herself. Between these two polar perspectives, most individuals cited a number of indications when they thought an induced abortion might be done.

In looking at the identity of a public issue, how it is seen and how it influences the decisions of individuals, one aspect which was not dealt with directly in this inquiry was how the values and attitudes of individuals change over a period of time. What is the direction of change in how people see the issue of induced abortion in Canada? In the absence of firm baseline information, no definite reply is possible to this question. There is some inconclusive information, but it is only that, which suggests the direction in which public attitudes may be changing. In a 1971 survey of the Canadian population, the Canadian Institute of Public Opinion asked individuals whether the Abortion Law should or should not be revised. At that time 44 percent of individuals said the law should be revised, 45 percent said no revisions were required, and 11 percent were undecided. Almost twice as many individuals with a college or university training (64 percent) as persons with an elementary school education (34 percent) were then in favour of changing the law.

<sup>5</sup> *Appendix 1: Statistical Notes and Tables*, see Note 3 and Tables 15, 18 and 19. The results of factor analysis and multiple regression analyses are the basis of these findings.

While the wording of the questions was different, and for this reason the results are not fully comparable, five years later 45.4 percent of individuals in the 1976 national population survey wanted this law to be revised, 24.0 percent endorsed the existing legislation, and 30.6 percent were undecided. In the interim, the proportion of persons who did not want the abortion legislation revised dropped considerably while there was an apparent sharp increase among those persons who were undecided about this issue. In both instances slightly over half of the persons in the two surveys either were satisfied with the current legislation or were undecided about this issue. The proportion of persons who wished to change the law remained the same, divided between somewhat more individuals who felt the legislation was too restrictive and fewer persons who said the law made obtaining an induced abortion too accessible. The opinions of individuals by their level of education had not changed much since the earlier survey, with 34.1 percent of persons with an elementary school education being in favour of the revision of the law. This opinion was held by 58.0 percent of individuals with a college or university training.

Across the country there was no strong mandate either to "tighten" or to "reform" the existing abortion legislation. Although their knowledge of the law and the conditions which it set for the termination of pregnancy were sometimes fragmentary, most persons implicitly endorsed the status quo. In this sense there was a considerable consensus which emerged out of an apparent diversity of viewpoints.

## Physicians doing induced abortions

The majority of induced abortions in Canada in 1974-75 were done by obstetrician-gynaecologists. While information received from provincial health authorities was not uniform, the proportion of abortions done by this specialty and their ratios per population for eight provinces were:

	Percent of Induced Abortions Done by Gynaecologists	Ratio of Gynae- cologists per Population
Newfoundland .....	95.6	1:41,993
Prince Edward Island .....	100.0	1:23,552
Nova Scotia .....	51.3	1:32,604
New Brunswick .....	95.3	1:26,804
Quebec .....	99.4	1:17,770
Manitoba .....	96.4	1:19,240
Alberta .....	90.3	1:17,479
British Columbia .....	75.6	1:20,698

The information which was given for Quebec included medical specialists, not just obstetrician-gynaecologists who did induced abortions. Abortions in

TABLE 6.3

INDUCED ABORTIONS DONE BY MEDICAL SPECIALTY OF PHYSICIANS:  
SEVEN PROVINCES, 1974-75

## PROVINCIAL HEALTH DEPARTMENTS

Province	Medical Specialty				Total
	General Practice	Obstetrics/ Gynaecology	General Surgery	Other	
Newfoundland*	4	215	5	1	225
Nova Scotia**	212	391	156	3	762
New Brunswick***	17	348	—	—	365
Quebec****	23	4,070	—	—	4,093
Manitoba*****	12	1,300	37	—	1,349
Alberta	365	3,620	22	4	4,011
British Columbia	1,847	6,261	171	3	8,282
<b>TOTAL</b>	<b>2,480</b>	<b>16,205</b>	<b>391</b>	<b>11</b>	<b>19,087</b>

\*Newfoundland total includes out-of-province procedures, excludes abortion procedures done by salaried physicians, and accounts for therapeutic abortions and hysterotomies.

\*\*Nova Scotia tariff fee code 2403 includes abortion, incomplete, including D&C.

\*\*\*New Brunswick, code 1401 with information for 1974.

\*\*\*\*Quebec, information given for specialists, 1974.

\*\*\*\*\*Manitoba, procedures done by 106 physicians in 1974.

TABLE 6.4

NUMBER OF PHYSICIANS DOING INDUCED ABORTION BY MEDICAL SPECIALTY:  
THREE PROVINCES, 1974-75

## PROVINCIAL HEALTH DEPARTMENTS

Province	Medical Specialty			Total
	Family Medicine	Obstetrics/ Gynaecology	General Surgery	
Prince Edward Island	—	4	—	4
Saskatchewan	25	18	1	44
	General Practice	Specialist Practice		
Ontario				
Therapeutic Abortion (saline)	105	423		
Amniocentesis	24	199		
Hysterotomy	7	123		

Saskatchewan in 1975 were done by 25 family practitioners, 18 obstetrician-gynaecologists, and one general surgeon. The information for Ontario listed the specific procedures done by physicians, with no accumulative totals being provided. For that province saline therapeutic abortions were done by 105

family physicians and 423 specialist physicians. The procedure of amniocentesis was done by 24 family physicians and 199 specialists in Ontario; and hysterotomies by seven family physicians and 123 specialists.

Based on reports from provincial health departments, obstetrician-gynaecologists did 84.9 percent of the reported abortions in seven provinces in 1974-75, followed by family physicians who did 13.0 percent, general surgeons who did 2.0 percent, and other medical specialists, 0.1 percent. The distribution of obstetrician-gynaecologists across Canada was one specialist for every 18,579 individuals (1:18,579). The relative supply of obstetrician-gynaecologists varied between the provinces, with Ontario (1:16,253) having 158.4 percent more physicians in this specialty than Newfoundland (1:41,993). The eight regions below the national average in the supply of obstetrician-gynaecologists were: Newfoundland (1:41,993), Saskatchewan (1:33,123), Nova Scotia (1:32,604), Yukon and Northwest Territories (1:28,605), New Brunswick (1:26,804), Prince Edward Island (1:23,552), British Columbia (1:20,698), and Manitoba (1:19,240). The three provinces where the supply of obstetrician-gynaecologists was above the national average were: Ontario (1:16,263), Alberta (1:17,479), and Quebec (1:17,770).

Family physicians and obstetrician-gynaecologists were asked in the national survey of physicians if "In your medical practice have you ever performed a therapeutic abortion?" The replies to this question by physicians involved in the abortion procedure in general paralleled information provided on the number of physicians who did this procedure and their specialty which was provided by provincial health authorities. Six out of seven family physicians (86.0 percent) had never done an abortion. The provincial and national distribution of obstetrician-gynaecologists who did abortions, from the national physician survey, was:

	Did Induced Abortions	Never Have Done Induced Abortions
	percent	
Newfoundland .....	41.7	58.3
Prince Edward Island .....	60.0	40.0
Nova Scotia .....	85.0	15.0
New Brunswick .....	76.5	23.5
Quebec .....	33.9	66.1
Ontario .....	78.7	21.3
Manitoba .....	84.8	15.2
Saskatchewan .....	84.2	15.8
Alberta .....	80.6	19.4
British Columbia .....	81.1	17.9
<b>CANADA .....</b>	<b>69.2</b>	<b>30.8</b>

Because there were two gynaecologists in the Yukon and the Northwest Territories, these physicians were not listed to preclude their identification.

While 69.2 percent of obstetrician-gynaecologists in the survey had done abortions, their distribution varied between the provinces. Over three-quarters of the obstetrician-gynaecologists who lived in Nova Scotia, New Brunswick, Ontario, Manitoba, Saskatchewan, Alberta, and British Columbia reported having done induced abortions. In Prince Edward Island, 60.0 percent of obstetrician-gynaecologists had done abortions, followed by Newfoundland (41.7 percent) and Quebec (33.9 percent).

The Health Insurance and Resources Directorate of the Department of National Health and Welfare provided information from its national medical care insurance records system on the distribution by province of obstetrician-gynaecologists who did therapeutic abortions in 1974-75. This information provided for eight provinces whose identity was not listed, indicated that the proportion of physicians who did abortions was substantially lower than the replies received in the national physician survey which did not specify whether induced abortions had been done during 1975. The time periods of the two sources of information were also different, with the federal report providing information for the fiscal year 1974-75, while the survey of physicians done by the Committee was completed during January-March 1976. The federal tabulation indicated that almost half (48.9 percent) of the obstetrician-gynaecologists in eight provinces during 1974-75 did no induced abortions. One out of seven of these specialists (14.2 percent) had done under 10 abortion procedures, while about 1 out of 5 (18.7 percent) had done over 51 abortion operations during this period. There was a substantial variation between the provinces in the proportion of obstetrician-gynaecologists who had done no abortions, ranging from 30.0 percent in one province to 80.6 percent in another province. In each province a small number of these specialists did the majority of this procedure.

TABLE 6.5

PERCENTAGE DISTRIBUTION OF OBSTETRICIAN-GYNAECOLOGISTS BY PROVINCE AND NUMBER OF THERAPEUTIC ABORTIONS PERFORMED

Fiscal Year 1974-75\*

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

Therapeutic Abortions Performed									Total Physicians**	Total Percent Distribution
	1	2	3***	4	5	6	7	8		
0 .....	30.00	40.00	80.60	66.66	45.16	31.55	64.00	50.00	526	48.90
1-5 .....	6.00	11.67	7.46	20.00	6.45	12.90	12.00	33.33	113	10.50
6-10 .....	6.00	1.67	0.90	—	9.68	5.36	—	—	40	3.72
11-15 .....	5.00	13.33	0.60	6.67	—	4.17	8.00	—	39	3.62
16-20 .....	2.00	5.00	0.90	—	12.90	4.56	—	—	35	3.25
21-25 .....	8.00	5.00	0.60	—	—	3.37	8.00	—	32	2.97
26-50 .....	15.00	10.00	2.68	—	19.35	10.12	4.00	16.67	89	8.27
51-75 .....	15.00	3.33	2.98	—	—	8.13	—	—	68	6.32
76-100 .....	3.00	5.00	1.19	—	3.23	5.56	—	—	39	3.62
100+ .....	10.00	5.00	2.09	6.67	3.23	14.28	4.00	—	95	8.83

\* Health Insurance and Resources Directorate, Department of National Health and Welfare, June 1976.

\*\* Total obstetrician-gynaecologists in eight provinces—1,076.

\*\*\* Fiscal year 1973-74.

If the several sources of information on the distribution of family physicians, obstetrician-gynaecologists, and general surgeons are considered together, several national trends emerge. Virtually all of the abortions performed in Canadian hospitals are done by physicians in these three specialties, with a majority done by obstetrician-gynaecologists. The number of physicians in this specialty who performed or did not perform induced abortions also varied between the provinces. In certain provinces there was a substantial difference in the number of physicians who had the requisite training and were eligible under provincial medical care insurance requirements to do the abortion procedure and the number of such physicians who actually did perform abortions. The decision on the abortion issue reached by family physicians, obstetrician-gynaecologists, and general surgeons was not based on factors related to their eligibility to do this procedure. Their decision was based on their personal judgment of this issue, the pattern of medical practice which was followed, and by local medical customs which determined the nature of hospital surgical privileges which they had been assigned.

## Distribution of accessible services

How health services are organized and the extent to which they are available profoundly influences the choices which women make who seek induced abortions. Because there is a time lag involved in the assembling and reporting of national abortion statistics, the most recently available information about the work of hospital therapeutic abortion committees available to Statistics Canada was for 1974. This federal agency provided the Committee with information about the volume of induced abortions done by hospitals in each region for that year. In 1974, 265 hospitals had established therapeutic abortion committees and of this number, 46 reported no abortions had been done. For each of the five regions of Canada, the ratio of hospitals in 1974 which did induced abortions (minus the hospitals with committees which did none) was calculated on the basis of the number of women between the ages of 15 and 44 years in 1974 who lived in these regions.

For the country as a whole in 1974 there was one hospital with a therapeutic abortion committee where this procedure was done for every 23,026 women between 15 and 44 years (1:23,026). These ratios varied across the nation, indicating some marked east-to-west differences. In Quebec there was the lowest number of these hospitals with committees where induced abortions were done in 1974, with a ratio of 1:96,733. In order, the distribution elsewhere was: 1:19,848, Maritimes; 1:20,387, Ontario; 1:19,007, Prairies; and 1:10:594, British Columbia, Yukon, and Northwest Territories.

In addition to the differences in the distribution of the hospitals with committees where induced abortions were done, the Committee obtained information in 1976 from 209 hospitals with therapeutic abortion committees about their use of residency requirements and the establishment of patient quota arrangements involving the number of abortion operations which were done. Approximately 1 out of 3 hospitals with committees across Canada (38.2



percent) used one or the other of these two requirements, sometimes both. Like the distribution of hospitals with committees where the abortion operation was done, there were regional differences among hospitals using residency or patient quota requirements. Two out of three of the hospitals with committees in Quebec (66.7 percent) in the national hospital survey used these requirements prior to their review of applications submitted on behalf of women for induced abortions. This proportion was lower for hospitals in the Maritimes where 2 out of 5 (43.8 percent) had established these screening requirements. Elsewhere across the country a third of the hospitals with therapeutic abortion committees on an average used these requirements.

TABLE 6.6

DISTRIBUTION OF HOSPITAL SERVICES  
FOR THERAPEUTIC ABORTION  
BY REGION

Region	Ratio of Hospitals with Functioning Therapeutic Abortion Committees, 1974, per Women Between 15 and 44 years*	Proportion of Hospitals with Committees Using Residency and Patient Quota Requirements**	Time in Weeks Between Initial Medical Consultation and Abortion Operation in Canadian Hospitals***	Ratio of Canadian Women Getting Abortions in U.S./Canadian Hospitals****	Percent Change in Number of Illegitimate Births, 1970-1973*****
Maritimes.....	1:19,848	43.8	9.2	1: 3.2	+9.1
Quebec.....	1:96,733	66.7	6.7	1: 1.3	-14.8
Ontario.....	1:20,387	36.1	8.1	1:13.8	-19.2
Prairies.....	1:19,007	31.0	8.4	1: 6.7	-10.0
British Columbia, Yukon, Northwest Territories.....	1:10,594	33.0	8.1	1:31.8	-19.2
CANADA.....	1:23,026	38.2	8.0	1: 6.9	-12.9

\* Based on the total of 265 hospitals with therapeutic abortion committees in 1974 minus those hospitals which did no induced abortions that year (46 hospitals) per number of women in each region between 15 and 44 years, Statistics Canada, *Vital Statistics: Preliminary Annual Report, 1974* (Ottawa, May 1976).

\*\*Based on national hospital survey, 1976, for 209 hospitals with therapeutic abortion committees, viz. Chapter II.

\*\*\* National patient survey, viz. Chapter 7.

\*\*\*\* Based on reports of abortion clinics in the United States of Canadian women obtaining abortions compared to 1974 statistics of women getting induced abortions in Canada, viz. Chapter 4.

\*\*\*\*\* Statistics Canada. Calculated on the basis that the number of illegitimate births in 1970=100.

These differences in the availability of hospitals with committees where induced abortions were done and the extent to which residency and patient quota requirements were used by these hospitals were related to three measures of the outcome of pregnancy. These were: (1) the length of time between an initial medical consultation by a woman and when the operation was done in a Canadian hospital; (2) the ratio of abortions done in the United States to the number done in a region; and (3) the changes in the number of illegitimate births between 1970 and 1973, with 1970 being taken as an index equalling 100.

In the Maritimes, the average length of time between when a woman consulted a physician and when the abortion operation was done was 9.2 weeks, or above the national average of 8.0 weeks among women in the national

patient survey. In that region, for every abortion which it was estimated was done for women from that part of the country who went to the United States for this purpose, approximately three induced abortions were done in hospitals in the Maritimes. Unlike other regions, the total number of illegitimate births rose between 1970 and 1973 by 9.1 percent. Two distinctive trends involving the obtaining of induced abortions occurred in Quebec. Among the women who obtained abortions in Quebec hospitals with committees, the average length of time between when a woman initially contacted a physician and when the operation was done was 6.7 weeks, or substantially quicker than elsewhere in Canada. But unlike women elsewhere, fewer women in Quebec took this course as there were fewer hospitals with committees which did this operation and more of these hospitals had residency and patient quota requirements. For these reasons far more women who lived in Quebec than elsewhere in Canada went to the United States to obtain induced abortions. For every induced abortion obtained by a woman from Quebec in the United States, slightly more than one reported induced abortion was performed in Quebec hospitals. The change in the number of illegitimate births in Quebec between 1970 and 1973 was similar to the national trend.

Elsewhere across Canada the average length of time between an initial consultation with a physician and when the abortion operation was done was close to the national average of 8.0 weeks. Relative to the population in these areas, there were more hospitals with committees which did the abortion operation, and fewer of these hospitals used residency and patient quota requirements. Unlike the experience in the Maritimes and Quebec, substantially more women in Ontario, the Prairies, British Columbia, the Yukon and the Northwest Territories had induced abortions in Canadian hospitals than the number from these regions who went to the United States for this purpose. The regional ratios of abortions obtained in the United States compared to the number of these operations in Canadian hospitals were: 1:13.8, Ontario; 1:6.7, Prairies; and 1:31.8, British Columbia. For Canada as a whole the ratio was 1:6.9, or, for every abortion obtained by a Canadian woman in the United States, seven Canadian women had this operation done in a Canadian hospital. Because the information on the residence of Canadian women who obtained induced abortions in the United States was limited and represents an underestimate of the actual number who go to that country for this purpose, in each instance these ratios would be expected to rise but retain their regional differences if fuller information was available. In the Prairies the change in the number of illegitimate births was close to the national average, while in Ontario, British Columbia, the Yukon and the Northwest Territories a more substantial decline had occurred.

**Coupled with the personal decisions of obstetrician-gynaecologists, half of whom (48.9 percent) 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. In addition to the fact of what moral and profes-**

sional ethics are involved for hospital boards and the medical profession about the abortion issue, the relative supply of health resources (eligible hospitals, hospitals with committees, and the number and distribution of obstetrician-gynaecologists) also determined the extent of accessibility to the abortion procedure.

The relative accessibility of these resources were 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.

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

