Chapter 11

Hospital Committees

In its Terms of Reference the Committee was instructed to examine "the criteria being applied by therapeutic abortion committees". The Committee drew upon two sources of information in its review of these terms. In the national hospital survey, all hospitals with therapeutic abortion committees were requested to provide information about: the staffing and the membership of these committees; the requirements set for abortion patients; the guidelines used in the review of applications for an abortion; and the disposition of patient charts. Of the total of 271 hospitals across Canada in 1976 which had established committees, 209 hospitals, or 77.1 percent, returned completed questionnaires. The Committee also drew upon information about the operation of these committees from its site visits to 140 hospitals across Canada. On these visits with senior hospital staff, the Committee met with the chairman and/or members of each hospital's therapeutic abortion committee. Like other findings obtained by the Committee involving the views and experience of the public, the opinions and patterns of practice of physicians, and the attributes of induced abortion patients, there were consistent broader trends in how these committees were organized and how they worked. To preclude the identification of hospitals with committees in the Yukon and the Northwest Territories, their replies were grouped with the findings obtained for British Columbia.

Size and specialty

The average membership of the therapeutic abortion committees from which information was obtained was five physicians. There were marked east-to-west trends in the average size of the committees and their composition. Committees were generally larger in eastern Canada than in western Canada, with the average membership being almost six physicians (5.6 physicians) in the Maritimes and about four physicians (3.9 physicians) in British Columbia. There were regional differences in the composition of these committees by the medical specialties of their members. In the Maritimes and Quebec, specialists outnumbered family physicians by ratios of over 2 to 1 and 4 to 1 respectively.

There was about an equal balance between family physicians and specialists on these committees in Ontario hospitals. The trend shifted in the opposite direction in the Prairies and British Columbia where family physicians usually outnumbered specialists on hospital therapeutic abortion committees. In a number of hospitals visited by the Committee, social workers and other personnel served as working members of therapeutic abortion committees, and on occasion had voting privileges in decisions about abortion patient applications.

What these trends about committee size and their composition show is that there were regional differences in how hospitals across the country interpreted their professional responsibilities relating to the review of abortion applications. Not only were more physicians usually involved in this process in eastern Canada, but this decision was less seldom entrusted to the judgment of family physicians. In the eastern provinces there was a more frequent appointment of obstetrician-gynaecologists, psychiatrists, and other medical specialists than was the case in the West, where fewer of these specialists were involved in the review of abortion applications. The different composition of these committees across the country had implications for the types of decisions which were reached concerning the disposition of abortion applications and in the extent to which physicians in different specialties could be expected to have had first-hand experience with the problems of women seeking abortions.

TABLE 11.1

MEMBERSHIP BY MEDICAL SPECIALTY OF COMMITTEES BY REGION

NATIONAL HOSPITAL SURVEY

Region of Country	Medical Specialty					
	Family Medicine	Obstetrics & Gynaecology	Psychiatry	General Surgery	Other Specialists	Average Size of Committee
Maritimes	2.4	0.6	0.9	0.2	1.5	5.6
Quebec	1.2	1.4	0.6	0.4	1.6	5.2
Ontario	3.2	0.6	0.3	0.3	1.1	5.5
Prairies	3.1	0.2	0.3	0.2	0.4	4.2
British Columbia	2.5	0.1	0.2	0.3	0.8	3.9
CANADA	2.8	0.5	0.4	0.3	1.0	5.0

Two medical disciplines in particular are closely involved with induced abortion patients. Because of the broad nature of their practices, family physicians are often the first physicians to whom women turn who have unwanted pregnancies. Obstetrician-gynaecologists are involved to a lesser extent at this early stage. Their involvement with abortion patients usually results from a referral and in the actual performance of the induced abortion operation. Because the composition of the therapeutic abortion committees

differed across the country, more physicians who reviewed abortion applications in eastern Canada had less likelihood of direct contact and involvement with these patients than was the case in western Canada. The decisions which were reached by these differently balanced committees and the guidelines which were followed contributed in part to making this procedure more accessible in western Canada than in eastern Canada.

Types of appointments

In virtually all hospitals medical staff appointments to committees are made on the recommendations of medical advisory committees and on occasion as in the case of therapeutic abortion committees, nominations are made by the hospital administrators and the presidents of the medical staff. These nominees are then appointed by the hospital board, usually on an annual basis. In the national hospital survey, 94.7 percent of the members of therapeutic abortion committees were reported to have had annual appointments. Where this was not the case, it usually reflected the fact that a hospital received few abortion applications. In these instances such committees may be struck to review single applications. A third of the therapeutic abortion committees in the Maritimes (33.3 percent) and 1 out of 5 in Quebec (20.0 percent) followed this appointment procedure. It occurred in none of the other provinces among committees for which information was obtained. About 2 out of 5 committees (40.9 percent) made provisions for alternate members in the event that a committee member was absent. This procedure was done more often in Ontario (52.9 percent) and British Columbia (55.0 percent). It was more unusual in the Prairies (22.7 percent) or the Maritimes (16.7 percent). This arrangement was made in 40.0 percent of the committees which were surveyed in Quebec.

Another procedure, one done less often, was the appointment of a large slate of committee members who served on a rotating basis. This arrangement made by 32.9 percent of the committees was done either to share the work load when many applications had to be reviewed or to provide an opportunity for staff members who served on this rotating basis to perform therapeutic abortions when they were not actually working as a committee member in reviewing applications. This procedure was followed in several hospitals visited by the Committee. When such appointments were made on an annual basis and such medical staff performed abortions when they were not actually involved in the review of abortion applications, this procedure raised a question about how the intent of the Abortion Law was interpreted in these instances. The Abortion Law stipulates that "a qualified medical practitioner, other than a member of a therapeutic abortion committee for any hospital" may procure a miscarriage if the approval for the abortion procedure has been made by a duly constituted therapeutic abortion committee. When the arrangement occurs involving a rotating membership with appointments made on an annual basis and where physicians with such appointments perform abortions while not being directly involved in the review of applications, this arrangement may constitute a breach of the law. Because the members of the Committee were

received as guests on their visits to hospitals, it was not feasible to review the minutes of hospital board meetings to verify whether in all instances short-term appointments to therapeutic abortion committees were ratified within the requisite time period. The Committee has reasonable doubt that this was always the case. As there has been no detailed recent review of the work and appointment procedures of therapeutic abortion committees by provincial health authorities, a step whose feasibility is allowed for in the Abortion Law, there was no information from these sources on this matter.

In the national hospital survey, hospitals were asked if they had had any organizational problems involving the work of therapeutic abortion committees. About a third of the hospitals (31.6 percent) had had none. Most of the hospitals which gave this answer were in the Maritimes (60.0 percent), Quebec (37.5 percent), and Ontario (34.8 percent). In contrast, more hospitals in the Prairies and British Columbia cited specific problems associated with the work of these committees which in part reflected the larger volume of abortion applications which were reviewed. Two out of five committees in British Columbia (40.0 percent) said that there were too few committee members involved in the review of abortion applications and for 1 out of 4 (23.5 percent), the frequency of committee meetings was a problem. In comparison, in the Maritimes and Quebec where on an average fewer abortion applications were reviewed, these problems either did not occur or were cited by only a few of the hospitals. None of the hospitals which were surveyed in the Maritimes had problems with the volume of work or the frequency of meetings, and for only 7.1 percent, there were difficulties in making arrangements for the scheduling and the sites of the meetings. Fewer than 1 out of 15 of the hospitals with therapeutic abortion committees in Quebec cited these problems (frequency of meetings, meeting site, volume of work, or small committee size). About 1 out of 5 hospitals with committees in Ontario had difficulties involving the frequency of committee meetings (19.2 percent) and the small membership of the committee (17.1 percent). Reflecting the east-to-west increase in the reported prevalence of therapeutic abortions which were performed and to an extent the greater distances involved, hospitals in the Prairies had more difficulties in scheduling committee meetings than eastern hospitals, but had fewer problems in this respect than hospitals in British Columbia where the highest proportional number of induced abortions were done. A third of the hospitals with committees in Manitoba, Saskatchewan, and Alberta said there had been problems with arranging committee meetings (32.1 percent). The volume of work was an issue for 15.4 percent of these Prairie hospital committees, and they had had about the average difficulties (7.7 percent) in arranging a convenient site for committee meetings.

The therapeutic abortion committees at about 1 out of 10 hospitals visited by the Committee did not routinely schedule meetings which were attended by committee members. In these instances several different courses were taken, the most common being the review of abortion applications which were kept in a central location where they were reviewed by physicians when they came to the hospital, or alternately, these applications were routed to physicians' offices to be reviewed. In those cases where there was no discussion of abortion applications and committee members held different views about the abortion

procedure, there was an element of chance about the decision which was reached about each application, one which depended upon the first three physicians who happened to review an application. In some instances where one or two physicians rejected an application, the chairman of the committee telephoned members about the decision which had been reached.

The length of time which it took members of therapeutic abortion committees to review applications varied greatly. At some of the hospitals which were visited by the Committee, several hours were involved in the review of each abortion application which had been submitted by a physician for a woman seeking this operation. In one case such a review required several meetings over a period of a week. At the other extreme there were a number of hospitals where all of the applications which were received were virtually automatically approved. In these cases where the acknowledged purpose of the meetings was to meet the "letter of the law", the review of abortion applications was a perfunctory ritual involving a minimal amount of time, usually just enough to see a case application and to affix the requisite signatures.

Interpretation of terms

The work of therapeutic abortion committees may involve *guidelines* upon which decisions are based in the review of abortion applications, and *requirements* which may be set for patients to meet before their applications are considered by these committees. In each instance these guidelines and requirements may result from an informal consensus reached among committee members, or constitute endorsed written statements outlining specific procedures to be followed. In the national hospital survey involving the work of therapeutic abortion committees, 89.9 percent had requirements involving patients and 83.5 percent used known guidelines in the review of abortion applications.

The only criterion for the assessment of a request for a therapeutic abortion given by the Abortion Law is that the continuation of the pregnancy of a female person (who is seeking an abortion) would or would be likely to endanger her life or health. The interpretation of this criterion is left to the members of a therapeutic abortion committee since paragraph 4(c) of section 251 of the Criminal Code uses, referring to the decision of the therapeutic abortion committee, the phrase "in its opinion". The actual wording of this criterion of assessment, and in particular the words: (1) *would* or *would be likely;* (2) *endanger;* (3) *life;* and (4) *health,* allows for a great breadth of interpretation and considerable discretion in what is meant by these terms. Considering the latitude of what these terms may mean in medical science and the imprecise knowledge of what complications affecting a person's health may be at stake, a variable emphasis can be, and in practice was, given in the interpretation of these terms. These general terms which are not further specified in the Abortion Law were seen and acted upon differently in various parts of the country, often in a contrasting fashion by hospitals in the same

locality, and even by the therapeutic abortion committee of a particular hospital whenever its membership changed. How their scope was defined was determined by the canons of local medical custom, and in turn, these norms were broadly set by the varying social values relating to abortion in different regions.

In its phrasing the Abortion Law uses the conditional tense, that a committee considers whether the continuation of the pregnancy *would or would be likely* to endanger a woman's health. This phrasing allows for such a threat to be seen in terms of its immediate consequences or its long-range impact on health which may encompass a woman's total life span. In practice, the Committee found that the full range of the potential interpretations of this phrase were adopted by different hospitals. There was no consensus on this point either in the work of the therapeutic abortion committees for which information was obtained or in the opinions of physicians which were obtained in the national physician survey.

The verb *to endanger* in its common usage is often taken to mean that a situation is serious enough to alter and to affect negatively the *status quo.* When this word is used in the context of a person's health, the idea of danger suggests that complications may be involved now or in the future which will result in risks or a deterioration of the existing state of a person's health. Its implications in terms of ensuing health complications may be immediate or long-term. The probability of danger is also involved in the interpretation of Abortion Law as the word *likely* is used which may range from being a virtual certainty to an unknown and an infrequently occurring outcome. The interpretation of this term as it relates to potential health complications can and does vary according to different patterns of medical practice, and it is indelibly affected in the case of induced abortion by the moral position and the professional ethics of the members of a particular therapeutic abortion committee. What constitutes danger to a woman's health in a review of her application for an induced abortion lies very much in the eyes of the beholder. There was no consensus among the members of the medical profession whose opinions were obtained on this point, and in the case of what dangers might be involved in the future, their actual proportions at the present time cannot be established with any exactness on an *a priori* basis.

In its work the Committee found that while its exact dimensions were imprecise, there was broad unanimity about what was involved if the continuation of a pregnancy posed a direct danger to a woman's *life.* While it was felt that in the past such a threat occurred more frequently, and in some instances it was affected by associated disease symptoms, there was a consensus among the hospitals which were visited, the reports received from other hospitals, and in the opinion of physicians in the national physician survey that at the present time the continuation of a pregnancy for the great majority of women posed little immediate threat to their lives. This judgment was verified by the declining maternal death rate in recent years in Canada, a change more broadly affected by a rising standard of living, a national health care system which is one of the most comprehensive in the world, earlier and more effective medical treatment provided now than in the past by a larger number of

obstetrician-gynaecologists, and in part, from the reduction of self-induced or other illegally obtained abortions.

But it was in the definition of what was meant by *health* that there was considerable ambiguity and a selective interpretation which was rarely more apparent than when the issue of induced abortion was involved. In considering the various aspects of health the *Dictionnaire Robert* for instance defines health as the physiological soundness of the body or the regular and harmonious functioning of the human organism over an appreciable period of time. This definition also includes the meaning of health as involving a balance and a harmony of a person's psychic life. The *Oxford Universal Dictionary* defines health along similar lines as "the soundness of body" or "that condition in which its functions are duly discharged". Derivative meanings included in this lexical source relate to healing and the spiritual, moral, or mental soundness of an individual.

Rape and incest are considered as indictable offenses in the Criminal Code,[1] but are not specifically mentioned in the Abortion Law as indications for therapeutic abortion. However, in practice, if the consequences of these actions were seen to affect a woman's health, then these ethical reasons were considered by most therapeutic abortion committees as a justification, depending upon the definition of health which was adopted, for the approval of a request for the termination of a pregnancy.

The concept of health can also be understood in the sense that it affects the health of a family. In this interpretation of the word, the idea of health involves not only a pregnant woman, but the health of her partner and her children. The Abortion Law does not explicitly recognize that the danger to the health of the family of a pregnant woman may be a reason to justify the approval for an induced abortion by a therapeutic abortion committee. Equally, in the absence of an explicit definition of health and depending upon what definition of health is adopted, this situation is not excluded.

Another possible indication which is not provided for in the Abortion Law concerns the possibility of physical or mental abnormalities in the foetus. The Committee was asked in its Terms of Reference to determine if "the likelihood or certainty of defect in the foetus (was) being accepted as sufficient indication for abortion". In medical practice this condition cannot usually be established with accuracy by means of amniocentesis at major hospital centres until about the sixteenth week of gestation. Its determination requires medical technology and specialist judgment which are not found in all Canadian hospitals. As the possibility of this outcome can affect a mother's mental health, when this condition has been established, this assumption was made by some therapeutic abortion committees as a sufficient reason for the approval of an abortion application.

In general, the health professions and all levels of government endorse a broad interpretation of health that encompasses the physical, mental, and social well-being of Canadians. This fact is manifest in the wide range of

[1] Criminal Code, s. 143, 144 and 145 (rape) and s. 150 (incest).

programs which have been mounted in the public interest and which range from a recognition of the need for comprehensive prenatal and postnatal care, the complete rehabilitation of patients to the care of the elderly person. These principles are anchored in the operation of social security measures and are endorsed in the payment procedures of hospital and medical care insurance for diseases which are physical, mental, and social in nature.

TABLE 11.2

STATEMENTS ON DEFINITION OF HEALTH
BY PROVINCIAL AND FEDERAL HEALTH DEPARTMENTS

Level of Government	Statement of Operational Definition of Health
Newfoundland	No formal statement. The World Health Organization definition is referred to.
Prince Edward Island	None.
Nova Scotia	Uses World Health Organization definition.
New Brunswick	Operational definition of health is that of the World Health Organization.
Quebec	No operational definition of health.
Ontario	No general statement.
Manitoba	Use of World Health Organization definition in all instances.
Saskatchewan	None.
Alberta	No general statement.
British Columbia	Uses World Health Organization definition.
Government of Canada	The World Health Organization definition is considered in a conceptual sense, but it is not formally ratified by the Department of National Health and Welfare.

Sources: Replies to an inquiry by the Committee which asked: "Does the Department have a general statement and/or operational definition of the concept of health?"

In its inquiry the Committee asked each provincial health authority and the federal Department of National Health and Welfare if they endorsed a formal definition of health upon which their program activities for the public were derived. The provincial health programs in six provinces were not based on such a known or stated principle. The word *health* in the titles of these provincial agencies derived by implication from the scope of the services which were provided, which in most instances were indeed broad in scope. In four provinces, Nova Scotia, New Brunswick, Manitoba, and British Columbia, the definition of health of the World Health Organization was used by provincial health authorities.

The federal Department of National Health and Welfare considers the World Health Organization's definition "in a conceptual sense", but the Department "has not formally ratified" this definition. The federal Department's reply to the Committee on this point was:

It would not be appropriate for the Department to adopt a definition of Health in any formal or legalistic sense. In general, the World Health Organization definition of Health is considered in a conceptual sense, although it is recognized that its precise application is difficult. The acceptance of this definition by the Department has not been formally ratified.

At the operational level regarding therapeutic abortion, the interpretation of the word "health" is dependent on the meaning ascribed to it by members of a hospital therapeutic committee. In some situations, guidelines may be provided by the province or the hospital concerned to members of the therapeutic abortion committee, in others, members may use their own judgment as to what they consider to be the meaning of health. Some members of therapeutic abortion committees consider that the words "social well-being" should be included as part of health, others feel differently. The final decision as to what constitutes health is considered at provincial or hospital levels where the operational components of the abortion services take place. In this context, the interpretation of the word health has been intentionally left by those who designed the legislation to the judgment of the members of a local hospital therapeutic abortion committee.

On several occasions the General Council of the Canadian Medical Association has considered the question of a definition of health. In 1972 for instance that Association's Council on Community Health was directed "to develop a suitable definition of health" for the purpose of the provision of health services in Canada. Subsequently, a number of different definitions were reviewed, none of which was endorsed, including one containing slight modifications of the World Health Organization's definition.[2]

As one of the founding members of the United Nations, Canada subsequently ratified the constitution of this international body's health agency, the World Health Organization. In taking this step the Government of Canada acknowledged the following definition: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[3] The Committee knows of no other formal definition of health which has been endorsed by provincial legislatures.

The comprehensive definition of health of the World Health Organization encompasses several levels of the functions of individuals including the following states: physical, mental, social, ethical, family, and eugenic. Because each of these functions may be interrelated and affect each other, it is not always possible in practice to distinguish where one factor affecting a person's health merges into another etiological cause. While there is broad agreement about the general principles of what constitutes good health, there has often been the feeling that specific definitions either may set unattainable objectives or be impractical in medical practice or the organization of health services. It is for these reasons that there has been much difficulty in defining health more explicitly.

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[2] *Canadian Medical Association General Council Transactions*, June, 1973: Definition of Health. The defeated resolution was: "Health is the state of physical, mental, and social well-being, and not merely the absence of disease and infirmity". Where this last resolution differs from the World Health Organization's definition is indicated by the underlined sections, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

[3] *Constitution of the World Health Organization*, ratified on July 22, 1946, and amended at the 12th World Health Assembly, Resolution WHO, 12.43, which went in effect on October 25, 1960.

The anomaly has not been resolved that while Canada is spending considerable sums of public monies on health care, these various programs are defined in terms of the services which may or may not be provided, not in terms of a clearcut statement of the state of good health which is to be achieved. Considerable discretion at every stage of medical treatment is left to decisions about what hospital and medical services will or will not be paid for under national health insurance, what conditions are classified by provincial medical fee schedules or disease classification systems, and at the primary level of medical care for what conditions physicians choose to provide medical treatment. In this situation involving much ambiguity and **in the absence of a legislative definition, the word "health" which is used in the Abortion Law may be considered to include the meaning of health defined in the *Constitution of the World Health Organization,* and the amendments brought thereto.**

Indications for induced abortion

The Committee obtained information from a broad cross-section of Canadians on what they thought about the circumstances when an induced abortion should be performed. Their replies were divided into nine categories which ranged from the opinion that under no circumstances should an induced abortion be done to the viewpoint that this operation should be permitted whenever a woman requested it. The seven other indications included options such as when the pregnancy had resulted from rape or incest, or where there were felt to be physical, mental, and social circumstances which might endanger a woman's health and the possibility of a foetal abnormality.

Most of the women and men who were interviewed felt that induced abortions should be permitted under certain circumstances, and most persons endorsed more than two indications.

Number of Endorsed Indications	Women	Men
	%	%
none	11.4	9.8
one	17.8	22.6
two	9.2	7.9
three	14.0	10.8
four	17.8	16.1
five	10.8	12.3
six	8.7	8.9
seven	5.6	6.7
eight	4.7	4.9
TOTAL	100.0	100.0

Individuals who held contrasting views on this issue were in the minority across the country and among all groups whose opinions were obtained. **About**

1 out of 10 women (11.4 percent) and men (9.8 percent) said that an induced abortion should never be performed. More individuals, but still a minority, held the opposite viewpoint. Among the individuals in the national population survey, **15.8 percent of women and 23.2 percent of men said that an induced abortion should be performed whenever such a request was made by a woman.** Taken together, these two contrasting viewpoints were held by about 1 out of 4 women (27.2 percent) and 1 out of 3 men (33.0 percent). **Three-quarters of the women and two-thirds of the men did not endorse either of these two positions, but they felt that this operation should be performed under specific circumstances which were related to an assessment of the impact of an unwanted pregnancy on a woman's life or her health.**

The indications which were given when an induced abortion should performed, with minor variations,. were similar for women and men. With the exception of persons who said that an induced abortion should never be performed, individuals who answered this question chose one or more of the eight listed categories.[4]

Indications for Induced Abortion	Women	Men
	%	%
danger to woman's life	71.0	66.8
rape, incest	61.7	58.7
danger to woman's mental health	58.9	56.6
physicial deformity of the foetus	53.2	49.4
on request when less than 12 weeks pregnant	23.7	27.3
economic circumstances	21.8	21.7
to prevent an illegitimate birth	17.6	19.3
on request by a woman at any time	15.8	23.2
should never be done	11.4	9.8

Two physical and mental health indications were endorsed by over half of all individuals in the survey, with two-thirds of the women and men giving priority to an induced abortion being performed when it was felt her life would be endangered, or when a pregnancy had resulted from rape or incest. Four social health indications were endorsed by on an average of less than 1 out of 4 individuals. These indications were:

—when a women who was less than 12 weeks pregnant requested an abortion;

—when there was an economic inability to support a child;

—to prevent the birth of an illegitimate child; and

—whenever a woman requested an induced abortion.

The Abortion Law makes no provision concerning the possibility of a physical deformity or a congenital anomaly of a foetus. One of the Terms of Reference for the Committee was: "to what extent is the condition of danger to

[4] For this reason their answers total more than 100 percent.

mental health being interpreted too liberally or in an overly-restrictive manner, and is the likelihood or certainty of defect in the foetus being accepted as sufficient indication for abortion?" Three out of five women and over half of the men said that an induced abortion was indicated when it was felt that a woman's mental health was endangered. Half of the women and men felt this operation should be done when there was a possibility of physical deformity of the foetus.

Between the two polar views about induced abortion—that it should never be done or it should be allowed whenever a woman requested it, there were two broad categories of indications which were endorsed by most women and men across the country. In each instance persons citing these indications endorsed the principle that induced abortion should be permitted but under different circumstances. These views were in support of: (1) physical and mental health; and (2) social health indications. In a detailed statistical analysis of these views on induced abortion[5], it was found that assumptions which are commonly held did not explain why people held these two different opinions. These two different outlooks on induced abortion were influenced little in the aggregate by a person's age, sex, level of education or income, religious affiliation, the usual language which was spoken or where they lived in the nation. These traditional assumptions associated with differences in the opinions which people hold did not explain why a majority of women and men in the national population survey endorsed the seven indications either for physical and mental health or for social health for an induced abortion.

What these results mean, based on these findings, is that the decision about the indications which are endorsed for induced abortion are very much a personal decision. Taking a person's full circumstances into account, no easy prediction can be made for the average woman or man from whom this information was obtained about their opinions on the indications for induced abortion. Each of these two perspectives, support for physical health indications and social health indications, appear to command considerable support. They account in part for the wide range of options which were found to exist in the hospital practices involving the abortion procedure.

Requirements of committees

Most of the therapeutic abortion committees (89.9 percent) about which the Committee had information had established requirements to be met by women seeking approval for an induced abortion. Among the 209 hospitals with therapeutic abortion committees which provided information to the Committee, the average committee had four requirements (3.9) with the range being from: 10.1 percent, none; 24.4 percent, 1 to 3 requirements; 50.2 percent, 4 to 6 requirements; and 15.3 percent, 7 to 11 requirements. Three hospitals had nine requirements and one hospital had 11 requirements.

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

The hospitals with committees in Ontario on an average set the fewest requirements (3.1) followed by: Newfoundland (3.4); Prince Edward Island (3.5); Alberta (4.2); Nova Scotia (4.3); Saskatchewan (4.5); Quebec (4.6); British Columbia (4.7); New Brunswick (5.0); and Manitoba (5.2). To the extent that these requirements represented in each instance a different consensus of medical judgment, and for the women concerned set fewer or more conditions to be met, they directly determined the relative accessibility of the abortion procedure in different regions of provinces and between different parts of the country. The Committee found on its site visits to hospitals that how closely these stipultated requirements were adhered to varied considerably between hospitals which apparently had the same requirements, and that the number of requirements by themselves were not a complete measure of how abortion applications were reviewed.

Virtually all of the therapeutic abortion committees required written documentation (97.8 percent) in their review of abortion applications. For the few hospitals where this was not done, physicians who submitted applications on behalf of their patients, and in some instances the patients themselves, gave information orally to committee members when their applications were being considered. **Two-thirds of the hospitals (68.4 percent) required the consent of the woman's spouse and 1 out of 5 hospitals (18.4 percent) required the consent of a spouse, if the couple was separated prior to the abortion procedure being performed.** Two out of five hospitals (38.2 percent) considered only applications from women who were considered to reside within the hospital's usual service catchment area. **Residential requirements and patient quotas were more often adopted in the Maritimes (43.8 percent) and Quebec (66.7 percent) than among hospitals elsewhere where about a third followed this practice. Where the proportion of the hospitals with committees having these residency or quota requirements was higher in a province or a region, there were proportionately more women who went to the United States to obtain induced abortions.**

Among the hospitals which were visited by the Committee, the major reasons for the setting of residency requirements or actual quotas on the number of induced abortions to be done were to put limits on what was seen as an excessive use of the facilities, to maintain a balance between service and training functions, and less often, as a means of exerting pressure on other local hospitals to do this procedure more extensively. In only a few instances did the quota strategy serve its intent of persuading other local or regional hospitals either to do the abortion procedure or to assume what was felt to be "their share" of the abortion patients. In most cases where this happened, women seeking an induced abortion either went directly to another urban centre, or more often to the United States.

In one hospital visited by the Committee in the Maritimes, the residency requirement was strictly invoked because the hospital had received a large number of applications from the region. It was felt that if these applications were approved, the balance of the hospital's services would be destroyed. The only exception to this rule at this hospital was when a personal request was made by a physician whose practice was outside of the hospital's defined patient catchment area.

TABLE 11.3

COMMITTEE REQUIREMENTS PRIOR TO REVIEW OF ABORTION APPLICATIONS BY REGION

NATIONAL HOSPITAL SURVEY

Region of Country	Committee Requirements for Review of Applications											
	Written Documentation	Consent of Spouse	Consent of Spouse if Separated	Residence	Length of Gestation	Specialist Consultation	Specialist Consultation over 14 weeks gestation	Social Service Review	Interview with Patient	Test for Congenital Damage	Contraceptive Counselling	Average Number of Requirements
	percent											
Maritimes	100.0	72.2	28.6	43.8	81.3	57.1	38.5	25.0	15.4	33.3	58.3	4.1
Quebec	100.0	66.7	8.3	66.7	100.0	93.3	42.9	46.2	0.0	35.7	33.3	4.6
Ontario	94.4	62.7	15.2	36.1	84.1	71.0	49.1	22.0	9.8	30.5	45.0	3.1
Prairies	100.0	68.8	20.0	31.0	87.5	50.0	55.2	17.2	25.8	30.0	55.2	4.6
British Columbia	100.0	76.9	22.2	33.3	94.7	42.9	71.9	12.1	9.1	12.5	48.5	4.6
CANADA	97.8	68.4	18.4	38.2	87.4	61.7	53.8	21.2	12.4	27.2	47.7	3.9

Note: Non-accumulative as each committee can have several requirements. Of the hospitals surveyed, 89.9 percent had specific requirements prior to the review of applications.

All of the hospitals which did the majority of therapeutic abortions in Quebec had established patient residency requirements, or had patient referral patterns which had the same effect. Several of these hospitals had specific quotas on the number of abortions which were done. One of these hospitals accepted only patients who lived in its usual service catchment area. Applications with few exceptions at a second hospital were only considered on behalf of patients who lived within a 60 mile radius of the hospital. This requirement was on occasion breached by patients who knew of its existence and who, when submitting an application to a physician, gave a local address. Two large hospitals which until recently had accepted abortion patients from all parts of Quebec as well as the Maritimes had introduced a residency requirement which gave priority to the review of abortion applications to residents of the local city. In effect, the change at these two hospitals limited the extent to which the abortion procedure was done for women who lived outside of this city. In the future, for instance, few applications will be considered at these hospitals for patients who lived in the Maritimes where a substantial number of women in the past had come for this operation.

Three hospitals which did the abortion procedure in Quebec did not have formal residency requirements, but their patient referral procedures had the same effect of limiting where these patients come from. At one of these hospitals only patients referred directly to the therapeutic abortion committee were considered (i.e., no referrals were considered from other hospitals). Two hospitals required that the physicians who submitted abortion applications had hospital staff appointments at these hospitals. Where this was not the case, the applications of patients living in the hospital's service area but who were referred by physicians without staff privileges at these two hospitals were not considered.

Five of the hospitals doing the abortion procedure which were visited by the Committee in Quebec had established quotas on the number of therapeutic abortions which were done. At one of these hospitals where there was an annual quota of 150 abortions, this limit had been established at the request of the obstetrician-gynaecologists on the medical staff on the grounds that the number of hospital beds for this service was limited and the hospital was a university-affiliated teaching centre. The quota of five abortions per week had been set at another hospital, according to the chief of obstetrics and gynaecology, in terms of the staff and technical resources which were available. That hospital's administrator felt the quota had been established because of the strong feelings of reluctance among the staff gynaecologists to do the abortion procedure. At two other hospitals the quotas for the number of abortions done were 15 and 50 per week respectively, limits which had been set relative to the facilities and beds which were made available to do this procedure.

While fewer hospitals which were visited by the Committee in Ontario than had been the case in the Maritimes or Quebec had explicit abortion patient residency requirements, such restrictions were observed by some other measures which were followed. Two hospitals which were visited did have direct residency requirements. A third, while placing no limitations on the number of patients who came from the province, refused to review applications

submitted on behalf of women living in Quebec. The physicians submitting abortion applications at three other hospitals were required to have hospital staff admitting privileges. Five hospitals, all located in large urban centres, had quotas on the number of therapeutic abortions which could be done. These quotas were established either in absolute terms of how many induced abortions could be done or on a basis of how many abortion operations could be done by each staff gynaecologist. Three hospitals in the first category had quotas of 12, 20 and 25 operations per week, while two hospitals set limits for this procedure of four per week and 12 per month for each staff gynaecologist.

Only two hospitals in the Prairies which were visited by the Committee had residency requirements and none had abortion patient quotas. At one hospital a geographical dividing line was drawn which was approximately half way between the city where the hospital was located and another major centre which had a hospital which did the abortion procedure. A directive had been issued at another hospital asking the staff physicians not to refer abortion patients who lived outside of the hospital's usual service area. This decision was based on the number of hospital beds which were made available for this procedure.

Although none of the hospitals which were visited by the Committee in the Prairies had quotas for abortion patients, the chief of obstetrics and gynaecology at one major hospital had considered recommending this policy to the hospital board. This specialist observed to the Committee:

> To maintain our standards as a university teaching hospital and to offer a valid and varied training to our interns and residents in gynaecology, the hospital cannot do only induced abortions and tubal ligations.

None of the hospitals in British Columbia, the Yukon or the Northwest Territories which were visited had quotas for abortion patients and only three of these hospitals had residency requirements. At one of these hospitals the medical staff bylaws stipulated that:

> Patients eligible to have a therapeutic abortion performed at _____ must either have resided in School Districts _____ or _____ for over three consecutive months or have been for the past three months a patient of a physician practising at _____.

The requirement at this hospital had been established because it had been feared that applications for abortion would be received from other regions. At another hospital whose policy was to serve patients within its service area, it was acknowledged that the residency requirement could not be readily enforced as patients, or their physicians on their behalf who were aware of this requirement, altered the addresses to accord with this provision.

From its site visits to hospitals and the findings of the national hospital survey the Committee found that where residency requirements and quotas on the number of induced abortion patients had been adopted, almost without exception these steps had been taken by large hospitals in major urban centres. Most of these hospitals were active in doing a large number of therapeutic abortions. For the most part their administrators and senior medical staff had been reluctant to impose these limits, but they had done so to preserve what

they felt was a necessary balance in the use of hospital gynaecological and surgical treatment facilities. There was a strong current of resentment, often voiced, that other hospitals which were eligible to do this procedure in terms of the scope and the availability of their facilities and the size and specialty complement of their medical staff, were being socially irresponsible by not providing this unwanted hospital service. It was asserted on several occasions that such hospitals lacked courage. By "playing it safe", it was asserted, they were like ostriches with their professional heads in the sand. While recognizing that in the short run the health and convenience of some patients might be jeopardized by their decisions to impose limits, the staff at many of these hospitals which set residency requirements or imposed quotas felt their decisions would serve to exert pressure on other hospitals or on provincial authorities to make other eligible hospitals undertake the abortion procedure.

At the time of this inquiry, the strategy of these hospitals had not achieved their intent. It was the patients who were caught in the institutional squeeze-play who were the most affected. Their decision to obtain an induced abortion was seldom deterred, but the timing of when they obtained this operation was delayed by their search for other available treatment centres. Many of these patients ended up by going to the United States. In terms of the provincial statutes governing hospital and medical care insurance, there may be reasonable doubt about the validity of these residency requirements when they are unilaterally extended concerning the accessibility by patients to hospital services for a single procedure such as induced abortion. The Committee knows of few other instances where similar provisions were made in this fashion by hospitals.

With little regional variation most hospitals with therapeutic abortion committees (87.4 percent) had requirements concerning the length of pregnancy above which the abortion procedure would not be approved. The Abortion Law does not set any maximum time limit within which the abortion procedure can be done. To the Committee's knowledge, from a legal point of view, no laws in Canada have explicitly determined the moment in a pregnancy when a foetus is considered to be viable. One province, Ontario, has a definition of abortion. This definition listed in Regulation 729 under the *Public Hospitals Act* states that an abortion is the termination of a pregnancy before the twentieth week of the period of gestation.[6] Several provinces have definitions of a stillbirth which are provided for in their *Vital Statistics* Acts.[7] These definitions which are almost identical, define a stillbirth as the complete expulsion or extraction from the mother after the twentieth week of pregnancy of a foetus which did not at any time after being completely expelled or extracted from the mother, show any signs of life. Some of these definitions also take the weight of the foetus into consideration (more or less than 500

[6] Ontario, *Regulation 729 under the Public Hospitals Act*, s. 1(a).

[7] Alberta, *The Vital Statistics Act*, R.S.A. 1970, c. 384, s. 2(21); British Columbia, *The Vital Statistics Act*, S.B.C. 1962, c. 66, s. 2; Prince Edward Island, *The Vital Statistics Act*, R.S.P.E.I. 1974 (Vol. II), c. V-6, s. 1(s); Manitoba, *The Vital Statistics Act*, R.S.M. 1970, c. V-60, s. 2(t), as amended; Nova Scotia, *The Vital Statistics Act*, R.S.N.S. 1969, c. 330, s. 1(u); Ontario, *The Vital Statistics Act*, R.S.O. 1970, c. 483 as amended by S.O. 1973, c. 114, s. 1(v); North West Territories, *Vital Statistics Ordinance*, R. O. 1974, c. V-4, s. 2(s); Yukon, *Vital Statistics Ordinance*, R.O.Y.T. 1971, Consolidated to December 31, 1973, c. V-2, s. 2(1) *Stillbirth*.

grams) as a criterion for assessment. In Quebec, section 1.101 of the regulations adopted under the *Public Health Protection Act*[8] provides that a therapeutic abortion must be declared. Without specifying what is meant by therapeutic abortion and stillbirth, information on the number of children of previous pregnancies is requested in Quebec in the declarations of birth, and for the stillborn infants, only those who were stillborn after twenty weeks of pregnancy must be declared. The time which is allowed to transmit the declaration of stillbirth after the confinement in Quebec differs according to whether the foetus weighed more or less than 500 grams. What is implied but not explicitly stated in the various provincial statutes is that a foetus is considered to be viable from the twentieth week onward of pregnancy.

TABLE 11.4

LENGTH OF GESTATION LIMITS SET BY COMMITTEES IN REVIEW OF ABORTION APPLICATIONS: BY REGION*

NATIONAL HOSPITAL SURVEY

Region of Country	Limits on Length of Gestation							
	Never Approve Applications	12 Weeks & Under	13-15 Weeks	16 Weeks	18-19 Weeks	20 Weeks & Under	No Time Limit	Total
	per cent							
Maritimes	6.7	40.0	0.0	0.0	6.7	26.6	20.0	100.0
Quebec	16.7	61.1	5.5	0.0	0.0	16.7	0.0	100.0
Ontario	3.2	46.0	4.8	3.2	9.5	15.9	17.4	100.0
Prairies	0.0	46.4	7.1	0.0	0.0	32.2	14.3	100.0
British Columbia	3.1	40.6	9.4	9.4	9.4	21.9	6.2	100.0
CANADA	4.5	46.2	5.8	3.2	6.4	21.1	12.6	100.0

* The number of hospitals with therapeutic abortion committees replying in the national hospital survey was 209. In 1976, there were 271 hospitals listed by Statistics Canada which had established therapeutic abortion committees.

Among the committees which provided information about their work, 4.5 percent indicated no induced abortion applications were approved and 46.2 percent did this procedure up to 12 weeks of gestation. The largest concentration of hospitals in these two categories was in Quebec where 16.7 percent of reporting committees did no abortions and 61.1 percent did this operation up to 12 weeks of gestation. From statistics made available to the Committee by the Quebec Department of Social Affairs, 41.1 percent of the 34 hospitals with committees in that province in 1973 did not perform the abortion operation and six hospitals, or 17.6 percent, each did one abortion that year. Among the hospitals in other provinces there was a sharp division between about half which limited this procedure to the 12-week period and about a third (33.9 percent) which either did the operation up to 20 weeks or which had no

[8] *Public Health Protection Act*, S.Q., 1972, c. 42.

specified time limit. About half of the hospitals with committees in the Maritimes and the Prairies were in these two categories, while a third of the hospitals in Ontario and British Columbia adopted these longer time limits.

Reflecting these differences in the time limits in the length of gestation set for the abortion operation, there was a predictable inverse distribution among the hospitals which required a specialist consultation for women who were beyond 14 weeks of gestation. This requirement was less frequently set in the Maritimes and Quebec where fewer hospitals did the induced abortion procedure over 12 weeks, but the proportion rose in other parts of the country. Conversely, more hospitals in eastern Canada than western Canada required one or more specialist consultation by a woman seeking an abortion, and more patients were required to have interviews, prior to the operation, with social workers. At 1 out of 10 hospitals (12.4 percent) either a member of the therapeutic abortion committee or the committee as a whole had interviews with patients, a practice which was most commonly done in the Prairies (25.8 percent). With the exception of British Columbia where tests for congenital damage were less often required (12.5 percent) if it was felt this was indicated, about a third of the hospital committees endorsed this practice. Half of the hospitals indicated (47.7 percent) that as a condition of performing the abortion operation, patients were expected to receive contraceptive counselling.

Reasons for approval of abortion applications

Virtually all hospitals with committees indicated that in their review of abortion applications, the physical (98.1 percent) and mental health (97.5 percent) of the pregnant woman was considered. The only hospitals which did not indicate that these criteria were used were a small number that had established therapeutic abortion committees, but which never considered any applications. **In a large number of hospitals in the national hospital survey (87.7 percent), the possibility of deformity or congenital malformation of the foetus was considered in the review of a pregnant woman's medical history,** although as indicated in the types of requirements followed by hospitals, relatively few hospitals reported that such tests were required and these procedures were only done if it was felt that they were indicated. Reflecting the east-to-west differences in the length of gestation requirements, fewer hospitals in the Maritimes and Quebec cited this guideline than elsewhere in the country.

Pregnancy resulting from rape or incest was a consideration given high priority by therapeutic abortion committees, most of which (80.6 percent) considered their occurrence as valid reasons for the approval of a therapeutic abortion. For this guideline, as well as the rest of the guidelines and reasons for the approval of therapeutic abortion applications, there was a more widespread endorsement in the western provinces than in eastern Canada. This east-to-west shift reflected a far stronger emphasis on the social reasons affecting an individual's health in Ontario, Manitoba, Saskatchewan, Alberta and British Columbia than among the five eastern provinces. In the former provinces more

TABLE 11.5

GUIDELINES OF COMMITTEES
USED IN THE REVIEW OF ABORTION APPLICATIONS:
BY REGION

NATIONAL HOSPITAL SURVEY

Region of Country	Review of Application Guidelines									
	Physical Health	Mental Health	Possible Deformity of Foetus	Rape or Incest	Family Health	Economic Situation	Extra-marital Conception	Under Age 18	Over Age 40	Prevent Illegitimate Birth
	percent									
Maritimes	87.5	87.5	73.3	61.5	61.5	46.2	33.3	33.3	33.3	27.3
Quebec	100.0	100.0	69.2	72.7	60.0	40.0	33.3	50.0	55.6	22.2
Ontario	100.0	98.5	90.9	79.2	77.3	70.0	56.4	55.3	61.9	37.5
Prairies	96.3	96.3	92.0	82.6	72.7	57.9	40.0	55.0	68.4	26.3
British Columbia	100.0	100.0	93.3	93.1	83.3	87.0	76.2	61.9	81.0	33.3
CANADA	98.1	97.5	87.7	80.6	74.3	65.7	52.5	53.5	63.1	31.5

Note: Non-accumulative as each committee could have several guidelines for the review of therapeutic abortion applications.

weight was given to a consideration of the continuance of a woman's pregnancy on: the health of her family; its economic implications; whether it had resulted extramaritally for married women; and greater consideration was given if women were under age 18 or above 40 years old. A majority of the hospitals (68.5 percent) were not prepared to support an abortion application solely on the grounds to prevent an out-of-wedlock pregnancy.

Hospital case studies

In addition to information obtained from the 209 hospitals with therapeutic abortion committees in the national hospital survey, the Committee visited hospitals in all regions of the country to obtain firsthand accounts of how the abortion procedure was being implemented. The Committee obtained a considerable amount of information from these visits which verified and expanded in their detail the broader findings of the national hospital survey. The vignettes given here in some detail show the breadth of how the Abortion Law operated and the latitude with which its terms were being interpreted. Almost all possible combinations in the interpretation of the terms of the law such as *health, endanger,* and *would* or *would be likely* were found.

MARITIMES

One hospital in this region had the following statement in its bylaws:

> Therapeutic abortion may only be performed in a case where there is a serious danger to the life of the mother, a danger that cannot be treated by any other means.

In a subsequent amendment which was made to this hospital's bylaws, the provision was added,

> That the therapeutic abortion committee be extended to include the approval of abortion in cases where there is proven scientific evidence of congenital defects of the foetus coupled with the psychological trauma of the mother because of this circumstance.

As a result of these bylaws which were known by the physicians who were in local medical practice, this hospital had not received therapeutic abortion applications since 1973. According to the hospital's executive director, this decrease did not result from the change in the bylaws, but from a strong negative reaction which had been voiced by people in the community. A somewhat different view was expressed by the past chairman of the therapeutic abortion committee of that hospital who felt that the decision had merely served to re-route women seeking induced abortions to a second hospital in that community. At the second hospital the 12-week period of gestation was adhered to and all abortion patients were required to have a psychiatric consultation.

• • •

The therapeutic abortion committees of two other hospitals visited in the Maritimes had not established formal guidelines for the assessment of applications for induced abortion. According to the members of these committees,

each case was individually assessed on its merit. Several cases were refused in one hospital because of the negative recommendations of a consulting psychiatrist. In the other hospital, according to the chairman of the committee, approval of abortion applications was given where there was a physical indication and where the mental health of the mother was felt to be endangered. The committee said it was cautious in its interpretation of what constituted a danger for the mental health of the patient. Therapeutic abortions at another hospital were performed up to the thirteenth week of pregnancy, and patients who were over this time limit were referred elsewhere, usually to New York City.

• • •

The medical director of one hospital in the Maritimes who told the Committee that its abortion policy was conservative, said that between 15 to 20 applications were reviewed annually and applications were approved for medical or psychiatric indications. This hospital's committee considered rape and proven serious defects in the foetus as sufficient reasons justifying a therapeutic abortion. The applications which were most often turned down came from women between 16 and 35 years who, according to the chairman of the committee, "should know better".

QUEBEC

Most hospitals in Quebec did not have therapeutic abortion committees and among those hospitals with committees, 95 percent of that province's induced abortions in 1974 were done in five hospitals. Among the 19 hospitals with therapeutic abortion committees which were visited by the Committee, there were three categories of hospitals: (1) those which did no abortions; (2) those which did one or two abortions annually or over a period of several years; and (3) a smaller number where this operation was extensively performed.

• • •

Among the group of hospitals with therapeutic abortion committees which did no abortions, one hospital which specialized in the treatment of cancer asked in its review of abortion applications: "Can the treatment required for the healing of the pathology be delayed without any major risk for the patient so that the latter can give birth?" If an affirmative answer was given, the application was not approved. At another hospital where approval had been given for one case involving an abortion, the board of directors had passed the following resolution:

> The Board of Directors express unanimously that the approval of this therapeutic abortion on account of the very exceptional circumstances, does not change in any way the policy of the hospital which in principle is against this practice. In addition, the Board of Directors emphasize the fact that in the event that intervention would again be required, each case shall be treated individually by the therapeutic abortion committee and a detailed report on the reasons involved for authorizing or refusing the therapeutic abortion shall be presented to the Board of Directors.

• • •

At another hospital in Quebec where no abortions had been done in the past three years, the members of the department of gynaecology required that only

the cases where the life of the mother was in danger be approved by the therapeutic abortion committee of the hospital and a gynaecologist, who might be asked to perform the abortion, should have the right to refuse cases already accepted by the committee, if he believed the indication which had been given was insufficient. For this reason one of the cases which had been approved by the committee at this hospital was transferred to another hospital in the region. The position at this hospital was subsequently changed and more abortion applications were being reviewed.

• • •

At three other hospitals with committees in Quebec which did no abortions, approval was given in principle for the criteria of the physical and mental health of the pregnant woman. In one instance the committee said it would require irrefutable proof that the physical and mental health of a woman would be in danger. At the two other hospitals the committees indicated they would be prepared to accept psycho-social reasons, but these indications were interpreted as psychiatric conditions. The possibility of serious defects in the foetus was not recognized as a reason to justify an abortion at these hospitals.

• • •

Among the small group of hospitals with committees where most of the reported induced abortions were performed in Quebec, most of these hospitals endorsed the definition of health of the World Health Organization. Three of these hospitals had written statements outlining their positions. After stating that an induced abortion was the termination of pregnancy when the life or health of a woman was in danger, one hospital had enumerated the following guidelines for its therapeutic abortion committee.

> Abortion "on demand" is not permitted.
>
> *Medical*: when the life of the mother is in danger or when a serious deterioration of her physical or mental health, or of her social conditions is feared because of this pregnancy.
>
> > Remark: to determine if such a risk exists or not, the total, actual or reasonably foreseeable environment of the patient must be considered.
>
> *Social*: in the cases where the pregnancy is the result of rape or incest (refer to remark above).
>
> *Foetal*: when the pregnancy would result in the birth of a child presenting physical defects or mental disabilities.

The chairman of this hospital's therapeutic abortion committee reported that social indications were accepted as reasons for which approval was given only if it was felt that the pregnancy constituted a permanent risk to the woman's health.

• • •

The written indications of a second hospital were:

> A therapeutic abortion is considered justified when the health of the mother may be seriously jeopardized by the continuation of the pregnancy.

"Health" is understood to encompass total health—physical and mental, etc., as defined by the World Health Organization and adopted by the American Society of Obstetricians and Gynaecologists.

Therapeutic abortion may be considered in the following situations:

a. Genetic factors or disease in the mother (parents) which indicate a strong possibility of defective development of the foetus.

b. Rape and incest.

Each case must be considered on an individual basis.

• • •

At a hospital whose therapeutic abortion committee had not refused applications since 1970, an extensive pre-screening of potential applicants was reported to occur in the out-patient department where the initial review of patients was done. About 25 percent of those patients seeking an abortion who were seen at the clinic were referred to the hospital's committee. This pre-screening, the Committee was told, occurred because of the limited hospital facilities which were available. The patients whose applications were referred for review were chosen on a "first come, first served" basis. The guidelines followed at this hospital were:

1. that changes in the law represent an increased liberalization of social values regarding abortion and an increased awareness of the problems of the unwanted pregnancy. It appeared, in other words, that society wished to have abortion made more easily available.

2. that the term "endangered health" in the legislation was not rigidly defined and that the World Health Organization definition of health—"physical, social and emotional well-being and not merely the absence of disease"—could be used in interpreting the indication for therapeutic abortion.

3. that in the final analysis, safe and effective therapeutic abortion should be made available to women who request it with the exception of those who would be emotionally and physically injured by this procedure.

• • •

Among the group of hospitals which did abortions but which did not have written criteria, there was some variation in their guidelines for the review of applications. At one hospital which had endorsed the World Health Organization's definition of health, the board of directors had asked the members of the therapeutic abortion committee to keep in mind the rules of medical ethics and to be cautious in their assessment of applications. This hospital board had also stipulated that a more strict interpretation be followed when psychiatric and social indications were considered. Few applications submitted to this hospital's committee were approved.

ONTARIO

Half of the hospitals with therapeutic abortion committees (53.1 percent) which were visited by the Committee in Ontario endorsed the World Health Organization's definition of health. At only one of these hospitals was a significant physical indication required as the basis for the approval of an

abortion application. Most of the hospitals did not have written statements of the guidelines followed by their committees. In one hospital where there had been a decrease in the number of therapeutic abortions between 1974 and 1975, this decline was attributed to a general reluctance among the physicians who felt it was preferable to refer their patients to another hospital in the same region. This hospital did not have a suction instrument. The physicians said there were fewer risks for patients if induced abortions were done by the suction procedure rather than by dilatation and curettage. No requests had been made by the medical staff for the hospital to obtain this equipment.

• • •

Following a change in the membership of its therapeutic abortion committee, the review guidelines of another hospital were modified with the intent of approving more applications. While the committee was prepared to approve most of the applications which it received, it continued to receive a relatively small number. Many local physicians continued to refer their patients to the United States and it was felt that patients themselves did not seek out the services of this hospital because they wished to preserve their anonymity in this small community.

• • •

At several hospitals visited by the Committee in Ontario, all of the applications which were forwarded to therapeutic abortion committees were approved with the exception of a few cases where the length of gestation was beyond the maximum time limit set for the termination of a pregnancy. These limits varied between 12 to 20 weeks. In its annual report, one of the therapeutic abortion committees concluded:

> The work of the Committee remains unchanged from the report of the previous year. Due to the type of screening procedure in the offices of the referring physicians and the consultants, very few requests to the abortion committee are turned down. The main indication remains as in previous years—an assessment of socio-economic conditions affecting the physical and mental health of the mother. Many times, various kinds of contraceptive methods which usually are considered reliable enter into the considerations.

Another hospital had a similar policy:

> Patients considered not suitable candidates for therapeutic abortion are turned down at the doctor's office or in the gynaecological clinic. Our committee does not feel it should be in the position of trying to give a second opinion regarding cases presented to it. Therefore, if the application meets the criteria regarding gestation, age and a satisfactory reason is given for the indication, approval is invariably given.

The members of the therapeutic abortion committees of these hospitals considered it was not their function to make judgments which, they felt, were more of a moral than medical nature. In turn, they felt it was their responsibility to make certain that the "letter of the law" on abortion was followed.

• • •

There were explicit policies about repeat abortions at some hospitals with committees in Ontario which approved most first abortions. In such cases

approval was given only if the therapeutic abortion committee had been assured that the patient had conscientiously used a contraceptive method. The members of these committees adopted the attitude that a first abortion could be understood as a mistake, but they felt there was no justification to sanction what they saw as the irresponsible attitude of women who had had a previous abortion and who subsequently had not used contraception. One therapeutic abortion committee refused to approve applications for second abortions unless the patients consented to tubal ligation.

• • •

At several hospitals in Ontario the members of the therapeutic abortion committees did not meet to review patient applications. At one such hospital for instance the assessment of the request for abortion was left to the conscience of each of the three physicians who individually studied the files of patients. In this instance the rules were unknown to all participants—patients and physicians. This situation did not preoccupy the medical staff at this hospital who felt that if an application were refused the patient could go to another hospital in the same city. During 1975, 15 applications were turned down, most of the cases involving married women in their twenties who had one or two children.

• • •

In one hospital visited by the Committee in Ontario, therapeutic abortion was approved only where there were significant physical indications of danger to the health of the mother. The number of therapeutic abortions performed at this hospital dropped subtantially between 1971 and 1975. This reduction resulted from an increased reluctance through time by the physicians to perform therapeutic abortions. According to the medical staff "two other hospitals in this city do therapeutic abortions; it is not necessary to do them here". According to the hospital's chief of medical staff "of twenty gynaecologists practicing in this city, only three do therapeutic abortions. None of these gynaecologists is an active member of the medical staff of this hospital."

• • •

On several visits by the Committee to hospitals in Ontario it was emphasized that the number of applications which a particular hospital received was only partly a result of the policies which were followed in the review of abortion applications. It was felt that an extensive amount of pre-screening was done by patients and physicians. This pre-screening was influenced by how physicians saw the decisions of different therapeutic abortion committees, their own ethical and professional position on abortion, and the wishes of some patients to retain their anonymity. With three exceptions, most of the larger cities in Ontario had hospitals with committees which performed a substantial number of abortions. In the urban areas which were the exception to this trend, a sizeable number of women seeking an abortion by-passed local hospitals which had established quotas, were known to have turned down a considerable portion of applications, or whose review of application policies was based on physical indications. Many women seeking abortions who lived in these centres were known through the various surveys of the Committee either to go to other cities in the province, or more often, directly to clinics in the United States.

The majority of the abortions done in these three provinces were performed in the major urban centres. In one province where none of the hospitals had formally adopted the World Health Organization's definition of health, and none of the hospitals which were visited had written guidelines, all of the hospitals which were visited by the Committee had endorsed a broad concept of health. As with hospitals in other parts of Canada, the membership of the therapeutic abortion committees affected the decisions which were reached. In one instance where there had been a 13.8 percent increase in the number of approved abortion applications between 1974 and 1975, this change according to the hospital's executive director had resulted from the nomination of a new consulting psychiatrist to whom applicants were referred prior to their review by the committee. The reverse result had occurred in another hospital when the composition of its therapeutic abortion committee changed in January 1976. After that date, 50 percent of the abortion applications were refused while before the change in committee membership over 95 percent had been approved. According to a local referral agency, most of the women whose applications had not been approved at this hospital subsequently went to clinics in the northwestern United States. These trends had occurred in several other hospitals in the Prairies.

• • •

The definition of health followed by hospital committees in the Prairies encompassed the full range of possible interpretations. In several hospitals for instance requests made on behalf of married women without children or for women who had less than two children were not approved. At one hospital the therapeutic abortion committee required an extensive documentation of the patient's mental health prior to its review of an application. According to some of the physicians whom the Committee met, this type of requirement leads a woman whose mental health is satisfactory either to simulate a psychiatric disorder, or more often, may involve a physician in writing a review letter to a therapeutic abortion committee which he knows to be dishonest by giving a false diagnosis.

• • •

The therapeutic abortion committee at one major centre had accepted the World Health Organization's definition of health, but it was interpreted differently by each member of the committee. One physician felt that no approval should be given to women who requested a second abortion; the chairman required detailed case presentations of the physical and mental health indications. The remainder of the committee members were prepared to accept social indications in their review of abortion applications. At this hospital, so the Committee was told, it was often a matter of who attended specific review meetings whether applications which were comparable in their indications were approved or rejected.

• • •

At several of the hospitals which were visited in the Prairies, women were required to agree to be sterilized if they were seeking a repeat abortion. Where this was not the case, this procedure was strongly recommended in several instances.

• • •

Most of the hospitals in the Prairies which were visited by the Committee accepted social indications in their consideration of abortion applications. The guidelines of one hospital are an example of this trend.

> *Health*—health is a state of complete physical and mental and social well-being and not merely the absence of disease or infirmity.
>
> *Social well-being* involved the familial and social situation of the patient which may affect deleteriously the ability of the patient to cope with the entire family unit, and in which this impairment to care for the family may result in adverse effects on their physical, emotional and functional well-being.

At two hospitals whose committees endorsed social indications, the diagnosis which was invariably given was that of a reactive depression. The reason cited for this diagnosis was that the physicians were uncertain about what was permitted on this point by the Abortion Law. They also said they wished to avoid criticism for approving what they considered to be abortion which was given "on demand". At another hospital where a phychiatric consultation was required, the chairman of the therapeutic abortion committee indicated that the entry of the fact of this consultation in the patient's record was more important than the consultation itself or the letter which resulted from it. In his words, "We do this to be seen to do it, not because it means anything to our review."

British Columbia, Yukon, Northwest Territories

The Committee visited several hospitals in different parts of British Columbia as well as hospitals in the Yukon and the Northwest Territories. Most, but not all, of these hospitals endorsed physical health, mental health and social indications as reasons for the approval of therapeutic abortions. At one hospital which had not rejected an application since its therapeutic abortion committee had been established, its bylaws stipulated:

> The therapeutic abortion committee must be satisfied that in the case of an abortion, the reason for termination given by the attending physician conforms to the provisions of section 237 of the Criminal Code. It must be clear to the committee that the physician requesting permission to do the abortion is acting in good faith and is of the opinion that the continuation of pregnancy would, or would be likely to endanger his patient's life or health.

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Among the hospital administrators and the senior medical staff who were met in this region, the Committee was consistently told that there was little justification for women seeking an induced abortion to go to the United States for this purpose. It was felt that a sufficient number of hospitals, often unknown to each other in the extent to which the abortion procedure was done, were performing a sufficient number of induced abortions to preclude the need for women to leave the region for this purpose. When this happened, it was suggested, it was because these women wished to have the operation done promptly without the "hassle" of a committee review or they sought to retain their anonymity.

Based on the information obtained in the surveys done by the Committee and its site visits to other hospitals in the region, these reasons were not a sufficient

explanation. In many parts of the region hospitals either did not have committees, or in some instances established hospital committees required extensive documentation of physical and mental health indications. At one of these hospitals the policy of the committee changed completely with the appointment of a new chairman in early 1976. Prior to this appointment, all applications had been approved, while under the reconstituted committee only specific physical and mental health indications were considered as valid reasons for the approval of first abortions and no applications for second abortions were approved. At another hospital which had had an established committee for several years, no applications had been approved since the departure of two staff physicians in 1973 who at that time were performing induced abortions.

Disposition of patients' charts

One concern frequently voiced by women seeking an induced abortion and by physicians who in one way or another were involved in the procedure was how to preserve the confidential nature of what was being done. This concern reflects the widely held sense of stigma which is often associated with this procedure and the curiosity which many individuals may have about its details. At some of the hospitals which were visited by the Committee, special steps were taken to hide the identity of abortion patients either by not listing this procedure or substituting another diagnostic category on the list of surgery which was posted daily. The procedure followed at one hospital for instance, if it was requested by a woman, was that the patient became an official "non-person". No indication was given to visitors that these abortion patients had been admitted to the hospital, they were not listed in the directory of patients which was kept at the hospital's reception desk, no telephone calls were taken on their behalf, and their mail was returned stamped as "address unknown".

Particularly in smaller hospitals and in centres where there was only one hospital in the locality, there was a heightened sense of concern among patients and physicians about retaining their anonymity. It was for this reason that a number of women living in smaller communities chose to by-pass their local hospitals in favour of going to larger centres or to the United States to obtain this operation. It was also partly for this reason that some physicians recommended to their patients that they take these steps, which while serving to maintain the anonymity of their patients also reduced their own involvement in the abortion procedure.

Because induced abortion is an issue which evokes more than a passing interest among some medical and hospital staff who are not directly involved in this procedure, some hospitals made special arrangements for the filing of committee decisions, the storage of patient charts, and established guidelines for the accessibility of these records for medical and hospital staff. These steps which were taken were a tacit recognition that there was often an open accessibility to patients' charts by a wide range of hospital personnel. In the type of the special precautions which were taken by hospitals with therapeutic

abortion committees, the concerns and the interests of physicians were more recognized than those of abortion patients.

TABLE 11.6

DISPOSITION OF CHARTS OF THERAPEUTIC ABORTION PATIENTS BY REGION

NATIONAL HOSPITAL SURVEY

Region of Country	Disposition of Patient Charts			
	Special Storage Arrangements	Special Files for Committee Decisions	Guidelines for Research Accessibility	Guidelines for Accessibility by Hospital/ Medical Staff
	percent			
Maritimes	37.5	87.5	40.0	40.0
Quebec	47.1	93.8	52.9	33.3
Ontario	32.0	77.3	45.8	37.7
Prairies	27.3	56.3	32.3	34.4
British Columbia	32.4	71.4	41.2	37.1
CANADA	33.0	74.3	42.4	36.5

Note: Non-accumulative as each committee could make several arrangements for the disposition of patient charts.

Among hospitals with committees from which information was obtained, 3 out of 4 of these hospitals (74.3 percent) made special arrangements and kept separate files of the decisions which were reached by committee members in their review of abortion applications. Representing a more heightened concern with this matter, these arrangements were more often made in the Maritimes (87.5 percent) and Quebec (93.8 percent) than in the Prairies (56.3 percent) or British Columbia (71.4 percent).

These special arrangements for the handling of the records of therapeutic abortion committees took many forms. In one hospital in the Maritimes visited by the Committee, only the executive secretary to the hospital administrator handled these records which were stored in the administrator's personal files. Only these two individuals had keys to the files which contained the lists through the years of physicians who had served on the therapeutic abortion committee and the decisions which had been taken in the review of abortion applications. At another hospital in the Prairies much the same arrangements were followed, with the executive secretary to the administrator attending all committee meetings, taking minutes, maintaining records, and preparing the statistical reports which were subsequently sent to Statistics Canada. In this instance the abortion records were directly accessible only to the administrator, the executive secretary, and the chairman of the therapeutic abortion committee. They were kept in locked files in an alcove of the executive secretary's office.

By taking these unusual steps these hospitals recognized the socially sensitive nature of the abortion procedure. These precautions were intended to

safeguard the reputations of the physicians who were involved. But similar steps were less often taken to protect the privacy and the interests of patients who had induced abortions. **In comparison with the special arrangements made by 74.3 percent of the hospitals for the records and minutes of therapeutic abortion committees, 33.0 percent of these hospitals took comparable precautions involving the handling and the storage of the charts of induced abortion patients.** There was little variation in this respect across the country. After the abortion operation had been done in two-thirds of the hospitals, these charts devoid of the therapeutic abortion committee's decision were stored along with all other hospital records. In this respect these records were accessible on a basis which was comparable for all other charts of patients to all medical and hospital staff.

Few hospitals with therapeutic abortion committees had established either special guidelines governing the accessibility to the charts of induced abortion patients by staff (36.5 percent) or for their use for research purposes (42.4 percent). This matter touches upon the much broader issue of ethical research standards involving the accessibility and the use of patient records. In the Committee's review of the few research studies which have been done in Canada dealing with abortion, it was not always clear whether the consent of patients had been obtained for these research purposes. This issue may pose an ethical dilemma particularly in hospitals (which are not affiliated with universities) where a stipulation of consent for teaching and research is not necessarily signed when patients are admitted to hospital. Many of the studies which have been done do not appear to comply well in these respects with acceptable ethical research standards governing the informed consent of patients, their personal identification, or the disposition of research records. These studies usually drew upon an accumulation of available hospital charts of induced abortion patients and presented a mixture of statistical findings and on occasion detailed clinical case studies. **Dual standards obtain in this regard, for comparable access is unknown to the Committee to have been given for research involving the review of the work of therapeutic abortion committees or for the analysis of the decisions reached by these committees on abortion applications.**

Interpretation of abortion law

Most of the larger hospitals which did a sizeable number of the abortions accepted physical health, mental health, and social indications as the basis for their decisions. It was more often the case that hospitals located in smaller cities and towns limited their criteria to physical and mental health indications. The meaning attributed to the diagnosis of mental health was varied and diffuse. No clearcut distinction could be made by the Committee between instances where this classification was valid, or was used to represent social indications. The classification of mental disorders given in the *International Classification of Diseases*, Eighth Revision, a classification system which is used across Canada, lists disorders whose etiology is both physical, mental, and social, or a combination of these in their origins. In the introduction to this

classification, no specific definition is given, with the categories listed being subsumed "where the main interest is in the mental state of the patient". The various mental disorders which are listed can assume any degree of gravity for a particular patient whose usual state of mental health may be affected.

The Committee was asked to determine "to what extent is the condition of danger to mental health being interpreted too liberally or in an overly restrictive manner?" As the mental health of an individual includes a wide range of conditions each of which can vary in its intensity, the *a priori* assumption must be made that a woman's state of mental health was fully known before she had her unwanted pregnancy. All of the information obtained by the Committee points to the conclusion that women who were seeking an abortion experienced an intense short-term anxiety which was not relieved until the operation had been performed, and if this step was delayed, the level of anxiety was further heightened.

If the assumption is accepted, which the Committee does, that a high degree of anxiety is associated with the abortion procedure, then **in the broad understanding of the meaning of mental health, this condition is not being interpreted too liberally for most, if not all, women seeking an induced abortion operation. If the definition of mental health is restricted to psychiatric disorders associated with physical conditions, psychoses, or long-term neuroses, then few abortion patients had these conditions.** There is much confusion in the use of these terms generally, a confusion which is further compounded when it is linked with the issue of induced abortion. Because the diagnostic labelling practices varied so greatly across the country and between hospitals within the same community, much of the general information which is available on this point must be considered suspect, if not invalid.

The Committee was also asked to consider the question, "Is the likelihood or certainty of defect in the foetus being accepted as a sufficient indication for abortion?" The direct answer to this question is yes. Most of these committees gave a high priority to this condition and would be prepared, were it so indicated, to approve an abortion application on the grounds that it would affect a woman's health. In the few instances where it was reported to the Committee that defects of the foetus were known to be present, the diagnosis which was given related to the mother's health as a consequence of the potential birth of such a foetus.

Central to the understanding of the criteria applied by therapeutic abortion committees is the definition of health adopted by the members of these committees or stipulated by hospital boards. While most hospitals endorse a broad definition of health, often acknowledging the Charter of the World Health Organization as the basis for their general treatment activities, the question of induced abortion draws a sharp dividing line in the recognition and the application of this concept. **How danger to the health of a woman seeking an induced abortion was judged varied from the estimation that in no instance was this operation justified, a great variety of intermediate interpretations, to the broadest possible definition which allowed an abortion to be done when it was requested by a woman. Based on these different understandings of the**

concept of health, a number of requirements were set for patients seeking this procedure and a wide range of guidelines were used in the review of applications for induced abortions. If equity means the quality of being equal or impartial, then the criteria (requirements and guidelines) used by hospital therapeutic abortion committees across Canada were inequitable in their application and their consequences for induced abortion patients.