# Chapter 9

# Medical Practice

The views and experience with therapeutic abortion of Canadian physicians were obtained in the national physician survey undertaken by the Committee. The physicians who were included were all obstetrician-gynaecologists in active medical practice in Canada and a 25 percent sample of the nation's family physicians. A total of 3,133 replies were received which represented 77.1 percent of the obstetrician-gynaecologists and 57.6 percent of the family physicians to whom the questionnaire had been mailed.[1] The physicians were asked what was included in their judgment in: a definition of health in the context of therapeutic abortion; what indications they would consider in reviewing requests for induced abortion; how the mental health of patients seeking this operation was being interpreted; their experience with the abortion procedure and whether they had served on a hospital therapeutic abortion committee; their practice in connection with contraceptive counselling; and their views on abortion and the Abortion Law. These questions dealt with four of the Terms of Reference set for the Committee.

> To what extent is the condition of danger to mental health being interpreted too liberally or in an overly restrictive manner . . .
>
> (What is) . . . the timeliness with which this procedure makes an abortion available in light of what is desirable for the safety of the applicant.
>
> (Do) . . . the views of doctors with respect to abortion not permit them either to assist in an application to a therapeutic abortion committee or to sit on a committee.
>
> To what extent are abortions which are being performed in conformity with the present law seen to be the result of a failure of, or ignorance of proper family planning.

How members of the medical profession, in particular obstetrician-gynaecologists and family physicians who are the most directly involved in the abortion procedure, interpret the health status of patients and what processes

[1] Four questionnaires were received after the cut-off date; this analysis is based on 3,129 replies.

are involved in the review of abortion applications, determine the extent and the timing of this operation. This procedure cannot be performed legally in a Canadian hospital without the concurrence of at least four physicians—a physician who does the operation and three physicians who serve on a therapeutic abortion committee. How physicians see this procedure, then, is a necessary and crucial factor in the performance of this operation, one which is also contingent on what type of hospital staff privileges they hold and on the policy which is adopted by the hospital with which they are affiliated.

The central themes which emerge from this review show a considerable diversity of opinion and experience among physicians concerning the therapeutic abortion procedure. The main trends tended toward an endorsement of the present situation with some modification of the actual procedures which are involved. There was no strong sentiment to change the Abortion Law either toward limiting the scope of this procedure or to move toward a position that the decision about induced abortion should be made by a woman alone. The findings did not give a broad perspective of how the views of physicians may have changed in recent years on this matter. However, there were indications of what the trends may be in the future. The views of younger physicians were somewhat different from the general outlook of physicians who had been in practice for more time, particularly contrasting with the opinions of physicians who were nearing the end of their professional medical careers. If these trends are valid, a different attitude toward the abortion procedure may emerge in the years ahead.

## Profile of physicians

Most of the physicians in the survey were men (85.9 percent) and 1 out of 10 were women (9.9 percent).[2] The largest number of the physicians were between 25 and 34 years (28.3 percent), followed by those who were 35 to 44 years (26.8 percent), 45 to 54 years (25.5 percent), 55 to 64 years (11.5 percent) and a small number who were 65 years and older (4.3 percent). The majority of the respondents were married (83.4 percent), while 7.6 percent were single, and 5.2 percent had been previously married (i.e., divorced, separated, or widowed). About half (45.1 percent) of the physicians were Protestant, a third (30.7 percent) were Catholic and 1 out of 15 (6.8 percent) was Jewish. The remainder (13.5 percent) either belonged to other faiths or cited no religious affiliation. The physicians in the survey had their practices in all regions of Canada. Beginning with the East, 6.3 percent of the physicians lived in one of the Maritime provinces, 23.1 percent in Quebec, 34.6 percent in Ontario, 13.4 percent in one of the Prairie provinces, and 13.4 percent in British Columbia. The replies of the physicians from the Yukon and Northwest Territories are included with British Columbia.

[2] Among the physicians returning questionnaires, no information was given by 4.2 percent about their sex; 3.6 percent, their age; 3.7 percent, martial status; 3.9 percent, religious affiliation; and 9.2 percent, the province where they lived.

# Definition of health

Physicians were asked what was included in their definition of health in the context of therapeutic abortion. The five major components which were listed were: physical health; mental health; social and family health; eugenic health; and ethical health.

TABLE 9.1

COMPONENTS OF CONCEPT OF HEALTH IN CONTEXT OF THERAPEUTIC ABORTION BY SELECTED CHARACTERISTICS OF PHYSICIANS

NATIONAL PHYSICIAN SURVEY

| Characteristicis of Physicians | Concept of Health | | | | | Row Totals (N) | |
|---|---|---|---|---|---|---|---|
| | Physical | Mental | Social | Eugenic | Ethical | | |
| AGE | | | | | | | |
| 25-34 years | 99.2 | 84.6 | 60.0 | 77.7 | 77.5 | 884 | (28.3) |
| 35-44 years | 95.5 | 81.5 | 60.5 | 75.4 | 76.9 | 840 | (26.8) |
| 45-54 years | 92.9 | 79.6 | 55.0 | 71.8 | 74.2 | 798 | (25.5) |
| 55-64 years | 91.4 | 75.8 | 50.3 | 68.1 | 70.3 | 360 | (11.5) |
| 65 years & over | 90.3 | 69.4 | 38.1 | 64.9 | 70.1 | 134 | ( 4.3) |
| RELIGION | | | | | | | |
| Catholic | 88.5 | 62.0 | 36.7 | 58.1 | 55.8 | 960 | (30.7) |
| Jewish | 98.1 | 94.9 | 80.8 | 83.2 | 88.8 | 214 | ( 6.8) |
| Protestant | 97.4 | 91.1 | 63.2 | 80.7 | 84.6 | 1,412 | (45.1) |
| Other | 94.6 | 88.8 | 68.9 | 78.2 | 79.8 | 312 | (10.0) |
| None | 97.3 | 82.0 | 63.1 | 78.4 | 80.2 | 111 | ( 3.5) |
| REGION | | | | | | | |
| Maritimes | 93.9 | 83.8 | 58.1 | 72.2 | 71.7 | 198 | ( 6.3) |
| Quebec | 92.5 | 70.9 | 46.7 | 70.0 | 66.0 | 724 | (23.1) |
| Ontario | 95.7 | 85.9 | 62.7 | 75.7 | 80.0 | 1,082 | (34.6) |
| Prairies | 95.7 | 80.4 | 53.2 | 72.6 | 75.9 | 419 | (13.4) |
| British Columbia, Yukon and Northwest Territories | 94.3 | 84.9 | 62.2 | 76.3 | 80.6 | 418 | (13.4) |
| SEX | | | | | | | |
| Female | 95.5 | 83.5 | 59.4 | 78.4 | 79.0 | 310 | ( 9.9) |
| Male | 94.4 | 80.4 | 56.4 | 73.1 | 74.8 | 2,689 | (85.9) |
| SPECIALTY | | | | | | | |
| General Practitioner | 93.5 | 80.7 | 55.9 | 71.8 | 74.6 | 2,207 | (70.5) |
| Obstetrics-Gynaecology | 93.5 | 77.7 | 55.6 | 74.8 | 73.9 | 922 | (29.5) |
| Column Totals (N) | 2,925 (93.5%) | 2,498 (79.8%) | 1,746 (55.8%) | 2,274 (72.7%) | 2,328 (74.4%) | 3,129 | (100.0) |

*Physical Health.* There was general agreement among physicians that the physical health of patients was central in their definition of health with

93.5 percent citing this reason. There was a broad consensus among physicians of different ages in the two specialties although there was a slight trend which increased with the age of the respondents. There were only minor differences in how this concept was seen by the sex of physicians or where they lived in the country. There were also small differences in this respect by their religious affiliation with 97.4 percent of the Protestants mentioning physical health in their definition of health as it applied to therapeutic abortion, 98.1 percent of the Jewish respondents, and 88.5 percent of the Catholic physicians.

*Mental Health.* Most physicians said that mental health was a valid part of the definition of health (79.8 percent) in the context of therapeutic abortion. Opinions on this point varied directly with the age of physicians with 84.6 percent between 25 and 34 years citing this factor, while the distribution among other age groups was: 81.5 percent, 35 to 44 years; 79.6 percent, 45 to 54 years old; 75.8 percent, 55 to 64 year group; and 69.4 percent, 65 years and older. Women mentioned mental health slightly more often than men as this concept applied to therapeutic abortion.

More substantial differences occurred by a physician's religious affiliation, a personal attribute which was partly linked to where physicians practiced. Mental health as it related to therapeutic abortion in the general concept of health which was held by physicians was endorsed by: 91.1 percent, Protestants; 94.9 percent, Jews; 88.8 percent and 82.0 percent by respondents of other or no stated religious affiliation; and 62.0 percent by Catholic physicians. With the exception of Quebec, the regional differences were not great. Among the regions, 83.8 percent of physicians in the Maritimes, 85.9 percent in Ontario, 80.4 percent in the Prairies, and 84.9 percent in British Columbia cited mental health in this context, while 70.9 percent of the physicians in Quebec endorsed this point. More, though not many more, family practitioners than obstetrician-gynaecologists recognized mental health in their definition of health as it applied to therapeutic abortion.

*Social and Family Health.* Over half of the physicians (55.8 percent) said that a patient's social circumstances and the implications of her well-being to her family were an integral part of health which should be considered in the context of therapeutic abortion. Younger physicians were more likely than their older colleagues to adopt this view. Among physicians who were between 25 and 34 years, 3 out of 5 (60.0 percent) gave this reply. The proportion of physicians holding this view dropped substantially among older physicians. This perspective was endorsed by 55.0 percent, 45 to 54 years; 50.3 percent, 55 to 64 years; and less than half (38.1 percent) among physicians who were 65 years and older. Slightly more women than men regarded social health as a component of health in the context of therapeutic abortion. There was no difference in the proportions of family practitioners and obstetrician-gynaecologists who accepted this indication.

There were broader differences between the views of Catholic and non-Catholic physicians regarding the validity of social health in the context of therapeutic abortion. Jewish physicians most often endorsed this view (80.8 percent), Protestants and those with no stated religion held it somewhat less

often (63.2 and 68.9 percent respectively), while most (2 out of 3) Catholic physicians did not accept this interpretation (36.7 percent endorsed this point). There was less regional variation in these replies. The distribution of physicians who accepted social health in the context of therapeutic abortion was: 58.1 percent, the Maritimes; 46.7 percent, Quebec; 62.7 percent, Ontario; 53.2 percent, the Prairies; and 62.2 percent, British Columbia.

*Eugenic Health.* While the phrase "eugenic health" can have many meanings, it is generally seen to involve genetic factors which may be associated with an individual's health. Three-quarters of the physicians (72.7 percent) included this consideration in their definition of health in the context of therapeutic abortion with a trend toward younger physicians emphasizing this component somewhat more than older physicians. This position was taken by 77.7 percent of physicians who were between 25 and 34 years; 75.4 percent, 35 and 44 years; 71.8 percent, 45 and 54 years; 68.1 percent, 55 and 64 years; and 64.9 percent who were 65 years and older. Slightly more female physicians than male physicians held this view. There was little difference by where they lived, or whether they were trained in obstetrics-gynaecology or family medicine. There were, however, more marked differences in terms of their religious affiliation. More Protestant and Jewish physicians (80.7 and 83.2 percent respectively) included the eugenic principle in their concept of health in the context of therapeutic abortion than did Catholic physicians (58.1 percent).

*Ethical Health.* The idea of ethical health involves events affecting a person's health status which may result from activities considered to be illegal or immoral. Some of these considerations may be clear-cut such as injuries resulting from assault, others may be somewhat more ambiguous such as venereal disease, while some issues such as induced abortion and euthanasia are deeply rooted in moral principles. Three out of four physicians (74.4 percent) believed that ethical considerations should be included in the concept of health when it involved therapeutic abortion. There was a trend, but one which was less marked than for some of the other components involved in the general concept of health, for younger physicians to hold this view more often than older practitioners. There were few differences on this point by the sex of the physicians, but there were more marked regional differences. More physicians who practiced in British Columbia (80.6 percent) and Ontario (80.0 percent) held this view than the proportion of physicians who lived in the Prairies (75.9 percent), the Maritimes (71.7 percent) or Quebec (66.0 percent). As was the case in how the social and eugenic factors associated with the general definition of health were seen by physicians, there were differences which occurred by their religious affiliation how the ethical aspects of health were seen in the context of therapeutic abortion. Considerably more Protestant (84.6 percent) and Jewish physicians (88.8 percent) than Catholic physicians (55.8 percent) endorsed this principle.

*Overview of Definition of Health.* Physical health considerations in the context of therapeutic abortion were endorsed by virtually all physicians. In contrast, there was less unanimity and several consistent differences as to how the other four components of the definition of health were seen. About 3 out of 4 physicians endorsed mental health, eugenic and ethical considerations. While

the idea of social health was less often cited, over half of the physicians in the national physician survey held this perspective. The most marked differences among the physicians endorsing these ideas were by their age and religious affiliation. Consistently, younger physicians and more practitioners who were Protestant and Jewish considered these four ideas to be central to their concept of health in the context of therapeutic abortion. Conversely, fewer older physicians and Catholic physicians endorsed these principles.

## Medical indications for abortion

Physicians were asked what health indications they would consider to be valid in the support of an application for an induced abortion. A distinction was made between a request for an abortion that occurred during the earlier stages of a pregnancy (first trimester) and one that was above this length of gestation (second and third trimesters).

| Indications for Supporting an Application for Therapeutic Abortion | First Trimester | Second Trimester | General Definition of Health in the Context of Therapeutic Abortion* |
|---|---|---|---|
| | percent | percent | percent |
| Physical Health | 91.7 | 67.7 | 93.5 |
| Mental Health | 81.8 | 47.3 | 79.8 |
| Family Health | 54.0 | 23.1 | 55.8 |
| Eugenic Health | 81.6 | 57.0 | 72.7 |
| Ethical Health | 85.5 | 52.3 | 74.4 |

*From Table 9.1.

There was considerable similarity in how the indications for an induced abortion during the first trimester were seen by physicians and in their ranking of the components of how they defined health more broadly in the context of therapeutic abortion. The level of endorsement was slightly higher for three indications (mental, eugenic and ethical) for a first-trimester abortion than the extent of their support cited in the general concept of health. For each of the five broad categories of indications, there was an across-the-board substantial drop between support of indications which were felt to be appropriate during the earlier weeks of a pregnancy than during its later stages. These differences did not reflect a different concept of health held by physicians, but represented the widely held medical judgment that induced abortions, if they were to be performed, should be done during the first trimester.

A regression analysis was done to determine if the personal characteristics of physicians and their experience with therapeutic abortion were related to the various indications upon which they would base their support of a woman's request for a therapeutic abortion.[3] Neither this general analysis nor the

[3] See Appendix 1, *Statistical Notes and Tables*, Note 2.

analysis of each specific indication showed any consistent trends which accounted for how most of these decisions were reached by physicians. In no instance could more than a fifth of the accumulative variance be accounted for in these analyses. **Among the physicians in the national physician survey such factors as their age, their sex, their religion, their primary language, their type of specialty training or where they worked in Canada, when these personal attributes were considered together, were not related to the range of indications upon which they would support a woman's request for a therapeutic abortion. Much like the attitudes which were held by Canadians in the national population survey, the issue of therapeutic abortion for these physicians was one which cut across all social backgrounds and types of medical practice experience.**

There was a broad diversity of views about the indications supported by physicians in their review of requests for therapeutic abortion. There was little consistency or uniformity with some physicians supporting all such requests, others never doing so, while the majority followed guidelines which varied according to their perception of health. In these circumstances for the woman who was involved, the choice of her physician was a crucial decision, one which might result in her request being referred immediately for review to a hospital therapeutic abortion committee, result in considerable delay, or be turned down completely.

## Interpretation of mental health

A majority of the physicians (79.8 percent) included mental health in their broader concept of health in the context of therapeutic abortion and an almost equal number (81.8 percent) would support a request for an abortion during the first trimester if this were indicated based on their assessment of a patient's mental health status. In its work the Committee found that in practice both abortion patients and their physicians held divergent views about the concept of mental health. Their ideas on this point ranged from transitory anxiety, fear, and unsettled social circumstances to major chronic neuroses and psychoses. All of these conditions are included in the broad definitions and the codification of mental disorders in the *International Classification of Disease.*

A majority of the diagnoses associated with therapeutic abortion reported by Statistics Canada were for reasons of mental health, mostly listed as reactive depression. Few physical indications were reported in these national statistics. What these findings may indicate is that in terms of their physical health, most women who had abortions in Canadian hospitals were considered by their physicians to be in good physical health, but as a result of their unwanted pregnancy, some aspect of their mental health had been affected. The extensive diagnostic classification involving the mental health status of women obtaining therapeutic abortions masks to a considerable extent what their actual state of mental health may be. The reason why this information must be considered to be unreliable is that many physicians gave their abortion patients

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

Physicians in the national physician survey were asked whether, in their judgment, mental health as an indication for therapeutic abortion was being interpreted too liberally, correctly, or too restrictively. Their replies indicated a sharp division of opinion on this question.

| Interpretation of Mental Health As Indication for Therapeutic Abortion | Percent |
|---|---|
| Too liberal | 43.9 |
| About right | 37.5 |
| Too restrictive | 14.9 |
| No reply, don't know | 3.7 |
| | 100.0 |

How this issue was seen by physicians varied directly with their age, their religious affiliation, and their type of work. Substantially more younger physicians than older physicians felt that the condition of mental health was being interpreted too restrictively in the context of therapeutic abortion. The attitudes on this point did not vary sharply among the physicians who practiced in different regions. Male physicians somewhat more often than female physicians felt that the mental health of abortion patients was being interpreted too liberally. Three out of five Catholic physicians replied that the interpretation of mental health was too liberal (60.1 percent); Jewish physicians more often endorsed the current situation, with fewer of them (24.5 percent) saying the interpretation of mental health was too liberal. Somewhat more Protestants, Jews, and physicians of other religious affiliations endorsed the current interpretation as being appropriate (45.6 percent, 45.2 percent, and 45.6 percent respectively).

The largest single proportion of family practitioners and obstetrician-gynaecologists felt the interpretation of mental health was too liberal. Among the remainder, rather more members of these two groups of physicians thought the interpretation to be appropriate (39.3 percent of the family practitioners and 37.4 percent of the obstetrician-gynaecologists) than the number who found it to be too restrictive (17.7 percent and 10.0 percent respectively). Among the physicians who said the current interpretation of the indication of mental health was too liberal (43.9 percent), a number stated that the abortion operation might endanger a woman's health or her ability to carry a normal pregnancy in the future.

> . . . Psychiatrists dishonestly vouch for patients' depression to make abortions *legal.*
>
> • • •
>
> Anyone who demands one (an abortion), I think, remains psychologically marked.

... I have seen much mental and physical anguish later from patients who have gone through with therapeutic (so-called) abortions.

• • •

Young people in particular have not been adequately educated about the risks of abortion *especially* in respect of future fertility (i.e., the abortion pregnancy may be their last).

• • •

Women who have had one or more "therapeutic" abortions have a higher incidence of premature deliveries in future, pregnancies with consequent cerebral palsy and mentally retarded babies.

• • •

To obtain a therapeutic abortion legally, it is necessary for the doctors concerned to state that the pregnancy is a danger to the patient's physical and mental health ... In the majority of cases this is nonsense as there is no real threat to the patient's health if the pregnancy goes on.

• • •

I believe that few pregnancies endanger the health of the mother and that each time I do one I could be breaking the laws of the land.

In contrast with these views, those physicians who felt that approval of therapeutic abortion was justified on the grounds of mental health said that this procedure had helped to avert other types of complications which their patients might experience.

... (Abortion Committee members) interpret the guidelines of the law in their own way, i.e., single girl, 27, working to support her immigrant sister, got pregnant after a party ... Reviewed by Committee members and refused on grounds of "no apparent mental health hazard". This patient, if forced to continue her pregnancy will *surely* become a psychiatric patient.

• • •

Disagree with the fact that the medical profession has to find a medical excuse for a patient to have an abortion which is done on a social basis.

• • •

Social aspects should be involved in indications—these are closely linked with emotional problems and in turn with mental health.

• • •

In 10 years of general practice I have had at least a dozen women who had given up unwanted babies, return for treatment of guilt and depression, some returning as long as a year or two later. The more liberal interpretation of the Abortion Law over the past four or five years has resulted in the fact that I have had no patients in that time who have carried through unwanted pregnancies and given up babies. I have, however, seen a fairly large number of patients who have had therapeutic abortions instead, and have not had one return seeking treatment for guilt and depression resulting from the fact that they had decided on, and carried through with abortion.

There is *much* long-standing emotional trauma to "give a child up for adoption" though valiant it may be!

• • •

I have found much less psychic trauma following a therapeutic abortion than completing an unwanted pregnancy and giving the baby up for adoption.

• • •

Contrary to all sorts of silly reports, I have seen nothing post-abortion but relief—no guilt complexes, no recriminations, no depression—just joyful relief.

While there may be a general definition of the mental health status of patients, as this indication applied to women obtaining therapeutic abortions, its interpretation was affected not just by medical considerations but as well by the nature of a physician's personal circumstances. More younger physicians, female physicians, and those doctors whose religious faith was Protestant or Jewish said that mental health was justified as an indication in their assessment of requests for induced abortions.

The Committee's Terms of Reference stipulated: "To what extent is the danger to mental health being interpreted too liberally or in an overly-restrictive manner ... ?" Based on the findings of the national physician survey, **the medical profession was deeply divided on this question. Considering the intensity with which different views were held, the basic principles at stake were unlikely to be easily or soon accommodated. Overall, 43.9 percent of the physicians said that mental health as an indication for induced abortion was being interpreted too liberally, 37.5 percent endorsed the present situation, and 14.9 percent felt that mental health in this context was interpreted too restrictively.**

## Length of gestation

While the Abortion Law sets no limits when an induced abortion may be done involving the length of gestation, most physicians in the national physician survey agreed with what they felt the law said on this point. Less than 1 out of 10 physicians said the law set no time limit, (7.6 percent), 3.9 per cent did not know or did not reply, and **9 out of 10 (88.5 percent) physicians reported the number of weeks which they said the Abortion Law stipulated about the length of a pregnancy when an induced abortion could be performed.** On the basis of this misinformation (the law sets no time limits), about a fifth (17.0 percent) of the physicians thought that the law was too liberal while a handful (3.7 percent) said it was too restrictive in terms of the time which they felt it set. The majority said the Abortion Law set specific time limits and agreed with what they thought these requirements were (68.3 percent).

There was some ambiguity in the replies of physicians who said they would never support a request by a woman for a therapeutic abortion. When

the physicians were asked for instance if they "under no circumstances would support an application for a therapeutic abortion", 203 physicians out of a total of 3,129, or 6.5 percent, agreed with this statement. However, when physicians were asked "Beyond what length of time in weeks do you think a therapeutic abortion should not be carried out?", 519 physicians, or 16.6 percent, listed either no time, or said that therapeutic abortions should never be done.

One out of five (20.5 percent) of the 3,129 physicians said they would support an application for an induced abortion anytime a woman requested it up to 14 weeks of gestation and half of this group (10.5 percent of all physicians) were prepared to provide such approval beyond 14 weeks, whenever a request was made. **The majority of physicians held views which were in between the 1 out of 6 doctors who would never support an abortion request and the 1 out of 5 who would always support such requests up to 14 weeks of gestation.**

The personal views of physicians about whether they felt therapeutic abortions should never be done or performed whenever a request was made were distinct from the medical judgment of beyond what cut-off point they felt induced abortions should not be done. Out of the 3,129 physicians a handful (1.2 percent) did not reply to this question and 1 out of 6 (16.6 percent) said abortions should never be done. Four out of five physicians (80.8 percent) said that abortions could be carried out up to and including 12 weeks of gestation. As the length of a pregnancy increased, fewer physicians felt that induced abortions could then be done with safety for their patients.

| Length of Gestation Beyond which Therapeutic Abortions could be done | Percent |
|---|---|
| No reply | 1.2 |
| Never | 16.6 |
| Under 11 weeks | 82.2 |
| 12 weeks | 80.8 |
| 13-15 weeks | 70.4 |
| 16 weeks | 59.3 |
| 17-19 weeks | 47.6 |
| 20 weeks | 40.2 |
| Above 20 weeks | 10.6 |

In contrast with younger physicians, fewer older physicians endorsed a longer cut-off limit. While a fifth of the physicians (22.2 percent) who were 65 years or older listed an upper limit of 20 weeks, a third (34.8 percent) of the younger physicians cited this 20 week period. There was little variation in the length of gestation which was given by a physician's sex or where he or she lived. About a third of the physicians in each region set 20 weeks as the point beyond which therapeutic abortions should not be done. There were more marked differences by the religious affiliation of physicians. The 20 week cut-off point was cited by 36.2 percent of Protestant physicians; 52.9 percent, Jewish physicians; and 21.8 percent, Catholic physicians. Family practitioners

set an earlier time limit than obstetrician-gynaecologists. Among the former, 28.3 percent set 20 weeks as a maximum, while 40.6 percent of the obstetrician-gynaecologists listed 20 weeks.

Physicians gave many reasons why induced abortions should not be done during the middle or later stages of a pregnancy. These reasons included: their concern for the safety of the patient; beyond 20 weeks the procedure was a stillbirth and the foetus approached viability; or their distaste for doing the procedure intensified as the length of gestation increased.

> Women should have unrestricted access to safe, effective, and humane therapeutic abortion facilities for pregnancies up to 20 weeks gestation.
>
> • • •
>
> In the second trimester up to 20 weeks gestation, the patient and the doctor of her choice should have access to public facilities for the more sophisticated management required at this stage.
>
> • • •
>
> Should be considered the same as any other form of elective surgery with the only restriction in most cases relative to gestational age because after 20 weeks the foetus may survive with all the attendant physical deficiencies possible to the resultant individual, along with the social phenomenal costs to the community as a whole.
>
> • • •
>
> The law could read: "The decision for abortion up to the 24th week is up to the patient and her physician as long as provisions and programs are made for sexual education and family planning . . ."

Many physicians felt that the increase in the number of therapeutic abortions in recent years had substantially reduced the occurrence of illegal abortions and the extent of its associated complications.

> . . . illegitimate childbirth and adoption are now a rarity but then so is *septic* criminal abortion and maternal morbidity and *death*.
>
> • • •
>
> I genuinely feel that more liberal abortions have saved lives. Septic abortions are almost a thing of the past here.
>
> • • •
>
> A woman who does not want to keep her pregnancy will find a way to obtain an abortion regardless of the existing law. I treated 3 to 4 patients on an average per month for septic abortions before the availability of abortions in the U.S.A. and in some liberal Canadian hospitals. I see about 2 septic cases per year at the present time.
>
> • • •
>
> Years ago I would see 2 to 3 septic abortions in the hospital each month and many *died*; others were sterile. I have not seen *one* in the past 2 years. That alone is a big improvement.

The physicians were asked to estimate the average length of time which elapsed between when patients initially consulted them and when the therapeutic abortions for these patients were done in Canadian hospitals. Most of the obstetrician-gynaecologists in the survey had at one time performed therapeutic abortions and most family physicians had been approached by women requesting their support for an abortion application. On this basis **4 out of 5 physicians (82.2 percent) found that this was a question which they preferred not to answer.** Of the 3,129 physicians, 4.4 percent said they did not know how much time elapsed between when abortion patients initially consulted a physician and when the operation was done, and 77.8 percent did not answer this item. Of the 1 out of 5 (17.8 percent) of the physicians who replied, most listed an interval that was less than two weeks.

| Physicians' Opinions of Time Interval Between Patients' Initial Medical Consultation and Therapeutic Abortion Operation | Percent |
|---|---|
| Under 7 days | 9.2 |
| 7-14 days | 6.4 |
| 15-21 days | 1.1 |
| 22-28 days | 0.6 |
| 29 days and over | 0.5 |
| Don't know | 4.4 |
| No reply | 77.8 |
| | 100.0 |

Among the small group of physicians who answered this question, those doctors who more often gave the time interval as being under seven days were: 80.0 percent, physicians 65 years and over; 65.4 percent, Catholic physicians; 63.5 percent, physicians in Quebec; 43.2 percent, family physicians; 33.1 percent obstetrician-gynaecologists. In contrast, among the 1 out of 5 physicians who gave a time interval, more younger physicians (42.5 percent) and male physicians (41.8 percent) cited a period of above a week.

The replies of these physicians and the decision by most physicians to report no time interval contrasts sharply with the actual experience of the 4,754 women in the national patient survey who had therapeutic abortions in Canadian hospitals during the first six months of 1976. On an average these patients had their abortion operation done 8.0 weeks after they had initially consulted a physician. **Less than 1 out of 200 physicians in the national physician survey (0.5 percent) accurately knew or reported the actual length of time (8.0 weeks) between when a woman had initially consulted a physician and when the operation was performed.** Among the physicians who replied to this question, most extensively under-estimated this time interval. Physicians, it would appear, either chose not to know how much time was taken in the processing of abortion applications or were optimistic on this point.

In general, physicians who set a lower cut-off time limit were more likely to report that less time was spent between a patient's initial consultation with a physician and when the operation was done. Fewer of these physicians were

directly involved in the abortion procedure. More of these physicians either were opposed to induced abortion on principle, or felt that if it were done, the medical decision should be based on demonstrable physical and mental health indications. The length of time involved between the initial medical contact and the timing of the operation cited by these physicians did not accord well with the length of time which patients actually experienced.

At the other end of the scale some physicians who consistently felt that the interval was longer between when a patient contacted a physician and when the operation was done, also gave estimates which did not closely match the experience in this respect of patients in the national patient survey. Only 1 out of 10 physicians between 25 and 34 years for instance had done this operation. What these findings suggest is that among some physicians who had little direct involvement in the therapeutic abortion procedure, their strong personal views—either those who were opposed to abortion or those who endorsed the view that it was a human right—may have affected their estimates of the actual time which was involved. In each instance, neither group of physicians had done many abortion operations.

There was no ambiguity, however, in the judgment of physicians within what time limits the abortion operation should be performed, if it were to be done. **A majority of physicians (80.8 percent) saw the abortion operation being performed with safety prior to 12 weeks of gestation. As the amount of time over this time limit increased, either due to a delay in the initial contacts made by patients in consulting physicians or due to the time which was taken in the medical review of applications, a larger number of physicians became apprehensive about the risks involved. Three out of five physicians (59.3 percent) set the upper limit at 16 weeks.**

## Abortion and the value of life

In addition to their general views on the definition of health, indications for abortion, and their interpretation of mental health in connection with therapeutic abortion, the views of the physicians in the national physician survey were obtained on three broad related issues. These questions dealt with whether in their judgment therapeutic abortion was a human right, whether this procedure lowered the value of life, and its comparison with an illegitimate birth or an unwanted child. Their replies were:

| Physicians' Attitudes About Induced Abortion | Agree | Disagree | No Reply or Undecided |
|---|---|---|---|
| | | Percent | |
| Abortion is a human right | 54.8 | 42.3 | 2.9 |
| Abortion lowers the value of life | 50.5 | 47.7 | 1.8 |
| Abortion is preferable to an unwanted child | 58.4 | 37.1 | 4.5 |

The replies to these three questions were consistent with the answers which physicians gave concerning indications for abortion. As a whole more physicians agreed with these views than disagreed with them. Few were undecided or gave no reply to these points.

Therapeutic abortion should be freely available to any woman requesting it.

• • •

I would no more go for abortion on demand than I would go for amputating a woman's right arm because it offended her.

• • •

An abortion should be the right of all females.

• • •

Therapeutic abortion should have no place in Canada, no place in Medicine.

• • •

Therapeutic abortion should be readily available to people all over the country, i.e., as available as they are in _____ .

• • •

I do not feel it is an unqualified right.

• • •

I feel strongly that a woman should have an abortion if she requests it.

• • •

There is no place for therapeutic abortion.

The same general trends by the social background of physicians were reflected in their views about whether induced abortion lowered the general value of life. Their replies were almost equally divided on this point. Physicians residing in the various regions were fairly evenly split as to whether they affirmed or rejected the view that abortion lowered the value of human life. The greatest agreement came from physicians in the Prairies (55.8 percent), the greatest disagreement from Ontario (51.2 percent), and among Quebec physicians there were substantially more who agreed or disagreed than in any other province.

I think legislators are paying too little attention to the value of human life, especially foetal life. This attitude is rapidly eroding the moral fibre of our society and leaving us with a decadent nation.

• • •

*Clearly*, if we accept "general" therapeutic abortion we will not be long in accepting euthanasia—easy death for those "unwanted" and useless in our society: the old, the senile, the retarded, the incurables.

The matter is getting out of hand: the case of obtaining an abortion is markedly contributing to the moral laxity and breakdown of family life which we are witnessing today.

• • •

When we lose our reverence for human life, we lose the hallmarks of a civilized nation.

• • •

A symptom of our general moral decay.

• • •

Abortion is only part of the answer but if there were not so many broken marriages then the family as a unit will become stronger and the sexual permissiveness decrease.

• • •

Most of the general public give their opinions solely on an emotional basis . . . they do not see the young people locked into poor marriages because "society" still pressures them into ill-timed and premature marriages.

• • •

With skyrocketing mental and nervous disorder, illegitimate children and cost of looking after unwed mothers and their children, it could be argued that easier abortions could alleviate a great many social problems.

• • •

Easy access to therapeutic abortion must *raise* the value of human life—because since fewer are born more value is placed upon them.

With the exception of physicians who were 65 years or older, 3 out of 5 (58.4 percent) said that it was preferable for a woman to have an induced abortion than to bear an unwanted child. More female physicians than male physicians held this opinion, one which also varied by the type of work which physicians did.

We must, above all, guard against making a single girl have a baby as a punishment for being careless. Above all every physician who refuses an abortion may be taking responsibility for yet another unhappy alienated individual arriving into the world (and there are plenty already).

• • •

I cannot feel deep concern for those who have not survived the experience of birth. We ought to concentrate on relieving the misery of the born before drawing up codes of rights of embryos.

• • •

To coerce young women who have become pregnant contrary to their wish and intent, to deliver babies for the purpose of supplying sterile couples with children, would be synonymous with forcing them into a "stud farm pool" . . .

• • •

Progress is yet to be made to clearly establish the individual right of a woman to decide as to whether or not she is mentally or physically capable, or desirous of bringing a person into existence, with all of the attendant responsiblity and change in her personal *modus vivendi*, and to do so with the necessary affection and care so as to facilitate the development of an adequate, responsible, and well adjusted member of society. The state of motherhood is hardly a state of being cared for by a man, with relatively simple duties, but rather constitutes a profession of considerable importance. From the time of birth, a woman will likely spend 60 to 80 percent of her time taking care of the physical and emotional needs of the child for about the next six years, and then gradually decreasing time as the child, in the natural course of events, grows to independence over approximately the next twelve years.

I can only arrive at the conclusion that it would be extremely presumptuous and arrogantly naive for me, on the basis of an interview, however detailed, to coerce a patient into making a decision to commit herself in such magnitude for the next decade and longer. The community is a continuum of ever-developing children, hence it is obviously in the interests of the community that the children develop in an environment of being wanted, adequately cared for, and well educated. Unwanted or maltreated children who have, however inadvertently, been conditioned into values contrary to the interests of the community, contribute to the number producing the ever-expanding crime rate, etc., and the ever-expanding need for emotional and mental health care facilities.

• • •

If a patient presents requesting an abortion, following a frivolous or other sexual encounter, the antithesis of which intent was procreation, it can readily be assumed that the impending potential child is unwanted. The omnipresent argument that the obliteration of potential human life represents devaluation of human life, is philosophical and without definite resolution, and is not practicably applicable to our society's present situation.

• • •

The unwanted child is certainly deserving of our consideration. This child should be transferred with expedience to parents who do want the child . . . There are thousands of responsible parents still seeking children to adopt and raise.

• • •

(Abortion) should be restricted until all adoption seeking couples are saturated. This will raise more native Canadians. The guidelines can then be adjusted on a 2 year basis . . .

• • •

Subsidize the pregnant girl to carry on with her pregnancy. We have too few babies up for adoption.

• • •

There are no unwanted children; there is always somebody who is longing for a child.

## Appointment to therapeutic abortion committee

**The majority of physicians surveyed had never served on a therapeutic abortion committee (77.9 percent) while 1 in 5 (20.2 percent) had.** (The remainder did not give this information). Regardless of their age most physicians had not served on a therapeutic abortion committee. The largest percentage of those who had (27.7 percent) were between 55 and 64 years with the smallest proportion being between 25 and 34 years (12.0 percent). In about equal proportions, female and male physicians had served on these committees (20.4 percent and 20.9 percent respectively).

More Protestant physicians (30.1 percent) than Catholic physicians (7.9 percent) had served on therapeutic abortion committees. Proportionately more physicians from British Columbia (33.4 percent) had been members of these committees than physicians who lived in other provinces. Physicians residing in Quebec were the least likely to have been involved (10.2 percent). A larger percentage of obstetrician-gynaecologists had been committee members (29.1 percent) than had family practitioners (17.0 percent).

Physicians were asked if they would be willing to serve as a member of such a committee. **Over one-third (39.2 percent) of the 3,129 physicians said they would be prepared to accept an appointment to serve as a member of the hospital therapeutic abortion committee, an almost equal number said they would not (34.6 percent), and the remainder (26.2 percent) gave no reply.** The proportion of physicians who were willing to accept this committee responsibility declined among older physicians, was about the same for physicians of all religious faiths, was slightly higher among female than male physicians and was fairly uniform in all regions of the country. Almost equal proportions of family physicians and obstetrician-gynaecologists said that if they were asked to serve, they were prepared to be a member of a therapeutic abortion committee.

The physicians in the survey made a number of comments about how therapeutic abortion committees functioned at the hospitals in the communities where they practiced.

> In this province there is but *one* active abortion committee—in a province where *all* hospitals are government supported.
>
> • • •
>
> In _____ —as much as anywhere—with large religious overtones throughout the hospital—there is no chance of getting an abortion committee—never mind an abortion—off the ground.
>
> • • •
>
> In this community there are two hospitals—one has a (therapeutic abortion) committee. The other hospital would only consider medical moral committee with one doctor and three moralists. It was dropped when doctors realized they were never going to be allowed to win an argument.

The main problem centres around small towns and small cities where hospitals have refused to set up a committee.

• • •

In our hospital the abortion committee has not met since July 23, 1973.

• • •

After 3 years on an abortion committee I feel that committees of this type serve absolutely *no* useful purpose and should be disbanded.

• • •

Our local problem is that the committee here blows hot and cold depending on the composition of the committee. Nevertheless, it has not been decided whether abortion is good or bad and it would seem to me that a committee will sway from right to left and (advance) one opinion more than another, depending upon the times. This would seem to reflect general opinions and therefore is not bad.

A wide variety of reasons were cited by the physicians who said they were unwilling to serve on therapeutic abortion committees. Some of the reasons were related to the nature of their affiliation with a hospital and whether a hospital where they had admitting privileges had established or had not established a therapeutic abortion committee. **Among the physicians in the national physician survey, two-thirds (66.1 percent) held appointments at hospitals which had established therapeutic abortion committees, almost a quarter (23.5 percent) worked at hospitals which did not have these committees and the remainder gave no information on this point (10.4 percent).** A small group of physicians (3.9 percent) said they could not be a member of a therapeutic abortion committee because they performed the abortion procedure. Among the physicians who said why they were unwilling to serve on these committees, their opposition on personal and professional grounds to induced abortion was the single factor which was most frequently cited (38.3 percent). Only 2 out of 3,129 physicians mentioned legal reasons, saying that they would not serve on such committees because they felt they would have insufficient legal protection.

In addition to a physician's willingness or unwillingness to serve on a therapeutic abortion committee, a second factor which was involved if a hospital had established such a committee, was how medical staff appointments to committees were made by a hospital administration. On its site visits the Committee was frequently told by hospital administrators, medical directors, and chiefs of medical services of the considerable care which was usually taken in the selection of committee members. In many instances it was known that some physicians who were members of the medical staff of a hospital would be willing to serve on these committees, but it was felt by those individuals who were responsible for the nomination of committee members that their views were not in accord with hospital policy. Where there was an acknowledged and well-known position, physicians holding contrary views seldom challenged a medical staff executive or a hospital board. This accommodation occurred in hospitals regardless of the number of abortions which

were done. Among some hospitals with committees where the views of the medical staff were divided on the abortion issue, it was more unusual for physicians known to hold strong views to be asked to serve on these committees. More often what happened in these situations was that the work of the committee fell to physicians whose views matched the hospital's policy. In this respect the requirements and guidelines of therapeutic abortion committees generally reflected the views of the majority of physicians on a particular hospital's medical staff.

Based on the findings of the survey of physicians and from its hospital site visits, the Committee concluded that: **for most hospitals which met other requirements, there was a sufficient number of physicians who were prepared to serve on therapeutic abortion committees. But for the slightly over a third of the physicians who were prepared to do so, there was a sifting process in the nomination of committee members which substantially reduced the actual number who were likely to be asked to serve on these committees.**

Among the physicians who said they would be willing to serve on therapeutic abortion committees, 70.9 percent were affiliated with hospitals which had established committees and 29.1 percent were members of the medical staff of hospitals which did not have committees. There was a somewhat similar distribution among physicians who said they were unwilling to be members of such committees, with 63.2 percent being affiliated with hospitals with committees while the remainder (36.8 percent) worked at hospitals without committees. Looked at somewhat differently, **almost half (46.3 percent) of the physicians for whom information was available who worked in hospitals without therapeutic abortion committees said they were prepared to serve on these committees, if they were established at their hospitals.**

From its site visits to hospitals across Canada and based on other reports which it received, the Committee found that in general several broad patterns of accommodation had emerged among the medical staff of hospitals about the abortion issue. These patterns were: (1) the self-selection by physicians of the hospitals where they held appointments; (2) the sifting process involved at hospitals in the nomination of physicians to therapeutic abortion (and other) committees; (3) an accommodation when there were strongly held and divergent views about abortion held by the medical staff; and (4) more rarely, an open conflict over the issue among members of the medical staff.

No direct survey of medical interns or residents was done for this inquiry. On its site visits to hospitals the Committee obtained information about the usual practices which were followed. It was reported that in the past obstetrical-gynaecological residents at a few hospitals had been required to perform the abortion procedure. In these instances those physicians-in-training who were not prepared to do this were not accepted in the training programs of some hospitals. While the extent to which this may have occurred is unknown, the Committee received several reports from physicians about their experiences in this respect.

> This is to certify that as a resident in training at _____ on two occasions in the past year my views on abortion have caused me to be replaced in proposed

training positions. The first incident occurred in mid-March 1974. I had been verbally informed of my appointment. The appointment was made in December 1973 and I was to commence work in July 1974. In March 1974 I received a phone call from the programme coordinator, stating that unless I would perform abortions, I could not have the position as previously arranged. The second incident occurred in February 1975. At that time I was interviewed by _____ in regard to my proposed appointment at _____ . At this interview I was told that I should not be required to induce abortions, but that I would be expected to deliver dead foetuses after saline induction. I was also informed that because of my views on abortion I should never become Chief Resident at that hospital as had been originally anticipated. On each occasion, I had to find suitable training posts where abortion was not a mandatory requirement of residents.

• • •

I saw Dr. _____ along with Dr. _____ today with respect to taking a residency here and the abortion activity in our clinics.

First of all let me explain our current situation. We book 20 patients per week in our clinic. A staff man attends every clinic and a staff man also does an abortion list by himself without resident participation in order to cut the load down on the trainees. About 60 percent of our entire abortion activity is with the clinic group of patients, with the minority being private abortions. Residents rarely participate in private abortions.

I explained to Dr. _____ our position in the matter, which is unchanged since the issue came to a head with Dr. _____ . It is as follows:

1. We would not expect Dr. _____ to attend abortion clinic or recommend abortion.
2. We would not expect Dr. _____ to perform abortions.
3. We would, however, expect Dr. _____ to give medical care to individuals with abortion complications and to assist in the management of a saline abortion at the time of delivery of the dead foetus or any time significant expertise was required subsequent to the actual act of intervention.

Dr. _____ 's position is that Dr. _____ would render care to this group if they were in trouble. Here is the stumbling block—in that the feeling of my staff and myself is that these patients should be treated with the same degree of skill, attention and understanding that Dr. _____ would bring to bear on any other patient once the act of producing the abortion had been done whether they are "in trouble" or not. Dr. _____ feels that this is participating in the abortion process; we feel that it is discriminating against a patient who has been aborted by someone else. With our rotation situation, he would be the senior on call and could not delegate to another senior at nights or weekends.

There is no resolving this difference in viewpoint since both parties hold their position firmly and I am sure, sincerely.

Our feeling is that hospitals are free to define their position in the abortion scene and to decide if the service is to be provided or not, to what segment of the population it will be aimed, how it will be provided and so on. Once this position is defined, however, it should be provided at a high level of care. If it

is to be altered it should be altered as the result of a considered position by permament staff, and cannot be altered by the opinion of trainees who are on the scene for a limited time. Nor should the quality of the care vary with the circumstances of house staff appointments.

I am sorry this is not going to work out with Dr. _____ and even more significantly when Dr. _____ reaches Chief Resident level there is no way he could function in terms of overall supervision of the quality of work on that service and exclude the abortion activity.

This position of ours is not new, and is quite consistent. We do not expect individuals to recommend or to do abortions if they feel this is wrong. However, we do expect the best level of care they can bring to bear on all patients who are aborting or have aborted whether or not this was spontaneous, self-induced or therapeutically induced.

• • •

It has been my experience that there are problems in undertaking training in the University of _____ in obstetrics unless one agrees to undertake pregnancy terminations. At _____ , where I undertook two years of post-graduate resident training in obstetrics and gynaecology, the situation is such that one teaching hospital will not train physicians who do not perform pregnancy terminations. However, the interpretation of "involvement" in pregnancy termination sometimes becomes confusing. I feel that an example is probably required to clarify this situation. If a pregnancy is terminated by injecting saline into the mother's uterus to kill the foetus and thereby induce labour, then the act of delivering the dead feotus is considered by some to have no bearing on the therapeutic abortion procedure. It is my feeling that to deliver these killed human foetuses is to become involved in the pregnancy termination procedure and I will therefore not perform this procedure. The feeling of one senior obstetrician in this city is the reverse of this and he insists that if a trainee physician will not perform delivery of the dead foetus then he will not train him in his obstetric unit.

• • •

Applied to Dr. _____ (Coordinator of post-grad. training for obstetrics and gynaecology) to have the next six months of training, which would normally have been in internal medicine, changed to general paediatrics as allowed by Royal College.

Offered six months gynaecology at _____ . Agreed as long as ok with Royal College.

Phone call—told six months residency at _____ approved—told would have one half day a week in the O.R.—told written confirmation would follow. _____ phoned Dr. _____ to ask why no letter—told letter typed and awaiting signature—should be in mail within 48 hours.

Few days later—Dr. _____ phoned _____ and reported that Dr. _____ had mentioned that she had been told _____ did not do abortions. Verified that this was correct. Dr. _____ then announced that since Dr. _____ was head of department and considered abortions essential to the service, Dr. _____ was not eligible for the appointment. It was cancelled.

All general paediatric appointments had been made and a general medicine appointment was available at _____ which Dr. _____ took.

The Committee found that the policies which were usually followed at most hospitals were:

—Residents did no abortions. They were all performed by staff physicians.

—Residents were not required to assist with the procedure, but they were required to provide post-abortion medical care.

—Residents were not required to participate, if it was against their personal beliefs.

—Residents did only a certain number of abortions, with the remainder performed by staff doctors.

These policies were not mutually exclusive. The majority of the hospitals respected the personal decisions of residents and interns if they did not wish to take part in the abortion procedure. The process of physicians selecting hospitals and of hospitals selecting physicians also occurs, an example of which was given by an obstetrician-gynaecologist.

> Since July 1970, I have had admitting privileges as an obstetrician and gynaecologist at _____ Hospital. In 1971, while resident in _____, I wished to transfer my practice to the same area, and therefore I applied for an appointment to the obstetrics and gynaecology staff of the _____ Hospital. I was interviewed by Dr. _____. Among other questions, I was asked whether or not I would perform abortions. I replied that I would never agree to destroying innocent human life for social convenience. I added that I am a Roman Catholic, I consider induction of abortion a moral issue, and therefore even if the Roman Catholic Church changed its views about abortion, I would not change my views. I stated that I was willing to perform sterilizations. I also agreed to do my share of running the "free clinic" that Dr. _____ discussed during the interview.
>
> My application for the staff appointment was refused. I would like to bring to your attention the fact that I am a member of the Royal College of Surgeons of Canada—there is no higher qualification obtainable in Canada.

At several of the hospitals which were visited by the Committee, difficulties had occurred in the scheduling of abortion operations because anaesthetists on the medical staff were reluctant to assist in this procedure. At one hospital the reluctance of these specialists had resulted in limiting the abortion procedure to those operations which could be done under a local anaesthetic. At several hospitals visited by the Committee, no abortion operations were scheduled on days when anaesthetists who were opposed to this procedure were "on call". At larger hospitals there was usually a sufficient number of anaesthetists on the staff so that alternate arrangements were made. In no instance known to the Committee was an anaesthetist forced to participate in the abortion procedure against his will.

Among the physicians who had appointments at hospitals which had therapeutic abortion committees, 3 out of 5 (58.5 percent) of these physicians agreed with their committee's guidelines, a quarter (23.3 percent) did not, and the remainder did not know the committee's guidelines. More doctors of all age groups approved of their hospital's guidelines than did not. The highest percentage of agreement was among doctors between 35 and 44 years (60.6

percent), while the lowest proportion (46.5 percent) was among physicians between 25 and 34 years. Proportionately more men than women concurred with the guidelines of their hospitals.

About a third of Catholic physicians were employed in hospitals which had no therapeutic abortion committees (35.9 percent). Of the remainder, approximately a half (45.7 percent) agreed, and less than a half (41.8 percent) disagreed with the committee's guidelines. Three out of four (75.8 percent) of the Protestant physicians endorsed the guidelines of their hospital committees. The regional distribution of the proportion of physicians who approved of the guidelines of the therapeutic abortion committees of their hospitals varied widely with the proportions being: 59.3 percent, Maritimes; 40.6 percent, Quebec; 65.9 percent, Ontario; 61.2 percent, Prairies; and 63.6 percent, British Columbia, the Yukon and Northwest Territories. Among obstetrician-gynaecologists who worked in hospitals with committees 70.6 percent agreed with the guidelines of these committees, 28.4 percent disagreed, and the remainder gave no reply.

Physicians were asked who should make the decision about an induced abortion. Like the results of the national population survey, no strong consensus emerged. The three choices which were listed most frequently were that the decision about a therapeutic abortion should be made by: (1) the woman and her physician; (2) the woman, her partner, and the physician; and (3) the hospital committee. **About a quarter (23.0 percent) of all physicians said the decision should be made by a hospital committee. Almost that number (21.7 percent) thought that the decision should be left to the woman, her partner and her doctor, and a third (30.7 percent) said the decision should be reached between a woman and her physician. Less than 1 out of 10 (8.3 percent) believed the decision should be the woman's alone.** The replies of the remainder were: 1.5 percent, a woman and two physicians; 8.5 percent, a mix of options; 2.9 percent, abortions should never be done; and 3.4 percent, no reply.

> I would favour continuing with the therapeutic abortion committee ...
>
> • • •
>
> I favour a hospital committee to judge the patient's request for abortion, (but) I wish to qualify that by adding, "only if that committee sticks to the letter and the spirit of the law".
>
> • • •
>
> I feel it is a decision between patient, her partner, and the physician.
>
> • • •
>
> The best people to do this (are) the patient, her consort, and the patient's trusted personal physician.
>
> • • •
>
> The decision should be between physician and patient and this would enable early suction of the uterine cavity in the doctor's office for a missed period of a few days with quite a saving in hospital costs and medical costs and anguish to all concerned.
>
> • • •

> I would like to submit my considered opinion, asserting that only one person can decide whether or not to carry through a pregnancy, regardless of the circumstances under which it occurred, and that person can only be the patient herself.

Different age groups favoured different solutions. Physicians between 25 and 34 years more often felt the decision should be made by a woman, her partner and her physician (25.1 percent) or by a woman and her physician (20.7 percent). More of their older colleagues endorsed the continuation of the therapeutic abortion committee. While few physicians felt the decision should be made by a woman alone, more younger physicians held this viewpoint (10.5 percent). One-quarter of the male physicians favoured the therapeutic abortion committee (24.2 percent) in comparison with one-fifth (20.4 percent) of the female physicians. Both men and women preferred to have the decision made by the woman, her partner, and her physician, or by the woman and her physician to other options. Catholic physicians endorsed the committee method (38.3 percent) more than physicians of other faiths. One-third of Jewish physicians thought that the decision should be made by the woman and her physician (33.5 percent) or said it should be decided by the woman, her partner, and her physician (31.1 percent). Protestant physicians specified a woman and her physician (26.5 percent), the woman, her partner, and her physician (22.0 percent), or the hospital committee (20.5 percent) as the decision makers.

The highest percentage of physicians from British Columbia, Ontario and the Maritimes felt that the decision to have an induced abortion should be made by the woman and her physician. In the Prairies and Quebec, the majority of physicians considered the hospital committee as the appropriate means of reaching this decision. In each instance almost one-quarter of the family practitioners thought that the decision for an induced abortion should be made by the woman in consultation with her partner and her physician (23.9 percent) or by a hospital committee (23.4 percent). Obstetrician-gynaecologists favoured that the decision be made by the woman and her physician (29.1 percent) or a hospital committee (25.5 percent).

Reflecting the social mosaic of the country and its medical profession, the options endorsed by physicians were numerous and diverse. Their perspective in this respect is in the tradition of how health services have been organized and provided to Canadians which have allowed for a great variety of choices. For these reasons it is not unexpected that several options on how decisions should be reached about therapeutic abortions were endorsed by physicians. **What these several choices mean is that no single course of action was widely supported by the medical profession. While there was no consensus about the utility of the present committee arrangement in reviewing abortion applications, the more prevalent mood among the physicians in the national physician survey was toward a structurally simpler means. Few physicians were totally against the principle of permitting induced abortions under any circumstances and a minority were for this choice being made by a woman herself. There was much broader support for the idea that this decision should be reached between a woman and one or two physicians.**

Part of the dislike that most physicians had about the committee arrangement went beyond the fact of abortion. It is accounted for by two facts which were often cited on visits made by the Committee to the 140 hospitals across Canada. While most physicians participated in provincial health insurance programs, the stance of many members of the medical profession was one of skepticism, often a staunch distrust of the role of government in what were considered to be professional medical decisions. This broader outlook was interwoven in the abortion issue with a consensus moving toward the perspective that the decision about abortion should be a matter between a woman and her physician. There was also a deep-rooted dislike of documenting for a potential audit, the decisions which were reached. This dislike did not appear to be affected by concern for any protection which such documentation might afford physicians, but went beyond the issue of abortion and involved the requisite paperwork that pertained to many facets of medical practice. It raises the unresolved issue of how much and what type of accountability there should be when decisions affecting the law or the public purse are involved. **The mood of many physicians about therapeutic abortion** as epitomized in their replies **was that the medical profession should retain its autonomy in this matter, that it was competent and should be trusted to do so. Government, most felt, should have no direct involvement in this matter.**

A second factor which was involved in the criticism by some physicians of the therapeutic abortion committee arrangement stemmed from a different and more practical concern. In their medical practice most physicians work as independent, fee-paid professionals. While their role in the hospital is indispensible, they neither own these public institutions, nor are they legally responsible for their administration. This authority is vested in hospital boards, or some comparable arrangement. As part of their medical staff duties at hospitals, physicians in return for certain "hospital privileges" of admitting patients for treatment are expected to serve, when requested, on various hospital committees. These responsibilities, usually well discharged, take time away from direct contacts with patients, and to the extent that they may involve more rather than less time, directly affect a physician's financial earnings. On its site visits to hospitals the Committee found in some instances a resentment that government by its imposition of the committee system in the review of abortion applications wanted to "get something for nothing" as physicians were not reimbursed for doing this work and the time which was spent in doing these duties meant a direct loss of income. Their acceptance of this direct loss of income was made none the easier by the overriding fact that most physicians regarded induced abortion with considerable distaste and would have preferred not to have been involved in this procedure. Another commonly cited reason why committees were disliked was that many physicians felt they were put in the awkward position of "second-guessing" the judgment of their medical colleagues who had submitted abortion applications. Without first-hand knowledge of a patient's situation, physicians in this position often felt they were not only making a decision about a patient, but as well about the competence of a medical colleague.

## Contraception and sterilization

While most of the physicians in the survey (69.2 percent) as far as consent for an abortion was concerned considered a woman to be a minor until she was between 16 and 19 years of age, they were more willing to start contraceptive counselling at an earlier age. Many of the physicians were prepared to start birth control counselling by age 16 or younger (64.7 percent, obstetrician-gynaecologists, 70.5 percent, family physicians). Younger physicians (25 to 34 years) were somewhat more prepared to begin the contraceptive counselling of their patients prior to puberty. Their older colleagues (55 to 64 years) were the least likely to start such counselling for very young females. More Catholic physicians (62.7 percent) than physicians of other faiths were prepared to begin contraceptive counselling for patients who were between 14 and 16 years, and fewer Jewish physicians said they would take this step (50.5 percent). The latter were more apt to say they would consider a patient's situation rather than her age (27.3 percent). More physicians from British Columbia (10.2 percent) were prepared to begin contraceptive counselling of their patients prior to puberty, while physicians in Quebec were the least likely to start this type of counselling at this age (6.4 percent). The highest proportion of physicians who started counselling between 14 and 16 years lived in Quebec (61.6 percent), while under half of the physicians in British Columbia began such counselling for patients of this age group (49.0 percent).

There was a widespread feeling among the physicians that more extensive knowledge of the means of birth control would decrease the need for induced abortions.

> I feel more adequate and thorough sex education including attitudes as well as physical facts for early adolescents would cut down on the incidence of abortions.

Much concern was expressed about the obtaining of adequate information by adolescents, especially when they were sexually active.

> I see girls 15 to 18 years old in my office who haven't used (birth control) methods and do not know about them.
>
> • • •
>
> It would be helpful if the law was changed to allow (doctors) to prescribe oral contraceptives for 14 year old patients without parental consent and without fear of litigation.
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> As far as contraceptive counselling to teenagers, I feel that when a patient is at risk, irrespective of age, contraceptive advice should be given. If a 14 or 15 year old is referred for advice, specifically for this or is inherited as a result of termination, contraceptive advice is given freely almost invariably with the knowledge of the parents.
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> If it appears intercourse is likely or has occurred, I counsel at *any* age with or without parental knowledge.

The physicians in the national physician survey were asked under what circumstances they would recommend the sterilization of patients seeking abortion. The categories listed were if such a patient: (1) had borne two or more illegitimate children; (2) had two or more abortions; (3) was 40 years or older and had the desired number of children; or (4) would never recommend a sterilization associated with an abortion.

> I believe the state has a right to expect no woman will need more than *one* therapeutic abortion in her lifetime, *if* she has access to adequate counselling and sterilization.
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> Birth control information should be more easily available and sterilization for older couples more widely promoted.
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> Any woman having a second therapeutic abortion should be offered an operation for surgical sterilization and if she refuses she should only be given the privilege of having a further therapeutic abortion if there is a threat to her physical health or a chance of her baby being deformed.
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> Sterilization must never become a condition even if a woman is seeking abortion more than one time. ***But*** it should be again a medical and social decision by the doctor and the woman.
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> The abortion committees should perform far more abortions and sterilizations on parasitic and inadequate families and make the well-to-do pay well for their too easy access to securing what they want whereas many poor cannot secure the help they need.
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> In the recent past sterilization has been recommended as a condition of abortion in some cases but this has not occurred since complaints from the Status of Women Council.

About a third (34.8 percent) of the physicians said they would recommend sterilization for a woman who had two or more illegitimate children. Half (48.9 percent) would do the same for a woman who had had two or more abortions. The majority (81.5 percent) were prepared to suggest sterilization for a woman who was 40 years or older who had completed her family. Only 1 out of 10 (9.6 percent) said they would never recommend sterilization at the time of an abortion.

Younger physicians (25 to 34 years) were more prepared to recommend sterilization for women 40 years or older who felt they had completed their families, while older physicians (65 or over) were the least likely to make such recommendations. One-quarter of the physicians aged 65 years or over would never recommend sterilization at this time. Physicians of both sexes were in close agreement when they would recommend sterilization. Almost half of the

Protestant physicians were prepared to recommend sterilization if a woman had two or more illegitimate children. Jewish physicians less often held this view. More of the Protestant physicians were willing to advise the sterilization of women who had had two or more abortions, while fewer of the Jewish physicians endorsed this course. Most of the Protestant physicians favoured the sterilization of a woman 40 years or over who had completed her family, while Catholic physicians were somewhat less apt to make this decision. More Catholic physicians than physicians of other faiths said they would never recommend sterilization at the time of an abortion (16.9 percent).

Half of the physicians in British Columbia (48.1 percent) would recommend the sterilization of women who had had two or more out-of-wedlock children. This recommendation would be made by a third (31.9 percent) of physicians in Quebec who were in the survey. The highest proportion of physicians recommending sterilization for women who had had two or more abortions was among physicians in the Prairies (60.1 percent) and was the lowest among Quebec physicians (46.1 percent). Physicians living in the Prairies were the most likely to advise a sterilization for a woman 40 years or older who had completed her family. Obstetrician-gynaecologists were a little more likely to recommend sterilization for women with two or more illegitimate children (43.1 percent versus 38.9 percent) and for women 40 years or over who had completed their families (89.1 percent versus 86.6 percent) than were family practitioners. Both groups of physicians held the same views about advising the sterilization of women who had had two or more abortions (55.7 percent and 54.2 percent). Family practitioners were somewhat less willing to advise sterilization at the time of the abortion operation than obstetrician-gynaecologists (13.3 percent and 7.9 percent).

From the information which is available, it is apparent that the sterilization of women and men has become more extensive at present than in the past. This decision involves at least two parties—a patient and a physician, and often as well the decision of a spouse or a partner. **The implications in the findings from the national physician survey suggest that more physicians in the future than at present may be prepared to advise patients to have the sterilization operation. This trend may be indicated by the higher proportion of young physicians who were prepared to advise their patients along these lines.** How these decisions were reached, as indicated in the national patient survey, did not uniformly affect all abortion patients. Because sterilization represents a permanent form of contraception, the emerging trends have profound implications for the future growth of the Canadian population and the selective patterns of growth for some groups and some regions of the country.

## Opinions of the abortion law

In obtaining more detailed information about the views and experience of physicians with induced abortion, several general questions were asked in the national physician survey about their opinions of the current legislation. **Over**

**half of the physicians (56.2 percent) wanted therapeutic abortion to be removed from the Criminal Code, 35.5 percent favoured the present arrangement, and the remainder either gave no reply or said they had no opinion on this issue.** Perhaps more than any other item in the national physician survey, this question resulted in strongly voiced comments.

> Abortion is a medical issue and the only applicable laws should be those regarding malpractice and incompetence. Otherwise the law should not interfere.
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> Remove it from the Criminal Code (it is a medical decision) and treat it as any other medical problem, College of Physicians and Surgeons and Ethics, etc . . .
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> . . . I would strongly recommend that the procedures for therapeutic abortion be removed from the Canadian Criminal Code or from any area where such a matter can be tampered with, depending on the political winds of the time.
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> If therapeutic abortion (is) taken out of the Criminal Code, I feel it leaves it open to individual interpretation, and money-making abuses.
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> The government must concern itself with the welfare of the foetus. The issue must not be removed from the Canadian Criminal Code.

Opinions on this issue varied most by the age and religion of physicians. Two out of three (63.4 percent) of the younger physicians (25 to 34 years) wanted abortion to be removed from the law, while this view was expressed by about half (52.4 percent) of physicians who were 65 years or older. A majority of Jewish physicians (84.1 percent), about two-thirds of Protestant physicians (65.4 percent), and less than half of the Catholic physicians (44.5 percent) held this view.

**About a fifth (21.2 percent) of the physicians said the present law was too liberal in its terms, 39.0 percent said it was too restrictive, and 30.4 percent endorsed the present arrangement.** The remainder were undecided or they did not reply. While the exact proportions varied, these opinions varied by the age, religious affiliation, and the type of work which was done. **While 3 out of 5 physicians (60.2 percent) were dissatisfied with the current legislation, there was no unanimity on this point.**

> The laws are too liberal both in law and practice.
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> The law disregards the value of human life in utero.
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> The law as it stands is reasonable, but its interpretation appears to vary.

I think the system in Canada is sufficiently flexible to allow all of us to satisfy our conscience and at the same time enable those women who really need abortion to have one.

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The law pertaining to abortion as it stands seems to work well.

• • •

The issue as it now stands is restrictive . . .

• • •

. . . I think the present abortion laws in Canada are too restrictive and that liberalization is urgently required.

• • •

I stand for the liberalization of legislation on therapeutic abortion . . .

• • •

In my opinion the laws are too restrictive.

**When they were asked where first-trimester abortions should be performed, two-thirds (63.5 percent) of the physicians endorsed a hospital day-surgery unit, followed by in-hospital patient service (51.6 percent). A fifth (21.0 percent) said this procedure could be effectively handled in a community clinic, and less than 1 out of 10 (8.0 percent) said this operation should be done in a physician's office.**[4]

The law stipulates abortions in the first-trimester must be done in hospital. In many hospitals this means general anaesthesia. Nosocomial (hospital acquired) infections occur in 2 to 13 percent of patients. The complication rate for general anaesthesia is around 5 percent. As a result, the complication rate reported for first-trimester abortions is in the neighborhood of 7 to 10 percent. In contrast, the complication rate for first-trimester abortions done in an office setting is less than 1 percent with newer techniques utilizing local anaesthesia. This phenomenon has been documented in the U.S. by the Joint Program for the Study of Abortion receiving reports from 66 institutions. It has also been considered by the U.S. Supreme Court in their historic decision to make abortion a matter only between patient and doctor in the first three months. Our law, therefore, is bad when it decrees that first-trimester abortions must be done under less safe conditions than would be the case if office abortions were allowed.

• • •

We should remove (therapeutic abortion) from the active treatment hospitals to some special abortion clinics in the community that have a broader interest than abortion, i.e., that are active in contraceptive and sexual counselling.

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Abortion is one area of medical practice where a central community clinic with appropriate paramedical counsellors and sessionally paid qualified doctors doing the procedure would be an advance over the present system of private practice and doing procedures in hospitals.

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[4] Replies non-accumulative as more than one response could be given.

> . . . I feel full hospital facilities should be available including possible blood transfusion.
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> Making abortions possible outside of hospitals would be a very retrogressive step.
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> I would urge more readily available facilities in the present general hospitals. I feel only doctors (who) are capable of handling any complications that might arise, e.g., perforation of uterus, should do the procedure.

On its site visits to hospitals across Canada, the Committee found broad support for the options endorsed in the national physician survey and, in particular, for designated day-care specialty units based at hospitals for first-trimester abortions. To maintain a standard of excellence, it was felt that this procedure required hospital-type services and facilities, and when these were available, the procedure should be done on a day-care basis. The option of doing this procedure in a physician's office was widely rejected on the basis that there would be an insufficient professional review of the type and the quality of medical care provided, and in the event of unforeseen complications, the required services would be less readily available.