

Chapter 12

Hospital Staff

With the change in the Abortion Law the work of some hospital staff was altered by their more extensive care of women having induced abortions. This change was true for many nurses and some social workers. The Committee found there was considerable confusion, some strong views, and little documentation about how the abortion procedure had affected these workers, how much stress this new professional responsibility had involved, or the redefined nature of the work procedures and job rights. One of the Committee's Terms of Reference was to determine, "Are hospital employees required to participate in therapeutic abortion procedures regardless of their views with respect to abortion?"

The Committee obtained information during its site visits to hospitals from hospital administrators, directors of nursing, and operating room nursing supervisors about employment practices, work assignment procedures, and how the performance of the abortion procedure had affected the morale of hospital staff. In most instances there was a frank review of these policies. But in about a third of the hospitals with therapeutic abortion committees, there was considerable apprehension and a feeling that a delicate equilibrium had been achieved which could be easily disrupted. The unstated policy at these hospitals was to leave well enough alone. The fervent hope was that there would be no outside intrusions or internal friction which would force a review of hospital practices and policies about induced abortion.

Implicit in the assignment of hospital employees and their job rights relative to the treatment of or the refusal to work with abortion patients is a broader principle involving the employment practices which concerned all hospital administrators. Epitomized in this issue is the question of who decides what type of work is to be done—the employee or the employer. The general policy of hospitals across Canada on this point has been that within designated job categories, employees are expected to accept the general duties assigned to them. General duty staff nurses for instance, when they are recruited to work in a particular nursing service such as orthopaedics, surgery, obstetrics, or paediatrics, are expected to provide nursing care to all patients on the wards to which they are assigned. According to widespread custom and the prevailing policies of hospitals, it is not considered to be a nurse's prerogative to "pick and choose" patients with whom she or he will or will not work.

On its site visits to hospitals the Committee requested permission to undertake a survey of the views and experience of hospital staff who were involved in the abortion procedure. The focus of this survey dealt with the issue of work rights, how these were dealt with and the feelings of nurses and social workers toward their work with abortion patients. The means of collecting information was not a random sampling design. That step was not feasible without extensive prior knowledge which the Committee did not have of the procedures which were involved at all hospitals. In the Committee's judgment that approach (random sampling) would not have been an appropriate way of obtaining this information. On its initial site visits to hospitals the Committee found that because many administrators and directors of nursing felt that abortion was a divisive and sensitive issue, a mailed request to take part in such an inquiry would likely be rejected. The alternative step taken was to seek permission at the time of the visits to hospitals to do the survey. The senior staff were asked to identify the group of nurses and social workers who were involved in the abortion procedure and to circulate a questionnaire which involved no personal identification of the respondent. The completed replies were then to be mailed directly, without an internal review by the hospital administration, to the Committee.

A total of 70 hospitals with therapeutic abortion committees in nine provinces and two territories took part in the survey of hospital staff involved in the abortion procedure. The location of these hospitals was: 1, Newfoundland; 4, New Brunswick; 2, Nova Scotia; 11, Quebec; 20, Ontario; 5, Manitoba; 3, Saskatchewan; 9, Alberta; 13, British Columbia; 1, Yukon; and 1, Northwest Territories. A total of 1,589 replies were received of which 1,513 questionnaires were fully completed and were used in this inquiry. Most of these hospital staff were women (97.2 percent); of the 24 men who replied to the questionnaire, a quarter were social workers and the remainder were nurses.

In addition to the survey of hospital personnel, the Committee asked provincial health authorities for information regarding situations known to them where questions had been raised about hospital staff involved in the abortion procedure. Similar requests for information were made to the Canadian Nurses' Association and the provincial human rights commissions.

Staff functions

The care of obstetrical patients is usually a popular work choice among nurses. The presence of happy families and the excitement of newborn infants is an appealing contrast to other hospital work. The increase in the number of induced abortions in hospitals confronted nurses with an aspect of obstetrics and gynaecology for which in many instances they were untrained and which in some cases involved them in a procedure to which they were morally opposed. This shift in recent years in their work has posed a dilemma, especially for nurses who have worked with mothers and infants for a long period of time. They had to re-examine their ideas of health. In some instances nurses felt that

therapeutic abortions were being performed for "health reasons" which frequently did not coincide with their personal definition of health. Pregnancy and motherhood in the past were considered a normal and essential experience for every married woman. Yet this fact in the case of therapeutic abortion was reversed, with motherhood being seen as a threat to a woman's health. For some nurses the consideration of pregnancy as a pathological condition was so contrary to their personal beliefs that they chose to work in other settings. Other nurses had resolved their feelings and were participating in work which they saw as a necessary professional responsibility. A few nurses had chosen to work primarily with women having therapeutic abortions and found it a rewarding experience.

Problems in the nursing care of abortion patients occurred more frequently when abortion services were based in the same unit as obstetrical services. In these instances the nurses were expected to provide nursing care under sharply contrasting circumstances: serving a mother and her new infant; a woman who might have a spontaneous abortion; a woman being treated for infertility; and a woman seeking to terminate her pregnancy. In this situation the nurse must deal with a wide range of emotional experiences involving herself and her patients. In half of the hospitals which participated in the hospital staff survey, there was a nursery on the same unit as the induced abortion services. Many nurses said they worked under much stress in this situation and felt that it upset many patients who had induced abortions. Operating room nurses were more often identified by supervisory personnel as having had difficulties or having objected to working with hospital abortion services. In some hospitals the nurses were hired specifically to work with women who were having therapeutic abortions. These nurses were responsible for preparing women physically and psychologically for the procedure, their physical nursing care, and in some instances the provision of birth control instruction to these patients before they were discharged from hospital.

How extensively nurses participated in the abortion services of hospitals which had established therapeutic abortion committees varied with their area of employment and the organization of abortion services at a particular hospital. Some of these functions were:

The prior assessment and counselling of women who were about to have therapeutic abortions;

Nursing duty at the time of the induced abortion;

Nursing care provided to women who had had therapeutic abortions;

Nursing care for women having second-trimester abortions;

The teaching of family planning to women before or after the induced abortion operation.

The procedures in which the nursing staff were involved varied among hospitals. Only first-trimester abortions were performed at some centres and in these instances the staff had little or no contact with second-trimester procedures. The staff in other centres were exposed to the full range of termination methods, such as: suction aspiration; dilatation and curettage; saline injection;

prostaglandin injection; and hysterotomy. About a third of the nurses in the survey (30.9 percent) were involved about once a week with patients having an abortion by the suction and dilatation/curettage procedures. While most of the general duty staff were not under much stress as a result of this procedure, this was in contrast to the experience of many operating room nurses. Some operating room nurses refused to be present in the operating room when these induced abortions were done. Arrangements were usually made among the staff so that another nurse who was willing to take this work would assume this responsibility. Among the nurses in the survey, 43.0 percent did not find this procedure stressful, 37.7 percent found it only somewhat stressful, and 13.2 percent said it was highly stressful. The remainder (6.1 percent) gave no reply on this point.

Because second-trimester abortions were less extensively done in most of the hospitals in the staff survey, fewer of the nursing staff from whom replies were received were involved in the saline, prostaglandin, and hysterotomy procedures. But the level of stress was high among those nurses who were involved in caring for second-trimester patients. Nurses who were present when a foetus was expelled experienced a great deal of personal anxiety. The more advanced the pregnancy, the more difficult it was for the staff. The nurses in the survey made extensive comments in their replies to the Committee about their work with abortion patients. What some staff felt they had gained from this experience was:

- Certain of the patients were very responsive and appreciative of the care given them. Staff could see how the person's life situation might be relieved or improved as a result of the abortion.
- Some felt they had become less judgmental and had learned to see and nurse women more individually. By their understanding further a woman's situation and needs, they had increased their understanding of themselves. Many nurses were satisfied when they had time or were able to talk with patients about their experiences and concerns.
- Some nurses were pleased when they had counselled and taught patients about family planning and birth control.
- The staff in certain hospitals found that the existence of the abortion services had increased the extent of communication with other hospital members through a discussion of their feelings and concerns. These discussions had created a work environment which allowed staff to provide care and maintain dignity for both staff and patients.
- Some staff felt that working on the abortion services had helped them come to terms with their feelings about induced abortion and in other cases to have an increased awareness and appreciation of the meaning of life itself.

In contrast, more nurses had had difficulties and frustrations associated with their care of women who had had induced abortions. Some of these general problems were:

- The abortion procedure was seen to be immoral and unnecessary by many nurses.

- A number of nurses resented that they were unable to work on obstetrical-gynaecological services at hospitals which did induced abortions if they refused to participate in the treatment of these patients.
- The abortion procedure was seen to have increased the amount of work that needed to be done by the same number of staff. Paper work had increased as documents had to be checked before the procedure was carried out.
- The unwillingness of certain hospitals to do induced abortions resulted in delays that often brought patients into hospital late and under much stress.
- The overloading of the abortion procedure in certain hospitals resulted in what the staff felt was an assembly-line process that was degrading to the staff and patients. When this happened, it did not allow for optimal care since there was a lack of time to teach and talk with patients.
- The existence of nurseries and obstetrical services in the same area with treatment for induced abortion patients created considerable stress.
- In certain situations there were negative feelings between the staff who did not work with abortion patients and nurses who did. The latter group sometimes felt that the staff who made these objections were not taking their share of professional responsibility and a heavier work load fell on those individuals who were willing to be involved.
- Lack of social worker counselling was cited as a difficulty that added responsibilities to the nursing staff who felt both unqualified to take on this work and lacked the time to do so.
- Staff were concerned about the feelings of patients who had lost a pregnancy or were unable to conceive.
- Most staff found hysterotomies to be distressing, especially if signs of foetal life occurred. The actual handling of a foetus was difficult for most staff.
- Some supervisors or head nurses had difficulties in making assignments and assisting their staff in dealing with their feelings.
- Patients who nurses felt treated their abortions too lightly or who caused disturbances were seen to be difficult. This concern was especially voiced about adolescent females whom some staff felt they did not understand well.

In the hospital staff survey about half of the 70 hospitals (55.7 percent) had social workers who were involved in the review of abortion applications and in the direct counselling of these patients. Of the 77 social workers involved in this procedure who were identified by hospital administrators, 49, or 63.6 percent, returned completed questionnaires. On its visits to hospitals, the Committee found that while relatively few hospitals included social workers in different aspects of the treatment of abortion patients, strong and contrary opinions were held about the need for their services. In a few hospitals a full social service review of an applicant seeking an abortion was required. It was on the basis of such a review that some committees made their decisions. In other cases the equally strong opinion was held that this step was unnecessary and for the women involved, it was a further intrusion into their privacy which only extended the length of gestation. In most instances a social worker was involved only when it was felt that a woman could benefit from such a consultation.

At the time of the survey, half (53.1 percent) of the social workers who responded were involved in the assessment, the support, and the counselling of women seeking therapeutic abortions and 3 out of 5 (59.2 percent) took part in the teaching of family planning. Half (51.0 percent) assisted in the follow-up of women after an abortion had been done. One out of five said they had little or no involvement with women who had therapeutic abortions. The general functions identified by social workers which they felt they could provide to women obtaining induced abortions were:

To assist a woman to reach a decision regarding her pregnancy;

To assess a woman's request for a therapeutic abortion;

To provide background information to the therapeutic abortion committee regarding a woman's request for a therapeutic abortion;

To provide support to a woman, and to provide her with instructions about the procedure;

To make alternate arrangements for a woman if her application was rejected;

To make referrals to appropriate consultants or agencies when these were indicated.

Staff recruitment and work assignment

In their patterns of work which are influenced by economic conditions but even more by their personal circumstances, young women in the Canadian labour force have been found in a number of studies to have relatively high job turnover rates. Among a number of large organizations such as public services, banks, and large corporations, the annual turnover rates vary between 20 to 40 percent. The average annual turnover rates of general staff nurses in Canadian hospitals in the 1960s was of the order of 60 percent, a level which subsequently dropped but which it is estimated had remained relatively high. It was in this work setting of a rapid seeking or leaving of jobs that nurses worked when the abortion legislation was amended and more nurses began to be involved with women who had induced abortions.

Among the 70 hospitals in which the staff survey was done, the directors of nursing of almost all of these hospitals (95.7 percent) said there had been no change in the usual turnover of jobs as a result of the abortion procedure. In the handful of cases where there had been a change, the turnover rate among the nursing staff had dropped, but this change was attributed to the general supply of nurses which in many parts of the country exceeded the demand for their services. The administrative staff of 20 percent of the hospitals in the survey of hospital personnel said that some nurses had left the hospital since 1970 because of the performance of the abortion procedure. From its visits to these hospitals the Committee found that most of these instances had occurred when the abortion procedure had been started and this turnover had involved nursing staff who were already on the gynaecological services. Usually only a few nurses had been involved. Six hospitals reported that one nurse had left for

these reasons, while eight hospitals indicated that two or more staff had been involved. As the hospital services for induced abortions had become established, different administrative arrangements evolved. There were few instances of general duty nursing staff reported to the Committee who had resigned on these grounds in recent years.

Most of the hospitals (97.1 percent) reported they had had no recent problems involved in the staff recruitment for the provision of abortion services. A few hospitals had separate abortion or pregnancy termination units. In some instances the nursing staff were hired specifically to work on these services. There was usually more flexibility in the work assignments of the operating room staff. Five hospitals which did not re-assign ward nurses permitted the exchange of assignments for nurses working in the operating room when the induced abortion operation was done. When staff resigned from positions on obstetrical-gynaecological services, there was no difficulty in filling their positions. In one hospital there was a waiting list of nurses who wanted to work on this service. At another hospital, where the abortion unit was separate and operated on an out-patient basis, the opportunity of working days with no weekend duty was felt to be an attraction for staff members. In 13.0 percent of the hospitals, the staff were told nothing specific about the abortion policies before their employment. In 21.4 percent of the hospitals the staff were told that their duties would include the care of women having abortions. If the potential employee objected, where possible, alternative work assignments were made. **In about 1 out of 4 hospitals (25.7 percent), a description was given of the services without other options being made available, 7.1 percent encouraged the prospective staff member to work with all patients, and 15.7 percent did not employ staff who felt they could not provide care to all patients.**

In reviewing the question of the work rights of nurses who may be involved in the abortion procedure, the Canadian Nurses' Association considered a motion in 1971 which proposed that the decision to obtain an induced abortion be made by a woman and her physician. To be endorsed as a policy of the national Association, this statement would have required the approval of the majority of the affiliated provincial nursing associations. It was subsequently endorsed by four provincial associations. The Canadian Nurses' Association requested information in 1973 from its provincial affiliates about instances where the views of nurses about induced abortion were known to have affected their jobs or seniority. No such cases were then documented. A year later the Association requested statements about induced abortion. It received replies from the provincial nursing associations in Nova Scotia, Ontario, and Alberta.

Registered Nurses' Association of Nova Scotia: In May 1971, the executive of the association accepted and issued individual members of this association the following statement: "The RNANS recognizes that nurses as individuals may hold certain moral, religious or ethical beliefs about therapeutic abortion and may be in good conscience compelled to refuse involvement. The RNANS supports the right of a nurse to withdraw from a situation without being submitted to censure, coercion, termination of employment or other forms of discipline, provided that in emergency situations the patient's right to receive

the necessary nursing care would take precedence over exercise of the nurse's individual beliefs and rights."

Registered Nurses' Association of Ontario: "The RNAO has taken the position that no one should be discharged from staff and any transfer from one department to another must be made at a comparable level. Many of our members do not endorse the regulations governing abortion, but feel obliged to work within the law. Many are not prepared to have this position used as a means of being assigned more than their share of the assignments, though."

Alberta Association of Registered Nurses: "It is recognized that nurses as individuals may hold certain moral, religious or ethical beliefs about therapeutic abortion and may be, in good conscience, compelled to refuse involvement. The AARN supports the rights of a nurse to withdraw from the situation without being submitted to censure, coercion, termination of employment or other forms of discipline, provided that the patient's right to receive the necessary nursing care would take precedence over exercise of the nurse's individual beliefs and rights. The nurse has an obligation to communicate her reluctance to become involved to her employer in order that a mutually suitable solution may be reached in the provision of necessary nursing care."

Up to the time of the inquiry the Canadian Association of Social Workers had not received any formal complaints from its members. This Association's statement on the work rights of social workers was:

Individual social workers should have the right to engage or disengage from family planning practice in accordance with his/her personal beliefs or convictions, but should ensure that adequate professional referral is made.

Provincial health authorities were asked if they had received complaints from hospital personnel about the operation of the Abortion Law. In only one province, Ontario, had a provincial health department had some written complaints. Such complaints, if they were received, were not catalogued in British Columbia, and for Quebec it was indicated that such information could only be obtained by contacting directly each hospital. One instance which was not registered as a formal complaint was known to have occurred in Newfoundland. This instance involved a nurse who in 1970 had requested not to be involved in the abortion procedure in an operating room. While no written personal complaints had been received in Manitoba, the Department of Health and Social Development had received a petition signed by hospital employees protesting the establishment of a central abortion clinic. The Ontario Ministry of Health had received a number of written complaints at the time when the abortion legislation had been changed. These complaints, mostly from operating room nurses, dealt with the moral issue of abortion. Where problems on the job had occurred, this situation had been resolved in most instances by the nurses being re-assigned to other nursing duties. During the past several years, the Ministry had received no further formal complaints.

With the exception of Ontario, the provincial human rights commissions had received no complaints involving abortion from hospital personnel. The Ontario Human Rights Commission had received two complaints from nurses between 1971 and 1975. These complaints were reviewed within the terms of the Commission's Code, section 4(1), which states:

No person shall refuse to ... recruit any person for employment ... discriminate against any employee with regard to any term or condition of employment because of the ... creed ... of such person or employee.

The Commission reviewed the two complaints to determine whether discrimination in recruitment and employment had occurred in situations where an employee's privately held religious convictions might have prevented him or her from performing the work which had been assigned. In the settlements which were reached through conciliation, the nurses who were involved were transferred to other duties; their salary levels were kept close to the amounts which they had previously earned.

The Committee received three accounts of work complaints involving the abortion procedure, one of which had been published, while the others were submitted statements.

A nurse, barred from the operating room of a _____ hospital for refusing to assist abortions, has lost her bid for financial compensation. The _____ Hospital turned down a request by the _____ Human Rights Commission to insert a "conscience clause" in their employment policy. The clause states that a nurse who on religious or moral grounds cannot participate in abortion surgery will be transferred to another area of the hospital without loss of pay. The clause also states there would be no loss of remuneration because of the transfer. The nurse's case involved loss of extra pay for being on call one weekend a month, steady day shift work and all weekends off. She now is in a medical wing doing 12 hour shifts with alternate weekends off.¹

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_____ had been employed in the operating room at _____ Hospital since December 28, 1974, until November 24, 1975. When _____ was hired in December of 1974 to work in the operating room, no mention was made to her by the Director of Nurses of abortion or of the necessity of assisting at such operations as a condition of employment in that department. _____ said she had been able to avoid being scheduled to assist at abortions for the first 11 months with the cooperation of the O.R. supervisor, who simply did not schedule _____ along with a few other O.R. staff who objected to assisting with abortions, by simply not booking these individual nurses as the scrub nurse for abortions. As a result of complaints from two other O.R. nurses to _____ against _____ and the abortion issue, she was transferred to the medical floor. _____ admits that she did not explain to _____ when she was hired 11 months previously that she would be required to assist in abortions.

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I worked in the _____ Hospital operating room as a registered nurse from March 1974 to October 1974. Before I was hired I was told therapeutic abortions were being performed and was told I must scrub and circulate for these abortions if I wished to be hired.

Over the 8 months I would guess around 250 abortions were done. These were mostly suction (Gompco) type, next most common would be D & C. There were several hysterotomy abortions and only one saline that I was aware of

¹ *Dimensions in Health Service* (Canadian Hospital Association) 52(1975): 18.

and that got to the O.R. The D & C and suction abortions took about five minutes to perform. They were always careful to have a patient history and abortion committee signed slip on every patient chart. I believe I only saw one abortion performed because the pregnancy was a direct threat to the mother's life—an older lady with severe heart and kidney disease.

I rarely talked to the patients who came for abortions but I did question one 19 year old university student who was there for her third abortion. I asked her if she was aware of birth control and she answered that she would not take the pill as it was "against her religion"!

I talked to the staff—the nurses said they didn't "like" assisting in abortions but said: a) it really didn't bother them, and b) if they weren't doing it, somebody else would.

One anaesthetist stated—"they aren't very nice but someone has to do them." Some doctors and anaesthetists refused to perform or assist with abortions, nurses could not refuse and maintain their jobs in the O.R.

I tried to refuse to scrub for a hysterotomy and was told I must even though there were other girls who would not have minded.

There are several sides to the disclosure of work complaints and the form which these complaints may take. Few of these concerns have been publicly voiced either to provincial health departments or provincial human rights commissions. To take such a step usually represents considerable effort and a breach of the work traditions and customs of hospital employment. Individuals considering such a step for any reason may be constrained from doing so because they may feel it represents unprofessional behaviour, or be restrained from making a complaint out of fear that they may be identified as a troublemaker. It is possible for these reasons that there was a sharp discrepancy between the number of formal complaints which were known to provincial governments and provincial human rights commissions and the number which were acknowledged to have occurred by hospital administrators and directors of nursing, and the reports received directly from staff nurses themselves. **Based on the stated hiring practices of some hospitals, their employment procedures relating to the abortion procedure may not be in compliance with the codes of provincial human rights commissions.** Among the 1,513 hospital staff employees in 70 hospitals, 65.1 percent felt they had had a free choice involving their work with abortion patients, 30.5 percent said they did not have this freedom of choice, and the remainder gave no reply. **About a third of the nurses (36.5 percent) were not prepared to leave their current positions which involved them in some aspect of the abortion procedure, but they would have preferred if they had the choice not to do this type of work.** Most of these nurses did not state why they had stayed in their present positions but among those who did, 2.0 percent did not want a decrease in income; 3.1 percent felt they would lose their job seniority; 5.9 percent did not want to go to less desirable working conditions; for 3.1 percent it would have meant leaving their friends; 4.1 percent were afraid of reprisals from the hospital administration; and 9.2 percent knew of no job vacancies for which they could apply.

In the hospital staff survey, **1 out of 13 (7.7 percent) of the nurses who worked in 41 of the 70 hospitals (58.6 percent) said they knew of one or more**

colleagues who had made a formal grievance related to the abortion procedure. The distribution of the hospitals where these formal complaints were reported to have been made were: 1 in Newfoundland, 2 in Nova Scotia, 3 in New Brunswick, 6 in Quebec, 9 in Ontario, 4 in Manitoba, 1 in Saskatchewan, 8 in Alberta, 6 in British Columbia, 1 in the Yukon, and none in the Northwest Territories.

How nurses define a formal grievance may be at variance with how this step is usually considered in labour relations procedures. What the nurses may have reported were requests for re-assignment which had been made to nursing supervisors, but which had not gone beyond this level as a formal complaint. While about a third of the nurses (36.5 percent) would have preferred not to work with abortion patients, it was unknown how many of them actually voiced these concerns when they were being hired. Based on reports received by the Committee, none of these complaints had been taken to work grievance procedures which were available at most of the hospitals (84.3 percent). Most of the hospitals in the staff survey (82.9 percent) had union contracts with nurses and 3 out of 5 (60.0 percent) had staff employee associations. These results were for the 70 hospitals which participated in the hospital personnel survey. Among the 209 hospitals with therapeutic abortion committees in the national hospital survey which provided information to the Committee, 81.8 percent had work grievance procedures, 71.8 percent had union contracts with nurses, and 45.5 percent had staff associations. Reports received by senior officials of national hospital employees' unions indicated that the issue of abortion had had a low profile in union contract negotiations with hospitals across Canada.

For most of the nurses who may have had complaints about their participation in the abortion procedure, the resources were available in the form of grievance procedures, union contracts, staff associations, or provincial human rights commissions, if they chose to use them, to seek a conciliation to resolve their concerns. What appears to have happened in most instances was that these issues either were informally settled or the nurses were reluctant for whatever reasons to register formal complaints. The tempo of the unionization of nurses has increased in recent years. From its visits to hospitals, the Committee learnt of no instance where contracts negotiated with nurses had at their request contained a "conscience clause" concerning the involvement of nursing staff with the abortion procedure.

Staff opinions

In the hospital staff survey, nurses and social workers gave their opinions about the indications for abortion, their knowledge of the legislation, and their reactions to women who were having induced abortions. In their definition of health, the following components were cited: 87.3 percent, physical health; 79.0 percent, mental health; 38.9 percent, family health; 34.0 percent, social health; 79.8 percent, ethical reasons; and 78.1 percent, eugenic reasons. Three out of five nurses (60.6 percent) felt that the interpretation by physicians of mental

health was too liberal as it applied to the approval of applications for induced abortions. Some of this group felt that mental health was being given as a justification for induced abortion which had little relationship to the actual emotional state of women or to their needs for an abortion.

I feel too many abortions are granted on grounds of "reactive depression" when the mother simply does not wish to bother having a child.

. . .

I find abortion hard to accept except in the case where it is done for health (true health) of the mother, or if it is proven that the foetus is malformed. It seems in our area of the province a pregnant woman just has to be emotionally upset and she can have an abortion.

. . .

I feel it should only be permitted if the mother's health, mental or physical, is involved. I think it is disgusting when 13 year old girls and younger come into the hospital. They should have the babies to show them sex is nothing to mess around with.

Among the staff nurses the limit on the length of gestation was seen as too liberal by 30.5 percent, about right by 60.6 percent, too restrictive by 2.7 percent, and no response was given by 6.2 percent. In terms of their knowledge of the Abortion Law, 76.0 percent of the nurses and 91.8 percent of the social workers said they knew the terms of this legislation. The accuracy with which nurses actually knew this Act was not in keeping with their general replies, for concerning the length of gestation stipulated in the Abortion Act, 34.1 percent said the law set an upper time limit of 12 weeks, 13.5 percent indicated 16 weeks, 16.7 percent cited 20 weeks, and the remainder did not know this information. It was more likely that these answers represented the policies on gestation set by the hospitals where these nurses worked, for few of them, like most other health workers whom the Committee met on its site visits, had read the legislation.

As with the findings obtained from the public and physicians, the actual accuracy of the nurses' knowledge of the Abortion Law was not a factor influencing what they thought the legislation stipulated nor how they saw the abortion situation. Among the nurses, 37.4 percent felt the Abortion Law was too liberal, 28.8 percent said it was about right, 28.3 percent said it was too restrictive, and the remainder were undecided. Some of the views expressed by the nurses were:

There is still a lot of ignorance about the legality of therapeutic abortions and the methods. This increased the stress on women tremendously.

. . .

The Government of Canada has no right to impose laws on husband and wife as to whether they do or do not bring a child into the world. Mature decision with the help of a doctor should be the criterion for a therapeutic abortion.

. . .

I personally feel that the laws governing abortions are much too liberal. I also feel that doctors have no right in taking human lives.

. . .

The law as it now stands does not give the poor and lower socio-economic levels the ability to have a safe abortion . . . stricter abortion laws tend to strike the people who can least afford the burden of another child. People with money and/or influence can get abortions by going elsewhere.

. . .

I feel the law is interpreted too liberally now. I think contraception should be emphasized rather than abortion. I think if abortion were not so easily obtained now—maybe contraception would be practiced more carefully.

. . .

The final decision should rest with the patient if she is of sound mind as she is the one who will have to cope with her feelings and emotions concerning the situation.

The opinions of the nurses in the hospital staff survey were also divided on who should make the decision about an abortion. Their opinions on this point were: 13.0 percent, the woman's decision; 19.9 percent, the woman and her doctor; 30.2 percent, the woman, her partner, and the doctor; 8.9 percent, the woman and two doctors; 23.3 percent, a committee; and 4.7 percent gave no reply. Almost 3 out of 4 of the nurses (72.0 percent) endorsed a method other than the therapeutic abortion committee. While nurses are not involved with the review of applications or the decision of therapeutic abortion committees, many had opinions about how they worked, or in their opinion, should work.

Abortion is leading us to think less of life. Abortion committees are merely rubber stamps and in many places never give individual consideration without bias.

. . .

I strongly feel that the abortion committee should be abolished along with removing it from the Criminal Code. The abortion committee is only present as a formality to satisfy the law and does nothing so that when it might be possible to do a simple D & C, proceedings take so long that the patient ends up waiting for a saline injection which is more traumatic to the patient.

. . .

A person who wants an abortion should have the consent of the husband and pass a committee. The committee should be more strict so people will not be coming back for another abortion.

. . .

I am opposed to any procrastinating by committees that results in more second trimester abortions.

. . .

Abortion should definitely be a decision of a woman and her physician. However, guidance to her final decision should be made available by a qualified person who is not prejudiced.

. . .

The committees should have stricter guidelines.

. . .

I do not feel that abortion should be an alternative to birth control. However, I do feel that every child should be a wanted child and that it should be a decision agreed on by husband and wife. I do not think that physicians and politicians should be "playing God" in deciding who can and who cannot have an abortion.

More of the social workers in the hospital staff survey were in favour of changing the Abortion Law than nurses or physicians. Among this group 8.3 percent felt the legislation was too liberal, 30.6 percent endorsed the present terms, 57.1 percent said it was too restrictive, and the remainder were undecided. Also, more social workers than nurses felt that the decision to obtain an abortion should be made by a woman herself (30.6 percent); a third (34.7 percent) said the decision should be made by a woman and her physician. Social workers also more frequently felt that abortions should be given for indications involving the ethical, family health, and social factors which were associated with a woman's circumstances.

The single aspect of their work which created the most stress among nurses was how much direct contact they had with women having second or third-trimester abortions and the products of conception. Not all nurses who worked with women obtaining induced abortions were involved in this phase of the abortion procedure. Among the 68.7 percent of the nurses who were, the frequency of their contact with the products of conception was: 6.2 percent between 1 and 5 times a year; 2.0 percent, 6 to 10 times annually; 25.8 percent, about once a month; 22.6 percent, about once a week; and 12.1 percent, daily. One effect of increased contact with the products of conception for the staff members was a significant decrease in their desire to work with abortion patients. Some of the reasons given by operating room nurses why they experienced stress were:

I feel as if my rights are transgressed—a doctor can refuse to abort any patient he wishes—I'm forced to nurse—and deliver—the patients having abortions. Recently one of the doctors was present and helped deliver a foetus following a saline induced abortion—he now says he'll not do any more saline injections—I'm not permitted to make this choice . . . The death on our unit following a therapeutic abortion was very stressful to the staff (patient 18 years) and even now, 4 years later, that patient is still remembered. I am pleased the Committee has taken the time to question nurses. It is the first time I've been asked about my feelings. Thanks . . .

. . .

. . . In 1968 we were doing anywhere from 16 to 30 therapeutic abortions per month. At the present we do 1 to 2 per month . . . More staff problems with

the saline abortions than the D & C suction or hysterotomies. The staff must cope with the patient's emotional stress of going thru a "mini" labour and also "deliver" the foetus. Several nurses have limited experience in the labour rooms and feel stressful when delivering the foetus and placenta. With the saline abortion I find the staff stating "this is good for her, maybe she will remember the next time she fools around". The staff's response I feel is a detrimental one to giving good nursing care.

. . .

. . . I had the misfortune of seeing a foetus that was very well formed and much older than 16 weeks. This made me sick.

. . .

The foetus of any abortion, induced or otherwise, is not easy to emotionally put aside. It is a hard and difficult specimen to witness but I would rather see it than see a battered or unwanted child, which is neglected.

. . .

Some foetuses have cried and some certainly appear larger than 16 week size. In some cases two doctors' histories have contradicted each other. In my opinion no person should be given a second saline or prostaglandin injection. Each case should be considered individually—there may be reason for a second abortion before 12 weeks, but after 12 weeks, never.

. . .

I have been involved in operations where a foetus has moved. I find this distressful and feel no government has a right to inflict this treatment or moral responsibility on an individual.

. . .

. . . I walked into the delivery room one day to happen upon a saline induction which failed. I saw a hand on the floor! You people don't know the *half* of it! That baby felt everything! The mother was given *local* anaesthesia, but what about the baby? I sound as though it's ugly. *Do something about it.*

. . .

. . . Personally I dislike assisting in abortions because it is uncomfortable for me to remove parts of a so-called "torn up foetus".

. . .

There have been instances of concern related to the punitive attitude of some nurses insisting that the woman view the foetus . . .

Staff training

Nurses face several dilemmas in their work with abortion patients. The first decision is the personal choice of whether or not they choose to do this type of work, and if so, then what their role will be. The nursing care of women

obtaining induced abortions can range from the provision of routine services to a comprehensive counselling role involving the emotional and psychological preparation of patients prior to an operation, supportive post-operative care, and the provision of family planning and contraception education. What a nurse does in this regard is a matter of personal choice, the priorities of a hospital and the extent and type of training which she has received. Nurses are increasingly being seen and expected to provide more rather than less care and counsel to maternity patients and women obtaining induced abortions. Some nurses who assumed these additional responsibilities had not had formal preparation for this work and they relied on a mixture of work experience and personal beliefs in what they have told patients who had induced abortions.

In its work the Committee drew on three sources of information about the preparation and the counselling functions of nurses with abortion patients. These sources were: (1) a survey of the curriculum relating to family planning and the nursing of abortion patients of schools of nursing; (2) the in-service training programs of hospitals in the hospital staff survey for nurses who worked with women obtaining induced abortions; and (3) the type and the extent of the preparation in these respects of nurses who worked with these patients. In addition, 26 replies were received from 32 schools of social work which were contacted.²

A total of 134 schools of nursing across Canada were requested to provide the Committee with information about the scope of their instruction in family planning and the preparation that student nurses received involving the care of abortion patients. The replies received from 93 nursing schools (69.4 percent) were from: 22 hospital nursing schools; 46 community colleges; 5 independent schools; and 20 university programs. The distribution of these 93 nursing schools was: 20.2 percent, Maritimes; 24.5 percent, Quebec; 26.6 percent, Ontario; 20.2 percent, Prairies; and 8.5 percent, British Columbia. All of these nursing schools reported that some aspect of family planning was given in their curricula; 97.8 percent indicated that the topic of induced abortion was dealt with. The amount of time which was actually spent on these topics varied. About half of the programs (57.1 percent) had set aside time to allow nursing students to explore their personal feelings and attitudes about therapeutic abortion. This point was stressed by nurses who worked with these patients who often felt they had been insufficiently prepared in these respects.

The availability of clinical facilities varied, with one-third of the nursing schools indicating there was no access for the clinical training of students with abortion patients. In 46.2 percent of the nursing schools, students had the opportunity to provide care for women having first-trimester abortions and in 38.7 percent of the schools, students had access to facilities where second-

² These programs consisted of 17 university programs, 8 community colleges, and 1 polytechnical institute. Family planning was included among the courses which were offered at 84.6 percent of these schools, most often in the curriculum dealing with: social services, justice and social welfare, and human behaviour and the family. Courses dealing directly with family planning were usually offered on an elective basis. Six of the schools of social work had courses which provided some instruction on the counselling of women obtaining therapeutic abortions and nine programs set aside time in the curriculum for students to discuss their feelings and views on this topic. A majority of the social work schools (20 out of 26) had at least one student who was in training at agencies which offered assistance to women seeking induced abortions.

trimester abortions were performed. Most of the clinical preparation of these students was with patients on the wards. One nursing school did not provide for the involvement of its students with patients obtaining induced abortions. Among the university programs one nursing school had developed a specialized diploma course in advanced obstetrical nursing in which special attention was paid to the nursing care of women having induced abortions.

Among the 70 hospitals participating in the hospital staff survey, 31 hospitals (44.3 percent) had some form of in-service training program for nurses working with abortion patients. Some of these programs dealt with the abortion legislation and provided a review of hospital policies on the abortion procedure. About 1 out of 5 (17.1 percent) dealt with the nursing care of these patients. From the site visits to these hospitals by the Committee, views ranged from the need for these in-service training programs to the unsettling effects they might have on the nursing staff who provided care to abortion patients. Many of the senior nurses in hospital administration at the hospitals said that while the current situation was "under control", it could easily become unsettled. In part, this reluctance grew out of the lack of experience in this field of some of the supervisory staff, their uncertainty of how to deal with this sensitive issue, and on occasion, their remoteness from pressures involved in direct nursing care.

Some of these concerns were recognized by nurses in their written comments to the Committee.

We feel that the present calmness of the situation arose from the decision not to do abortions beyond 12 weeks.

. . .

Most of our abortions are done on a day care unit; there are no problems. We did have some problems when late abortions were done. There were also more problems when the abortions were on the same unit as obstetrics.

In the hospital staff survey the comments made by a substantial number of nurses indicated their need for more information about their work with women obtaining induced abortions and for the opportunity of discussing this matter.

In this hospital abortion is politely ignored, as are the needs of particular patients. Another nurse and myself sat down and drew up an outline for an in-service program on therapeutic abortion and the feelings involved of staff and patient. It was quietly squelched.

. . .

Since this is probably the only time someone will give me the chance to express my feelings on abortion, I will take this opportunity to state that as a whole, I disagree with the procedure. Thank you for letting me express how I feel.

. . .

These girls may have difficulty in ever conceiving again if they marry or change partners.

Staff should be given the chance to explore their own feelings about abortion *before* the services are started at their place of work.

. . .

In-service for staff on floors working with therapeutic abortion patients would be exceedingly helpful.

Therapeutic abortions are too easy to come by. These girls that have a therapeutic abortion may have severe mental breakdowns after.

. . .

As a staff member in this hospital I have been told nothing about the rules and regulations of therapeutic abortions. I have no idea of the rules and regulations of this hospital or city. Other places I have worked present these to you to read.

. . .

I feel that allowing therapeutic abortion has not decreased back alley criminal abortions.

. . .

I wish the stigma of therapeutic abortions would or could be lessened. People seem to treat these girls as something other than what most of them are: frightened people who have made a mistake.

. . .

We have a policy that nurses do not indicate their views to patients. Some staff need counselling about expressing their pro life views to patients.

. . .

I feel that in years to come a number of people will really have psychological backlash.

. . .

I don't think staff members can really know how they feel morally until they are personally involved with the problem, either themselves or somebody close to them.

Few nurses in the hospital staff survey (20.0 percent) said they had received in-service training since the start of their hospital employment about their work with abortion patients. Only a small group (8.7 percent) had had preparation in the social and psychological aspect of the nursing care of these patients. Most of the staff who had attended these training programs said they had found them useful. These staff were concerned about the type of preparation and the counselling which patients received before and after their abortion operations. They saw the need to provide more comprehensive immediate care to these patients and more effective preparation in family planning and contraceptive education.