Report of the Committee on the Operation of the Abortion Law

1977

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Committee on the Operation
of the Abortion Law

The Honourable Ron Basford,
P.C., Q.C., M.P.,
Minister of Justice and
Attorney General of Canada.

January, 1977

Dear Mr. Basford:

Appointed by the Privy Council on September 29, 1975, to determine and report upon whether the procedure provided in the Criminal Code for obtaining therapeutic abortions is operating equitably across Canada, we submit our Report for your consideration.

Robin F. Badgley

Robin F. Badgley
Chairman

Denyse Fortin Caron

Denyse Fortin Caron

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Marion G. Powell

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Chapter 1

Work of the Committee

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

Establishment of the Committee

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

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

Collection of information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

• • •

> None of the government's business.

• • •

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

• • •

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

• • •

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

• • •

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

Good questionnaire—covers most if not all the bases.

• • •

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

• • •

Send out questionnaires like this to all the doctors.

• • •

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

• • •

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

• • •

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

• • •

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

• • •

1) Read the Lane Report.[1]

2) Grow up!

• • •

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Confidentiality of information

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

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

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

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

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

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

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

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

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

Staff of the Committee

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

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

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Chapter 2

Abortion in Canada

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 3
Terms of Reference and Summary of Findings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Related findings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Three meetings of the inter-departmental committee were held.

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

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

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

Part II

Findings

Chapter 4

Induced Abortion: Classification and Number

Broad changes in recent years in the standard of living and the scope of coverage under social security and national health insurance have affected the way of family life and the health status of Canadians. While the marriage rate has remained fairly constant, the size of the population has grown and with it there has been an increase in the number of women of child-bearing age. At the same time there has been a decline in the birth rate, an absolute decrease in the number of infant deaths, and fewer mothers have died at childbirth.

As a profound social, moral, and legal issue, and one which may involve much stigma, induced abortion is an area of human concern which involves great risk of personal and collective bias influencing the approach, the interpretation, and the use of "facts". As part of a cluster of issues related to sex and the family which includes family planning, genetic counselling, out-of-wedlock parenthood, social security programs, and ultimately a potential population policy, induced abortion in this broader context has seldom been considered in a consistent manner. While induced abortion is an indisputable fact of life, the way this issue is seen by a people is reflected in the nature of a nation's laws and the types of information which are routinely collected, what is analyzed and published, and the use to which this information is put.

Bill C-150, the Criminal Law Amendment Act, 1968, was introduced in the House of Commons in December 1968. It was given Royal assent on June 27, 1969, and its terms went into effect on August 26, 1969. In 1970, the first complete calendar year after this legislation was passed, the number of reported therapeutic abortions was 11,152. By 1974 the number of reported therapeutic abortions was 48,136.

The increase in the number of reported abortions reflects a complex web of changing social forces. These forces involve gradual shifts in the age and sex composition of the population, and on occasion, almost imperceptible but shifting ideas about the relations between men and women, the bonds between children and parents, and of the role of the family in Canadian society. Changes in recent decades in where Canadians live and work and the larger number of married women in the work force have been coupled with both a higher level of education for most individuals and modified ideas about social

and religious morals. Scientific advances and modern medical technology have raised new ethical issues which require the re-evaluation of traditional professional imperatives.

As the way of life of Canadians has gradually changed, there have been shifts in their sexual behaviour and sexual norms, subjects which have not been easily and frankly dealt with in public. The idea of a social taboo, a practice which involves forbidden or prohibited behaviour, has pervaded the public consideration of sexual behaviour. There have been few inquiries and none of national scope which have dealt with the sexual behaviour of men and women, the extent of sex-related diseases, the knowledge and practice of contraception, sterility and voluntary sterilization, homosexuality, or the health and fertility consequences of these sexual experiences. The discussion of these issues in public has often been on a basis of what is held to be ideal or moral behaviour, or conversely, in terms of what is sensational, aberrant, or prurient.

It is within this context that information about induced abortion has been collected by government, professional associations, and other groups in Canada. The full story on sexual behaviour and its related health and demographic implications has yet to be told. In terms of what has not been done collectively, it appears that the health professions, demographers, and government health departments for the most part have not wanted to know about these issues and they have done little to change this situation. Most of the factual information on these subjects comes either from Statistics Canada or provincial medical and hospital insurance sources which classify morbidity records for financial accounting purposes. The few reports on abortion which have been published by government have given lean, selective, and incomplete statistics. These reports have ignored the health consequences and social essence of induced abortion for the public. A number of "confidential" reports have been prepared by different levels of government which have been made available to the Committee, but which have not been published.

The number of 48,136 reported therapeutic abortions for 1974 constitutes a minimum of the actual number of induced abortions which Canadian women had during that year. Excluded from this total were: (1) self-induced abortions which did not require further treatment in hospital; (2) abortions which were classified as "spontaneous" and "other"; (3) abortions induced illegally outside hospitals; (4) abortions obtained by Canadian women outside the country; and (5) induced abortions which were done in hospitals which were not classified as abortions. For these reasons precise information is not available on the total number of Canadian women who have had induced abortions in a given year, nor is there a reliable estimate of the total number of Canadian women who previously had abortions.

Demographic trends

According to demographic theory when a country makes the transition from an agrarian economy to an industrial society, it passes through three

stages in terms of its fertility and mortality trends. The fertility of women refers to the actual number of children who are born, while fecundity is the biological ability to become pregnant. Reflecting changes in the economy, the use of contraceptive measures, and the impact of more extensive health care, the three demographic stages are: (1) a high birth rate and a high death rate; (2) a high birth rate and a low death rate; and (3) a low birth rate and a low death rate. Implicit in this concept is the fact that when a society's way of life changes along these lines, the decline in mortality occurs before a drop in fertility, a change which usually follows after a period of time. Once a country has completed these population shifts, the demographic process is usually irreversible. The experience of most industrial western countries including Canada conforms to this pattern with the exception of the "baby boom" years following World War II.

Taking 1970 as the first full calendar year after the Criminal Code amendments on abortion came into effect, an index of 100 is used as a baseline in the review of trends in vital statistics.[1] In the five-year period from 1970 to 1974, the population of Canada rose from 21,297,000 to 22,446,300, or from the 1970 index of 100 to 105.4. In 1974 there were 5.4 percent more people in Canada compared to 1970. The number of women in the fertile age group in 1973 was 7.5 percent higher than in 1970. The number of marriages increased steadily during the 1960s and reached a high of 200,470 in 1972. This number declined in 1973 and in 1974, reversing the trend of a decade for the first time.

The birth rate for the country started to decline around 1960. By 1970 the crude birth rate per 1,000 population was 17.5, which dropped further to 15.4 in 1974. The largest decline was in Newfoundland, while Quebec and British Columbia had the lowest crude birth rates. The total fertility rate for the country dropped from the index of 100 in 1970 to 78.6 in 1974. The decline in fertility went below the population replacement level for the first time in 1972. This decline in fertility continued in subsequent years.

During the past three decades there was a sharper reduction in the number of infant and maternal deaths than in the total number of deaths for the Canadian population. These changes resulted from a combination of factors including an improved standard of living, more extensive health care, and special maternal and child health programs. From 1950 to 1964 the Canadian death rate dropped from 9.1 to 7.6 per 1,000. At the same time the number of infant deaths during the first year of life (the infant mortality rate per 1,000 live births) declined by 40.5 percent from 41.5 to 24.7. Neonatal deaths, or the number of infants dying who were less than four weeks old, decreased by 29.1 percent from 24.4 to 17.3 per 1,000 live births. These trends continued in the 1970s, with the infant death rate dropping by 20.2 percent (18.8 to 15.0) between 1970 and 1974 and neonatal deaths by 25.2 percent (13.5 to 10.1) during this five-year period.

The characteristics of women who have had reported therapeutic abortions in hospitals have been documented since 1970 in the annual reports on

[1] Experience listed above 100 (e.g., 280.0) represents an increase, while figures below the index number represent a decrease (e.g., 78.0).

Therapeutic Abortions published by Statistics Canada. The increased number of Canadian women who had reported and unreported induced abortions was a contributing factor to the general decline in the birth and fertility rates. In 1970 there were 11,152 reported induced abortions done in Canadian hospitals, a number which rose to 48,136 in 1974. If this information is considered by itself, it might be inferred that general social factors influencing the decline in the birth rate accounted for 21.6 percent of the decrease in the number of births, while the increased number of reported induced abortions between 1970 and 1974 determined 78.4 percent of the fewer births which were reported. This conclusion is invalid. It assumes full knowledge about the growing use of contraception, trends in the surgical or voluntary sterilization of men and women, and the volume of illegal and out-of-country abortions.

There is no fully accurate appraisal of how many women in the 1960s had induced abortions. From information which is available, their numbers were not inconsequential in terms of contributing to the slower rate of population growth. The usual child-bearing age for women is between 15 and 44 years and may extend for a few women to 50 years or older. The experience with induced abortion of women over age 51 is an approximate measure of the extent to which abortions were obtained in the 1950s and 1960s. Based on the findings of the Committee the rates of illegal and self-induced abortions for these women were 2.2 and 15.5 per 1,000 respectively, while the rate of induced abortions obtained in Canadian hospitals was 0.71 per 1,000. If the crude birth rate of 1970 had remained the same in 1974 (17.5 versus 15.4 per 1,000 population), there would have been an estimated 47,200 more births than the 345,645 in 1974.

The decline in the birth and fertility rates for the country, and their even sharper drop in some provinces, was influenced not only by a growing number of induced abortions but as well by a sizeable increase in the number of individuals who were sterilized.[2] The total number of reported induced abortions between 1970 and 1973 was 124,129. During the same period there were 9,880 reported male sterilizations and 244,963 female sterilizations. The rate of female sterilizations rose from 1.5 per 1,000 population in 1970 to 3.8 per 1,000 in 1973. If these rates are considered for women between the reproductive ages of 15 and 44, the rate rose from 7.1 per 1,000 to 17.4 per 1,000 during this period. There were considerable provincial variations in the rates of sterilization. In 1973, 5,065 women who had induced abortions (11.7 percent of women obtaining reported induced abortions) were concurrently sterilized; 94.0 percent of the 84,941 women who were sterilized that year had this operation done as a separate procedure.

The increase in the number of reported induced abortions since 1970 may have influenced the course of illegitimate live births. The increasing trend in the number of illegitimate live births and the illegitimacy rate, clearly visible from 1966 to 1970, subsequently dropped. The illegitimacy rate, which is calculated as a percentage of illegitimate live births of all live births, was 7.6 in 1966, 9.6 in 1970, and 9.0 in 1973. There was an absolute increase in the

[2] Statistics Canada, special tabulations for the Committee.

number of illegitimate live births by 4,583 from 1970 to 1973. For British Columbia, Ontario, and Alberta which had reported induced abortion rates which were consistently higher than the overall rate for the country, the reduction in illegitimacy rates after 1970 was clearly visible. For Newfoundland, Prince Edward Island, Nova Scotia, and New Brunswick with reported induced abortion rates which were lower than the national rate, the illegitimacy rates increased since 1970 for some of these provinces.

The number of infant and maternal deaths has declined substantially during recent years. In 1970 there were 75 pregnancy-related deaths of mothers, a number which decreased to 35 maternal deaths in 1974. Between 1970 and 1974 the decline in stillbirths was 24.0 percent (foetal deaths of 20 or more weeks of gestation); for infant deaths under one year of age by 20.2 percent; neonatal deaths (infants under 4 weeks) by 25.2 percent; and perinatal deaths (foetal deaths of 28 or more weeks of gestation plus infants under 7 days) by 23.4 percent. Maternal and infant death rates are sometimes used as barometers of the health status of a nation. But these measures lose their statistical significance, as in the case of Canada, when they reach relatively low levels. While it has sometimes been suggested that changes in these pregnancy-related death rates were due to one or another particular measure, it is a composite of factors which accounts for their reduction.

The reported increase in the number of induced abortions in Canada since 1970 coincided with and contributed to the broader demographic changes which were taking place in the composition of the Canadian population. For several decades there had been trends toward fewer births and smaller families, sharply reduced numbers of infant and maternal deaths, and since 1970, a reduction in the total number of illegitimate births.

The national crude birth rate has declined since 1960. Between 1970 and 1974, it dropped from 17.5 to 15.4 per 1,000 persons. The number of pregnancy-related deaths of women decreased from 75 in 1970 to 35 in 1974. The number of female sterilizations was 244,963 and the number of reported induced abortions was 124,129 between 1970 and 1973. The recent changes affecting induced abortions accelerated, but only partly contributed to the broader population trends.

Classification of abortions

Subsection 5(a) of Section 251 of the Criminal Code authorizes the provincial minister of health of the respective province to order therapeutic abortion committees of hospitals to supply him with copies of certificates which are issued "together with such other information relating to the circumstances surrounding the issue of that certificate as he may require." Under subsection 5(b) the minister can also require a medical practitioner who has performed the "miscarriage" or abortion to furnish "a copy of that certificate, together with such other information relating to the procuring of the miscarriage as he may require." There is no authorization in this legislation to make compulsory

the reporting of all therapeutic abortions nor for the establishment of a uniform national reporting and classification system for the coding of induced abortions. The legislation uses the terms "miscarriage", "therapeutic abortion", and "termination of pregnancy" interchangeably and as synonyms without direct definition.

While the legislation did not directly define an induced abortion, it stipulated that this procedure may be done in accredited or approved hospitals. An accredited hospital is one defined as "a hospital accredited by the Canadian Council on Hospital Accreditation in which diagnostic services and medical, surgical, and obstetrical treatment are provided." One of the recommendations of the Canadian Council on Hospital Accreditation in its review for accreditation of hospitals is that "a recognized adaptation of the current revision of the *International Classification of Diseases,* which includes an operative classification, is recommended."[3] The 1955 edition of the *International Classification of Diseases,* published by the World Health Organization, was used in this country until 1969. This classification gave no definition of abortion. The revised edition of the manual published in 1968 defined abortion as follows: "Abortion (640-645): Includes any interruption of pregnancy before 28 weeks of gestation with a dead fetus."[4]

Prior to 1969 Statistics Canada coded the information on abortion which it received from the provinces based on the Seventh Revision of the *International Classification of Diseases.* This classification system then included three categories for the coding of abortions:

650—Abortion without mention of sepsis or toxemia

651—Abortion with sepsis

652—Abortion with toxemia without mention of sepsis.

Information on induced and spontaneous hospital abortions was provided for in the fourth digit of this international classification system. The hospital code for Operations and Non-Surgical Procedures which was used by the provinces until 1969 did not specify the causes of abortion. No distinctions were made between spontaneous abortions, induced abortions, or dilatation and curettage. For these reasons a review of trends by the various types of abortion over a period of time is precluded.

In 1969 the format for the classification of abortions in Canada was expanded when Statistics Canada adopted the Eighth Revision of the *International Classification of Diseases,* a coding system which had been adapted for use in hospitals by the United States Public Health Service. This system for the first time provided for the coding of induced abortions for medical, legal or illegal indications at the third digit level. It identified spontaneous abortion as a separate category. The association of sepsis or toxemia with abortion was

[3] Canadian Council on Hospital Accreditation, *Guide to Hospital Accreditation* (Toronto, 1972), p. 88.

[4] *Eighth Revision, International Classification of Diseases* (Washington, D.C.: United States Public Health Service, 1968), p. 298.

identified in the fourth digit. The categories for the classification of abortion which have been used since 1969 are:

640—Abortion induced for medical indications.

This category includes surgical abortion and therapeutic abortion and has subsections with or without sepsis or toxemia.

641—Abortion induced for other legal indications.

This section includes cases of rape, incest, and has subsections classifying sepsis and/or toxemia.

642—Abortion induced for other reasons.

This section includes criminal or self-induced abortion and has a subsection for sepsis, haemorrhage, or trauma to a pelvic organ.

643—Spontaneous abortion.

This category deals with abortion (complete) (incomplete) (with accidental haemorrhage of pregnancy).

Habitual abortion.

Diagnosis of miscarriage.

This section includes a fourth digit category with or without sepsis or toxemia.

644—Abortion not specified as induced or spontaneous.

In this section, cases are assigned where the diagnosis is of "abortion" without any further specifications. This section has subcategories of sepsis and/or toxemia.

645—Other abortion.

This category is a specialty section reserved for abortion associated with unusual medical conditions as carneous mole, placenta previa. This has septic and toxemia subsections.

When this more detailed means of classifying abortion was introduced and in combination with extensive information maintained on morbidity, personnel and facilities for hospitals operating under the federal-provincial hospital insurance program, the means were available to establish a detailed and continuous assessment of abortion trends. The information on hospitals maintained by Statistics Canada included: the age, sex, residence, and disease classification of patients; the size, location, and ownership of hospitals and their types of medical and surgical facilities; and the number and occupational categories of hospital personnel. These sources included information on hospitalized patients who had a primary diagnosis of abortion (induced and spontaneous) for all hospitals whether they had established or had not established therapeutic abortion committees. Out-patient services (patients who were treated on a day-care basis), as in the case of patients who were aborted yet who were not admitted to an overnight stay in hospital, were not included in these statistics. While limited in certain respects (e.g., the omission of out-patients), these sources of statistical information provided the potential to

outline in considerable detail the trends in abortions and their associated complications for the country or to focus on specific questions such as factors associated with the variable prevalence of spontaneous abortions, the volume and distribution of illegal abortions, or the provincial and rural-urban distribution of hospitals where abortions were done by the residence of patients. Until the time of this inquiry these sources of information had not been used to provide detailed reviews of these questions.

In addition to adopting the Eighth Revision of the *International Classification of Diseases* in 1969, a federal inter-departmental committee was established that year which represented the Department of Justice, the Department of National Health and Welfare, and Statistics Canada in order to undertake the development of a national therapeutic abortion statistics system. This step was initiated by the Department of Justice which in a request on June 26, 1969 to Statistics Canada stated:

> During the passage of the Criminal Law Amendment Bill (Bill C-150) through the House of Commons, the Minister gave an undertaking to follow the new abortion law in practice... It would be appreciated if you could obtain statistics relating to the number of therapeutic abortions performed in the approved and accredited hospitals in Canada under this proposed new provision.

Within the framework of the information collected by Statistics Canada, the decision was reached to make use of the statistics available from hospital in-patient records. The disadvantage of this system was that records from all provinces were not usually received until between 12 to 18 months after the year for which they were assembled. On August 1, 1969 a letter under the signature of the Dominion Statistician was sent to the heads of hospital services plans in the 10 provinces, Yukon and the Northwest Territories. The letter mentioned the requests by the Department of Justice for information, noted that the new legislation was expected to be proclaimed by about the middle of August and asked the provinces to make arrangements with hospitals with therapeutic abortion committees to submit information to the province to complete on a monthly basis a one-page form requesting the following information:

(1) Number of certificates for permission to perform a therapeutic abortion issued by therapeutic abortion committees in the province;

(2) Number of abortions performed on residents of the province;

(3) Number of abortions performed on residents of other provinces;

(4) Number of abortions performed on residents of other countries.

The response to this letter was not encouraging. Some provinces were slow to respond to the request. Where the collection of information was started, there was a widespread reluctance on the part of hospital administrators and individual doctors to provide the information. Officials in some hospitals feared the effects on the hospital of reporting the number of abortions which were being performed, or even of reporting that any were being done in the hospital. Individual doctors in some hospitals refused to cooperate in any abortion reporting program because of their dissatisfaction with the legislation.

During the 11 months from August 1969 to the end of June 1970 following the Dominion Statistician's letter of August 1, 1969, Statistics Canada sent additional letters and telex messages to provincial officials and telephoned or had personal contact with provincial and hospital officials. The results of this activity at the beginning of July 1970 were:

(1) Unwilling to supply any information—one province;

(2) No acknowledgement of communication—one province;

(3) Indicated willingness to supply statistics but none supplied—two provinces and two territories;

(4) Submitting information but incomplete information submitted—one province;

(5) Supplying statistics, perhaps complete but not verifiable by Statistics Canada—five provinces. One of the provinces had supplied information for March and April of 1970 only; four provinces supplied information for the months January to May 1970.

On the request of the Minister of Justice who was concerned about the inadequacy of the information which was being obtained, at a meeting on August 7, 1970 between the staff of the Department of Justice and Statistics Canada, it was agreed to undertake a "crash" program. The Department of Justice specifically requested that information be obtained on:

(1) The number of accredited hospitals with therapeutic abortion committees;

(2) The number of non-accredited but provincially approved hospitals with therapeutic abortion committees;

(3) The reasons why other hospitals had not set up committees;

(4) The number of applications made for therapeutic abortions;

(5) The number of applications approved and the number of applications rejected by therapeutic abortion committees;

(6) The number of deaths from illegal abortions, historically and for the most recent time period.

In conjunction with officials from the Department of Justice and the Department of National Health and Welfare, Statistics Canada designed a one-page form for completion by all hospitals with therapeutic abortion committees in Canada and on August 25, 1970 sent copies of the forms to the provinces. To meet the deadlines requested by the Department of Justice, the provinces were asked to attempt to have hospitals complete the form and submit it through provincial health authorities or directly to Statistics Canada by September 11, 1970. By September 14, 1970 the receipt of the letter of August 25 (sent under the signature of the Dominion Statistician, registered, special delivery, and airmail) had not been acknowledged by seven of the provinces, the Yukon and Northwest Territories. Two provinces had acknowledged receipt of the letter and had promised to have the forms completed. One province had submitted forms but the forms contained omissions or peculiarities which made it impossible to prepare all the proposed tables. Although the response by the hospitals was slower than the timetable required to enable

Statistics Canada to meet the deadlines requested by the Department of Justice, all hospitals in Canada with therapeutic abortion committees, except for 2 or 3 hospitals in Ontario and Quebec, had submitted reports. Based on information from this special survey, Statistics Canada issued its first report on therapeutic abortions in Canada on November 20, 1970.

Early in 1971 the interdepartmental committee recommended the setting up of a more detailed reporting system than the existing "crash" program format on therapeutic abortions. Requiring the approval and participation of provincial health authorities, the committee recommended that an individual case register for therapeutic abortion patients be established. The information which it was agreed would be collected for each patient who had had an abortion approved by a hospital therapeutic abortion committee included:

I. General Items

1. Hospital identification—name and address;
2. Case identification—hospitalization number or hospital case number;
3. Province of report;
4. Province of residence of the patient.

II. Demographic Items Concerning the Patient

5. Age;
6. Marital status;
7. Previous deliveries;
8. Previous abortions—spontaneous and induced;
9. Date of last normal menses;
10. Date foetus expelled.

III. Medical Items Concerning the Patient

11. Surgical procedure(s) used;
12. Concurrent sterilization and procedure used;
13. Abortion complication(s), if any;
14. Days of hospitalization;
15. Indication—medical, psychiatric, or social.

All participating hospitals were asked to complete the General and Demographic Items (1-9) and the days of hospitalization (14). The completion of the five Medical Items (10-12, 13, 15) was requested on an optional basis. During the autumn of 1971, this format was pre-tested in Manitoba, Saskatchewan and Alberta with the revised program submitted for review to all of the provinces in November 1971. The use of the individual case register started in one territory and six provinces in January 1972. By May 1974, all areas in the country were participating in this information collection system. It was not until that date that full information for the whole country was obtained on patients who had therapeutic abortions.

Areas Included	Date Started	Therapeutic Abortions Reported in Individual Case Register
		(%)
Alberta, Manitoba, New Brunswick, Newfoundland, Prince Edward Island, Saskatchewan, Yukon	January 1, 1972	17
Nova Scotia, Quebec	January 1, 1973	26
British Columbia, Northwest Territories	January 1, 1974	49
Ontario	April 1, 1974	86
All areas	January 1, 1975	100

The information provided by participating hospitals was routed through provincial health departments (three provinces and two territories) or sent directly (seven provinces) for tabulation to Statistics Canada. Providing a more extensive baseline of items on therapeutic abortion than had previously existed, the individual case register included information which permitted the analysis of: the length of gestation up to 28 weeks of induced abortion patients by other patient attributes; the types of procedure done by hospital attributes; post-operative complications related to the age, parity, and duration of pregnancy of patients; the identification of regions (provincial, rural-urban) and of categories of hospitals with unusual proportions of second and third-trimester abortion patients; health risk factors for young (under age 15) and older (above age 40) patients; the distribution of abortions comparing the location of hospitals where these procedures were done by the residence of patients on a local, regional, and provincial basis; the effects of abortion trends on fertility relating to the composition and growth of the Canadian population; and the attributes of hospitals with and without therapeutic abortion committees on the volume of type of abortion, and for hospitals with committees, factors related to the volume of induced abortions which were done.

Provincial medical care insurance commissions maintain information on the procedures paid for under existing fee payment schedules for physicians. Because there are sizeable variations between the provinces in how procedures are classified for payment, and in particular, how these relate to induced abortion, no uniform summary from these sources can be made for the country. Within the context of the categories used in a particular provincial fee schedule, and when combined with provincial hospital insurance sources, the following types of information have been compiled by some provincial medical care insurance sources: (1) age; (2) sex; (3) marital status; (4) place of residence; (5) the procedure paid for; (6) the location of hospitals; (7) the range of hospital facilities; (8) the cost of procedures; (9) the number of physicians doing specific procedures; and (10) the volume of procedures done by each medical specialty. Since 1970, four of the ten provinces have undertaken special reviews of abortion. These studies have been done by: Alberta (1975), Manitoba (1973), Ontario (1972), and Quebec (1974). One report on

abortion trends was published by Quebec, *Dossier sur l'avortement* (Conseil des Affaires Sociales et de la Famille, 1974).

Each provincial health authority and the federal Department of National Health and Welfare were asked about the means which they used to classify all categories of abortion, whether there had been any changes in these systems since 1969, and if they had any special problems involved in the classification of abortions. No problems in the classification of all categories of abortions were reported by six provinces. In Ontario the full four digit classification of the *International Classification of Diseases* was adopted in 1971. This classification provides for the listing of "abortions induced for other legal indications". This category of induced abortions is reported, although it is recognized that "medical indications are the only legal reasons for abortion in Canada". A separate classification is maintained in Ontario for the reporting of "medical indications".

In Manitoba, complications associated with therapeutic abortions are coded separately. Incomplete abortions (dilatation and curettage) are generally classified under code 643 (spontaneous) of the *International Classification of Diseases* in Alberta, while abortions induced by the saline procedure which are followed by a dilatation and curettage are classified under code 640. Abortions whose indications are not specified are listed under code 645. A dilemma in coding induced abortions according to the *International Classification of Diseases* used by Statistics Canada is that, as in the instance of Alberta, an intermediate step is required to derive this code which is based on the classification of the provincial medical fee schedule. As new procedures involved in the termination of pregnancies have been used, in British Columbia these procedures, such as intra-amniotic injection of urea, aspiration curettage or the laminaria tent have been subsumed within the existing codes of the *International Classification of Diseases.*

In its classification of medical care insurance statistics, the federal Department of National Health and Welfare relies upon provincial reports which classify abortions according to provincial fee code schedules. These systems of classification do not specify the types of abortions, but indicate the nature of the medical procedures which have been used. The Department of National Health and Welfare indicated there was a problem of comparability involved in the continued use of two different classification systems at the national level—the use of the *International Classification of Diseases* by Statistics Canada and the federal health department's use of the reporting system based on prescribed provincial medical fee code schedules. The federal health authority recognized that code 644, "abortion not specified as induced or spontaneous", of the *International Classification of Diseases* was a "catch-all" category, one which "may be used for abortions other than those induced directly for 'therapeutic' purposes".

Since the enactment of the abortion legislation in 1969, extensive sources of information have become available to federal and provincial health authorities and Statistics Canada. Three main sources on abortion statistics (hospitalization information; individual case register maintained by Statistics Canada; and provincial hospital and medical care insurance sources) were drawn upon

by the Committee in meeting some of its Terms of Reference. Because of changes in the means of classification, the variable range of items which were included in a particular source, and differences in the definitions of specific abortion procedures, trends for all categories of abortions cannot be analyzed with consistency and continuity. In each instance where these sources are used in the Committee's Report, the findings are interpreted within the context of how the information was obtained.

Two different systems are used in the classification of induced and other types of abortions at the national level. These systems lead to much confusion and inaccuracy in the classification of all categories of abortions.

The discrepancy is great between the actual and the potential use of existing sources of information about all types of abortion and their associated health complications.

Reasons other than a lack of information account for the paucity of resources allocated by government to the investigation of abortion or the full study of the questions which were initially put by the Minister of Justice on August 7, 1970. In these respects there is a need for more sunshine about information collected in the public interest. The fact that there has been little analysis of available sources is a measure of the sense of trepidation with which induced abortion has been seen and of the fragile accord which involves patients, physicians, hospitals, and federal and provincial authorities in the collection of abortion information.

Indices and trends: 1961-1974

The number of reported therapeutic abortions obtained by Canadian women over a period of years can be considered by itself, or compared with other factors involved in the composition and growth of the population. If the first approach is taken, then there was an absolute increase of 332 percent between 1970 and 1974. This change, which is substantial, gives little indication of other factors which may be related to the increase. Several means of comparison can be used to describe the number of therapeutic abortions done in Canadian hospitals. While all of these comparative measures show there has been an increase during this period, the size of the change varies with the index which is being used. The baseline indicators most often used in studies of births, maternal deaths, and abortions are: (1) total population; (2) women between the ages of 15 and 44 years;[5] (3) live births; and (4) live births and abortions.

The dilemma involved in using these several indicators of population growth, or in basing conclusions on only one measure, revolves around the definitions and the assumptions upon which they are based. In this context the equation of an increasing abortion rate with a declining birth rate poses a

[5] Depending upon the source of information from Statistics Canada, the age range varies between 10 and 54 years.

double-blind situation. Abortions function to lower a birth rate. Sterilization—a permanent means of contraception—by reducing the number of fertile women in the reproductive years serves to raise the birth rate among women who are capable of childbirth. Likewise, the comparison of live births and abortions with a total population composed of men and women provides no indication of the distribution by sex for that population which may have a balanced distribution, or as is the case with some communities in Canada, may have more men than women. If women in the childbearing years are taken as a denominator with which live births or abortions are compared, then the assumption is made that all women between 15 and 44 years are capable of reproduction. That this is not the case in Canada is evident from the 257,795 women who were sterilized between 1969 and 1973, which reduced the number of women in the reproductive years by 5.3 percent and on this basis revises upward both the birth rate and the reported abortion rate if this denominator is used. For these reasons no single measure by itself is sufficient to account for changes either in the birth rate or the abortion rate. The assumptions upon which these standards are based, some of which have been used for a long time in international studies, are no longer completely valid. A fresh look is called for to develop a composite index of the components of population growth which accounts for the number of women in the reproductive years, the number of live births, neonatal and perinatal deaths, the extent of sterility and sterilization, and the impact of various categories of abortion.

Prior to 1960 there was no accurate or uniform assessment of the number of abortions done in Canadian hospitals. This change came about as a byproduct of national hospital insurance. At the time Statistics Canada was given the authority to collect information on hospital morbidity and facilities. Prior to 1969 when the Eighth Revision of the *International Classification of Diseases* was introduced, there was no means of accurately identifying the several categories of abortion. Full information for Quebec and Alberta was not available for 1960. The records maintained by Statistics Canada listed all categories of abortions which were done in hospitals on an in-patient basis. No estimates are available for the 1960-1969 period of the number of induced abortions which may have been done on an out-patient basis. The shifts which have been published in how many abortions have been obtained relate directly to trends in all categories of reported abortions. With this in mind, only rough measures are used which relate the number of abortions in all categories per 1,000 individuals in the total population and to the number of women between the ages of 10 and 54 years. This age category is taken for there is no age-specific information for women who had abortions in the 1960s.

The rate of all abortions to the total population of 4.8 per 1,000 in 1961 was the highest rate reported between 1961 and 1974. That was the first year after the introduction of national hospital insurance for which there was a complete listing of abortions done in hospital. During the rest of the 1960s, this rate dropped, reaching 2.1 per 1,000 in 1969. At the start of the 1970s the rate rose again. By 1973 it had increased by 81.0 percent over the rate for 1969, but it was 20.8 percent lower than the highest rate which was recorded in 1961.

The rate of increase of reported induced abortions was greatest between 1970 and 1971, when there was a change of 177.3 percent. In succeeding years,

based on this measure, there was a sharp curtailment in the pace of annual growth, which was 11.4 percent between 1973 and 1974. Each of the other four measures used to analyze abortion trends shows comparable trends—a high rate of increase between 1970 and 1971 and a declining rate of change in recent years. When the number of abortions is compared with the size of the Canadian population, the rate was 2.1 abortions per 1,000 individuals in 1974. While this rate had risen substantially from the 1970 rate of 0.5 per 1,000, between 1973 and 1974 it rose by 4.8 percent. **In 1974, 10 out of every 1,000 women (9.5 per 1,000) between the ages of 15 and 44 years had a reported induced abortion in a Canadian hospital. For every 100 live births there were 13.9 induced abortions.** What these measures involve is a comparison of two shifting trends as in the case of the increase in the number of abortions with a declining birth rate.

TABLE 4.1

THERAPEUTIC ABORTIONS PER 1,000 FEMALES 15-44 YEARS AND THERAPEUTIC ABORTIONS PER 100 LIVE BIRTHS: BY PROVINCE, 1970-1974*

STATISTICS CANADA

Province	Therapeutic Abortions per 1,000 females 15-44 years					Therapeutic Abortions per 100 live births				
	1970	1971	1972	1973	1974	1970	1971	1972	1973	1974
All areas	2.4	6.4	7.9	8.6	9.5	3.0	8.6	11.2	12.6	13.9
Stratum I										
British Columbia	6.4	15.0	16.7	17.8	19.0	7.9	20.2	23.7	26.7	28.3
Yukon	1.6	2.0	10.9	17.3	14.6	1.3	1.6	10.6	18.1	12.7
Ontario	3.3	9.4	11.5	12.5	13.7	4.1	12.4	16.2	18.3	20.0
Alberta	3.3	8.6	10.2	10.7	11.4	3.6	10.2	13.3	13.8	14.7
Northwest Territories	—	—	5.6	6.1	9.4	—	—	3.6	4.2	7.2
Stratum II										
Nova Scotia	1.6	3.9	5.0	5.3	6.1	1.8	4.5	6.2	7.0	8.2
Manitoba	1.2	4.0	5.6	5.9	6.6	1.3	4.6	6.8	7.4	8.2
Saskatchewan	1.1	4.1	5.7	6.6	6.5	1.3	4.7	6.7	8.2	7.8
Stratum III										
Prince Edward Island	0.8	1.8	2.0	1.7	2.1	0.9	1.9	2.2	2.2	2.6
New Brunswick	0.5	1.1	1.3	2.4	3.1	0.6	1.2	1.6	3.0	3.8
Quebec	0.4	1.3	2.0	2.2	3.1	0.6	2.1	3.4	3.7	5.2
Newfoundland	0.2	0.7	1.1	1.6	1.6	0.2	0.6	1.0	1.6	1.8

* Rates per 1,000 females 15-44 years of age for 1970 and 1971 and for some areas for 1972 to 1974 were based on the estimated number of induced abortions in the age group.

Two measures, the number of women between the ages of 15 and 44 years and the number of live births, show substantial differences in the distribution of induced abortion rates between the provinces. The induced abortion rates for British Columbia, Ontario, and Alberta for the five-year period, based on the number of females between 15 and 44 years of age and the number of live

births, were between one and one quarter times to two and one half times higher than the rates for all areas. These provinces contributed more than 80 percent of the total induced abortions for Canadian residents for each year between 1970 and 1974. The abortion rates for Nova Scotia, Manitoba, and Saskatchewan ranged approximately from one-third to slightly more than half of the abortion rates for all areas. The abortion rates for Newfoundland, Prince Edward Island, New Brunswick and Quebec were less than one-third of the abortion rates for all areas.

The U-shaped distribution of all categories of induced abortions from 1961 to 1974, high-low-high, was influenced by three related trends which involved the reporting of abortions by government sources. These factors were: (1) the definitions used in the classification of abortions; (2) the number of illegal abortions obtained by Canadian women; and (3) the number of Canadian women obtaining abortions in the United States.

Induced, spontaneous, and other abortions

Prior to 1969 there was no statistical breakdown for the country of the reported number of spontaneous and therapeutic abortions. The total number of reported abortions (induced in hospital; induced on an out-patient basis; spontaneous; and other categories) rose from 77,228 in 1971 to 84,106 in 1973. When these abortions are considered as a proportion of the number of live births, induced abortions rose from 8.6 to 12.6 percent; spontaneous abortions from 1.4 to 1.7 percent; and other abortions dropped from 9.2 to 8.5 percent. Almost half of all reported abortions in Canada in 1971 (49.7 percent) were induced; 6.5 percent were spontaneous; and other abortions accounted for 43.8 percent. This distribution shifted by 1973 to include 57.3 percent induced abortions; 7.1 percent spontaneous abortions; and 35.6 percent other abortions. In absolute numbers, abortions classified as "other" declined from 33,275 to 29,938 between 1971 and 1973.

In the Eighth Revision of the *International Classification of Diseases* the coding categories of 640-641 are used to list therapeutic abortions; category 642 includes abortions induced for other reasons such as criminal or self-induced; category 643 is used to list spontaneous abortions or miscarriages; and categories 644-645 constitute a catch-all classification for abortions not specified as induced or spontaneous. Categories 640 and 641 listing induced abortions for medical or other legal reasons are the codes used to list officially reported therapeutic abortions, i.e., those induced abortions which have been performed after approval has been given by a hospital therapeutic abortion committee. By definition, abortions which are not considered or listed in these two coding categories do not require the approval of such a committee. Abortions in categories 643-645 constituted 42.7 percent of reported abortions in 1973.

Category 642, "other induced abortions", does not involve a review of patients by a hospital therapeutic abortion committee. Patients classified under

this code dropped from 87 in 1969 to 65 in 1973. The number of spontaneous abortions, or those occurring naturally for physical and genetic reasons, are regarded as invariate or unchanging. Although estimates vary, after a woman has missed her first period it is generally estimated that among women living in western countries the spontaneous abortion rate is about 15 percent. It has been found in some studies that the spontaneous abortion rate varies by a woman's age with older women having higher rates than women in their early twenties. The rate for reported spontaneous abortions remained relatively constant in Canada between 1971 and 1973.

Categories 644 and 645 are the two final categories used for the classification of abortion. The full listing for category 644 is:

644—Abortion not specified as induced or spontaneous.

Includes: abortion (complete; incomplete; with accidental haemorrhage of pregnancy), not specified as induced or spontaneous.

The listing for category 645 is:

645—Other abortion

Includes: carneous mole
fleshy mole
haemorrhagic mole
molar pregnancy
} not specified as undelivered
placental polyp with abortion
retained products of conception

Abortions not specified as induced or spontaneous (category 644) accounted for 113,533 reported abortions between 1970 and 1973, a number almost equal (91.5 percent) to the 124,129 reported therapeutic abortions done in Canadian hospitals for the same period.

TABLE 4.2

ABORTION RATES PER 1000 POPULATION, 1973

STATISTICS CANADA

Province	Classification of Abortions*			
	Induced	Spontaneous	Other	Total
Newfoundland	0.4	0.13	2.1	2.6
Prince Edward Island	0.4	0.03	1.8	2.2
Nova Scotia	1.2	0.06	1.3	2.6
New Brunswick	0.5	0.05	1.5	2.1
Quebec	0.5	0.24	1.3	2.0
Ontario	2.8	0.05	1.6	4.5
Manitoba	1.3	0.37	1.3	3.0
Saskatchewan	1.3	0.12	1.3	2.7
Alberta	2.4	1.73	2.4	6.5
British Columbia	4.0	0.24	4.0	8.2
TOTAL	2.0	0.27	1.3	3.6

* Based on codes 640,641 (induced), 643 (spontaneous) and 644 (other) of the *International Classification of Diseases.*

The ratio of induced abortions was three times higher for Nova Scotia than Newfoundland and Prince Edward Island, while the rate in British Columbia was 10 times higher than for Newfoundland and Prince Edward Island. **Provinces with lower rates for induced abortions had substantially higher rates for spontaneous abortions and other abortions** (Code 644). The rate for spontaneous abortions in Quebec was five times higher than its two neighbouring provinces of New Brunswick and Ontario, while the rate for Alberta of 1.73 spontaneous abortions per 1,000 live births was 35 times higher than the 0.05 rate for New Brunswick. With the exception of Nova Scotia, the eastern provinces of Newfoundland, Prince Edward Island, New Brunswick, and Quebec had lower rates of induced abortions than other abortions (Code 644) in 1973. The rate of induced abortions in Ontario was higher than for other abortions, and this ratio between induced and other abortions was balanced for the four western provinces.

The rate of spontaneous abortions, those abortions classified as resulting from physical or genetic causes, was 17.4 per 1,000 *live births* for Canada in 1973. The rate of spontaneous abortions varied substantially between the provinces, with low rates occurring in Prince Edward Island (1.6), New Brunswick (3.1), Ontario (3.4), and Nova Scotia (3.8); intermediate rates in Newfoundland (5.7) and Saskatchewan (7.6); and high rates in British Columbia (16.0), Quebec (17.1), Manitoba (21.8), and Alberta (99.7).

In terms of their rank order from low (1) to high (10), the rates by province for induced, spontaneous, and other (code 644) abortions per 1,000 *live births* in 1973 was:

	Induced Abortions	Spontaneous Abortions	Other Abortions
Newfoundland	1	5	7
Ontario	2	3	9
Prince Edward Island	3	1	10
New Brunswick	4	2	5
Quebec	5	8	6
Nova Scotia	6	4	3
Manitoba	7	9	2
Saskatchewan	8	6	8
Alberta	9	10	1
British Columbia	10	7	4

In addition to an absolute decrease between 1969 and 1973 in the number of "other" abortions (code 644), the distribution of abortions in this category varied considerably between the provinces. Similar substantial differences occurred among the provinces in the reported rates for spontaneous abortions. There has been no detailed study of the medical reasons of the diagnoses associated with the sizeable number of abortions listed in the "catch-all" categories of 644 and 645 in the *International Classification of Diseases.* While the trend was not uniform for all provinces, and varied somewhat with the comparative baseline which was used, provinces which had lower rates of induced abortions in 1973 had proportionately higher rates of "other" abor-

tions. In contrast, in those provinces which had higher rates of therapeutic abortions, these rates were of the same order for "other" abortions.

While it is usually assumed that within defined proportions the prevalence of spontaneous abortions is relatively invariate, this was not the case in the rates of reported spontaneous abortions among the provinces. In reviewing the classification of all categories of abortions and the trends for induced abortions with the senior medical staff of the 140 hospitals visited by the Committee, while there was no consensus on these issues, the explanations most frequently advanced to account for the variation in abortion rates involved the impact of induced abortions in lowering the rate of spontaneous abortions and the nature of variable medical customs used in the classification of abortions. A number of heads of hospital departments of obstetrics-gynaecology concluded that trends and differences in the rates of spontaneous abortion were accounted for by an improved standard of living, more extensive maternal care, the use of more effective drugs, and because the rate of induced abortions had risen, a number of women, because of their lower parity and the more extensive use of contraception who otherwise might have spontaneously aborted had instead had therapeutic abortions.

TABLE 4.3

ABORTIONS PER 1000 LIVE BIRTHS, 1973

STATISTICS CANADA

Province	Classification of Abortions*			
	Induced	Spontaneous	Other	Total
Newfoundland	16.2	5.7	95.2	117.1
Prince Edward Island	21.7	1.6	108.7	132.0
Nova Scotia	70.1	3.8	79.2	153.1
New Brunswick	29.8	3.1	83.2	116.1
Quebec	37.4	17.1	90.6	145.1
Ontario	18.3	3.4	99.7	121.4
Manitoba	74.2	21.8	67.9	163.9
Saskatchewan	82.3	7.6	97.1	187.0
Alberta	138.2	99.7	8.8	246.7
British Columbia	267.1	16.0	80.7	363.8
TOTAL	125.4	17.4	84.3	227.1

*Based on codes 640, 641 (induced), 643 (spontaneous), and 644 (other) of the *International Classification of Diseases.*

While plausible, these reasons do not fully account for the fact that Alberta and British Columbia, both of which had high rates of therapeutic abortions in 1973, also had high rates of spontaneous abortions (99.7 and 16.0 per 1,000 respectively in 1973), or for the sharp inter-provincial differences in the rates for spontaneous abortions. An alternate explanation put forward by some obstetrician-gynaecologists was that variations in the rates listed for therapeutic abortions, spontaneous abortions, and other abortions (code 644)

resulted from how these operations were classified. According to this perspective, what might be classified after a review by a hospital committee as a therapeutic abortion in one hospital could be listed either as a spontaneous abortion or "other" abortion (code 644) in hospitals without committees. The extent to which social and professional factors might influence the definition and the classification of spontaneous and other abortions was reviewed on the basis of information obtained by the survey of hospitals undertaken by the Committee.

In the survey of general hospitals, information was requested on 1975 vital statistics relating to stillbirths, maternal deaths, and spontaneous abortions. Information was incomplete for a number of hospitals which used central statistical compilation sources. Representing 195,317 reported live births for 1975, or 56.5 percent of 1974 live births,[6] the experience of 404 general hospitals was considered in terms of the number of reported spontaneous abortions relative to the number of reported live births. In listing this information for the Committee, hospitals included information on spontaneous abortions (code 643) and abortions not specified as induced or spontaneous (code 644). The rate of these reported non-induced abortions per 1,000 live births by the size of hospitals is given in Table 4.4 for: (1) hospitals with therapeutic abortion committees; (2) lay hospitals (voluntary associations, municipal, provincial, or federal) without committees; and (3) religious hospitals (owned by or affiliated with a religious denomination) without therapeutic abortion committees.

On the basis of the usually accepted definition of spontaneous abortion and the fact that abortion not specified as induced or spontaneous (code 644) is a residual category, a relatively uniform distribution of abortions in these categories might be expected among all general hospitals. This was not the case. **The rates of spontaneous and other abortions (codes 643 and 644) varied substantially by: (1) the size of hospitals; (2) whether hospitals had established or not established therapeutic abortion committees; and (3) the type of ownership of hospitals without committees.**

For the 404 hospitals in which 195,317 live births were reported for 1975, the ratio of spontaneous and other non-induced or spontaneous abortions was 78.2 per 1,000, or in terms of percentages, were 7.8 percent of live births. Small (under 99 beds) and intermediate size (200-299 beds) hospitals had the highest ratios, followed by hospitals with 100-199 beds. The largest hospitals, those with more than 300 beds where a majority of the live births occurred (58.0 percent) had a ratio of 72.7 per 1,000 or 18.2 percent lower than small hospitals under 99 beds which had 11.8 percent of the live births.

For the 161 hospitals with therapeutic abortion committees which provided full information, the ratio of spontaneous and other abortions (77.0 per 1,000 live births) was comparable to the ratio (78.2) for all hospitals. For the hospitals with committees, there was an inverse distribution of spontaneous and other abortions by the size of the hospital. The ratio for small

[6] The total 1975 live births were unknown for the country at the time of the survey.

hospitals was 96.4 per 1,000 live births, a ratio which was 26.4 percent higher than the ratio of 71.0 per 1,000 of hospitals with over 300 beds. For those hospitals without committees which were owned by community associations, municipalities, and provincial and federal governments, the overall ratio of these categories of abortions of 87.9 per 1,000 live births, was 11.1 percent higher than for all hospitals. With the exception of hospitals with over 300 beds, there was a direct relation between the size of a hospital and the ratio of spontaneous and other abortions per 1,000 live births. This ratio rose from 82.8 per 1,000 for small hospitals (under 99 beds) to 119.9 per 1,000 for intermediate hospitals (with 200 to 299 beds). This ratio of 119.9 per 1,000 live births was 34.8 percent higher than the ratio for all hospitals (78.2 per 1,000).

TABLE 4.4

SPONTANEOUS AND OTHER ABORTIONS PER 1,000 LIVE BIRTHS IN COMMITTEE AND NON-COMMITTEE HOSPITALS: BY SIZE AND OWNERSHIP OF HOSPITALS, 1975*

NATIONAL HOSPITAL SURVEY

Size of Hospital	Spontaneous and Other Abortions per 1,000 live births			Total
	Hospitals With Committees	Lay Hospitals Without Committees	Religious Hospitals Without Committees	
Under 99 Beds	96.4	82.8	85.7	88.8
100-199 Beds	84.0	90.7	65.3	82.1
200-299 Beds	85.8	119.9	81.8	88.4
300 Beds and above	71.0	85.2	68.4	72.7
Average	77.0	87.9	70.7	78.2

*Codes 643 and 644, *International Classification of Diseases.*

The experience of religious hospitals without committees was different from hospitals with committees and non-religious hospitals without committees. These hospitals had the lowest ratio (70.7) of spontaneous and other abortions per 1,000 live births. Small and intermediate-sized religious hospitals had higher ratios, followed by large hospitals (over 300 beds) and hospitals with 100 to 199 beds. In comparison with non-religious hospitals without committees, the ratio of spontaneous and other abortions per 1,000 live births of religious hospitals was 19.7 percent lower.

Like the uneven 1973 provincial distribution of therapeutic, spontaneous and other abortions, this information on the committee status and ownership of hospitals revealed marked differences involving their experience with spontaneous and other abortions. **Religious hospitals, most of which on stated moral**

principles were opposed to induced therapeutic abortion, had the lowest ratio per 1,000 live births of spontaneous and other abortions.

In the judgment of the Committee, this ratio for religious hospitals represents a more accurate estimate of abortions which result from natural and biological causes. Hospitals with therapeutic abortion committees had a higher ratio than religious hospitals, but one which was considerably lower than for non-religious hospitals without committees. For hospitals with therapeutic abortion committees, the option was available to classify abortions as therapeutic (codes 640-641). For whatever reasons, this option was not available to non-religious hospitals without committees. Their experience with considerably higher ratios of spontaneous and other abortions may represent differences in: (1) the attributes of patients seeking care at these hospitals; (2) the quality of care which was provided; or (3) the definitions used to classify abortions. From the site visits made by the Committee to 140 hospitals, there was no indication of marked differences in the age, marital status, or social circumstances of patients seeking care along these lines. All of the hospitals in the Committee's survey were approved by provincial health authorities and a considerable number in each category (with and without committees) were accredited. The substantial differences in the rates for spontaneous and other abortions resulted from the different definitions which were used in the classification of abortions.

Illegal abortions

For the purposes of this inquiry legal abortions were defined as abortions done after approval had been given by a duly constituted hospital therapeutic abortion committee in an approved or an accredited hospital in Canada, as well as those spontaneous abortions and "other" abortions designated in the *International Classification of Diseases*, codes 644-645. Illegal abortions were defined as those induced abortions which were not so classified which were done in Canada: (1) in hospitals without committees; (2) in physicians offices; (3) by laymen; and (4) were self-induced. Induced abortions obtained by Canadian women outside the country were not defined as being illegal, as under Section 5(2) of the Criminal Code, "Subject to this Act or any other Act of the Parliament of Canada, no person shall be convicted in Canada for an offence committed outside of Canada".[7]

Knowledge of the Law. A substantial number of patients who had induced abortions as well as many physicians, nurses and people across Canada did not know the terms of the Abortion Law. A large number of individuals in each group who were surveyed by the Committee either said that obtaining an abortion was illegal in Canada, attributed to the law terms which it did not have, or did not know what the statute involved. Despite this lack of knowledge about the law, the Committee found that many individuals—patients, doctors,

[7] *Criminal Code* Revised Statutes of Canada 1970, C. c-34, s.5.

nurses and the public—held strong views on the issue of abortion and on what they imputed to be the terms set out in the law.

The Abortion Law does not directly stipulate the length of time in weeks for a pregnancy concerning the abortion procedure. In requiring that this operation must be done either in an accredited or an approved hospital, the requirement of the Canadian Council on Hospital Accreditation is involved concerning the use of the *International Classification of Diseases*, a codification system which defines abortion as "any interruption of pregnancy before 28 weeks of gestation with a dead fetus".[8] In the survey of all obstetrician-gynaecologists in Canada and a 25 percent sample of family doctors, these physicians were asked: "What is your understanding of the length of gestation set for a therapeutic abortion in the Abortion Law?" The results indicated that a majority of doctors believed that the law sets a specific time requirement in terms of the number of weeks when the abortion procedure can be done.

More family doctors (55.0 percent) than obstetrician-gynaecologists (22.4 percent) reported that the length of gestation was under 16 weeks. A third of the family doctors (30.5 percent) and two thirds (63.6 percent) of obstetrician-gynaecologists set the upper limit at 20 weeks. An almost equal number of both groups of physicians gave the length of time as above 20 weeks. Less than 1 percent of family doctors and obstetrician-gynaecologists stated that the Abortion Law set no time limits within which it was legal to do this procedure. These opinions of physicians have direct implications in terms of the guidelines set for the length of gestation by hospital therapeutic abortion committees and how doctors, in particular family physicians who were the source of primary contact by patients, counselled women seeking an abortion. About 3 out of 4 nurses in the hospital personnel survey (76.0 percent) done by the Committee said they knew the terms of the Abortion Law, but 34.1 percent set 12 weeks as the legal limit for induced abortions, 13.6 percent cited 16 weeks and 16.7 percent 20 weeks.

Knowledge of the law was obtained by the Committee from two groups of patients, a small number who had abortions in the United States and from 4,754 patients who had abortions in Canadian hospitals in 1976. A fifth of the patients who went to the United States (22.6 percent) said they had been told by a physician that getting an abortion in Canada was illegal. The patients who obtained abortions in 1976 in Canadian hospitals were asked: "Would you tell us what rules and laws are used to decide if a woman can have an abortion?" Half of these patients knew nothing about the law (50.5 percent) and a few (2.0 percent) felt abortions were illegal. Among the women who were carrying their pregnancies to term and who were assisted by welfare agencies or living in maternity homes, 2 out of 5 (40.0 percent) said that obtaining an induced abortion was illegal in Canada.

The findings from these surveys indicate that **there is a widespread lack of knowledge about the Abortion Law. Its specific terms are often misunderstood.** There has been some considerable public discussion about the law. A

[8] Eighth Revision *International Classification of Diseases*, Washington: United States Public Health Service, 1968, p. 298.

number of widely quoted surveys and polls have been done. In the light of the information obtained by the Committee, it is not clear what some of these previous findings may represent, for it has been usually assumed that people whose opinions were recorded knew what they were talking about in terms of the actual sections of the Abortion Law. The Committee did not accept these assumptions about an *a priori* knowledge of the Abortion Law. In seeking information from patients in Canada and the United States, physicians, and in the national population survey, each group was asked either if obtaining an abortion was legal or illegal in Canada or about their knowledge of the specific terms of the law. A number of other questions seeking opinions about whether individuals felt the law was too liberal or too restrictive or the conditions under which they felt induced abortions should be obtained were also asked. But these questions, like those used in other investigations, must be seen in the context of whether in fact people know what the law is about abortion. This was decisively not the case for the individuals from whom information was obtained by the Committee.

Although the terms of the Abortion Law went into effect on August 26, 1969, over six years later in 1976 a majority of physicians who were surveyed did not know its terms relating to the length of gestation, approximately half of the patients who had abortions did not know about the law, and only one third of the individuals in the national population survey said that getting an induced abortion was legal in Canada. Lack of knowledge or inaccurate knowledge about the law poses a major dilemma in how its procedures operated in practice. This lack of information contributed in part to different standards which were used by hospitals and physicians involved in the abortion procedure and accounted for the fact of some patients leaving the country to obtain abortions. For some abortion referral agencies in Canada and a large number of abortion centres in American states adjacent to the Canadian border, it served well their financial and practice interests to maintain a mystique about the issue and to reinforce the myth that induced abortion under any circumstances was illegal in Canada.

Charges and Convictions. It is estimated that a sizeable number of Canadian women in recent decades obtained illegal abortions. While their exact number is unknown, many women attempted or succeeded in self-induction. Most of the illegal abortions were procured from laymen, itinerant quacks, and licensed or unlicensed physicians. The "tracer" effects of illegal abortions were visible in the form of an extensive number of medical complications (sepsis, perforated uterus) or to a lesser extent maternal deaths associated with abortions. Although information for Ontario is missing, the number of operations for abortion with sepsis across Canada rose from 849 in 1961 to 1,608 in 1966, or almost doubled during this period. The number of such cases dropped to 1,302 in 1969, 1,173 in 1970, 1,239 in 1972, to 907 in 1973. Between 1962 and 1966, abortion became the leading cause of maternal deaths in Ontario, accounting for 19.7 percent of these deaths of women. **The number of deaths of women for Canada resulting from attempted self-induced or criminal abortions, which averaged 12.3 each year between 1958 and 1969, dropped to 1.8 deaths annually from 1970 to 1974. In 1970 there were five**

maternal deaths due to illegal abortion in Canada, one in 1971, one in 1972, none in 1973, and two in 1974.

While self-induction and the involvement of illegal sources to terminate a pregnancy were criminal offences, virtually no charges through the years were laid against the women who sought an abortion. Such women were regarded as the victims of unfortunate circumstances. The force of the law was brought against illegal abortionists. During the 1950s and 1960s almost every major city in the country had laymen or physicians who were known to do abortions, and to whom patients were referred. These cities included Halifax, Moncton, Montreal, Toronto, Hamilton, Winnipeg, Calgary, Edmonton, and Vancouver, as well as smaller centres such as Waterford, Blind River, Sturgeon Falls, Olds, and Lacombe. The nature of this practice which was said to have occurred was given by two physicians.

> I am no longer in practice. My colleagues in medicine shunned me, although 90 percent of the women who came to me had been referred by physicians from as far away as Nome, Hawaii, New York, Montreal, Miami and points in between.
>
> I will not tell you how many abortions I procured, but I will say that I never lost a woman. The incidence of morbidity was nil. All operations were performed in my office under rigorous aseptic conditions; demerol was given as a sedative. The operation was done under simple infiltration anaesthesia, and the method was dilatation and curettage. No patient over twelve weeks was accepted. My youngest patient was 14 years of age. She was brought to me by her parents on the recommendation of another physician. My oldest patient was aged 47 years. I aborted the same woman eight times, without incident. She refused to be sterilized. It was against her beliefs as she was Roman Catholic. I am unalterably opposed to the institution of Abortion Committees. They waste too much valuable time. Furthermore, there are no such things as Appendectomy, etc. Committees.
>
> As far as I am concerned, abortion is a matter between a woman and her physician, and in the final analysis concerns the woman alone, if her physician will not serve her she should be sent to one who will, soonest! Time which is of the essence should not be wasted.
>
> • • •
>
> I have personally performed over 1,000 illegal first trimester abortions between 1967 and 1970.
>
> I am vehemently opposed to forcing hospitals to set up abortion committees when its personnel and doctors are substantially opposed. Of course, no staff should be forced to cooperate in any hospital or clinic, against their will. I now see few patients. But even then, when I meet women who are now much more in evidence who project an honesty and warmth and iconoclastic humour that has absorbed this new view of the cosmos, it is almost past the agony of indignation at the oppression they have suffered from male authority—political, social, ecclesiastical.

The Abortion Squad of the Morality Department of the Metropolitan Toronto Police estimated that thousands of criminal abortions were procured

annually in that area. Informal routes were well known. It was part of the folklore of the times that women were advised to "go to visit their aunts (or uncles) in _____ ". Most of the illegal abortionists were women. Several of the physicians who did abortions were reported to have been highly respected members of the medical profession, on occasion, a head of a hospital department, or the chief of medical staff.

Many family doctors and obstetrician-gynaecologists whom the Committee met across Canada reported that they had treated a high incidence of complications resulting from induced abortions. Prior to the change in the Abortion Law the hospital insurance statistical reporting system which documented the extent of reported complications resulting from illegal abortions was little used by health authorities or the medical profession. When visited by the Committee, none of the provincial health departments had any formal knowledge, past or present, of the scope of illegal abortions. The existence of known abortionists indicates that those practitioners who were felt to be competent were often tolerated as a necessary "social evil", a safety valve whose existence was allowed to preclude the flagrant incompetence of quacks.

TABLE 4.5

CRIMINAL CHARGES AND CONVICTIONS FOR INDUCED ABORTION: CANADA 1900-1972*

STATISTICS CANADA

Year	Charges	Convictions	Percent Convictions/ Charges
1900-1910	97	33	34.0
1911-1920	172	87	50.6
1921-1930	210	115	54.8
1931-1940	427	271	63.5
1941-1950	358	243	67.9
1951-1960	254	194	76.4
1961-1970	267	204	76.4
1971-1972	8	8	100.0
TOTAL	1,793	1,155	64.4

*Justice Statistics Division, Statistics Canada.

Between 1900 and 1972 there were 1,793 individuals charged with procuring or attempting to procure an abortion of whom 1,155, or 64.4 percent were convicted. The highest incidence of charges was during the decade of the Great Depression of the 1930s. The rate dropped substantially during the 1940s and levelled off during succeeding decades. During 1971 and 1972, there were eight individuals charged, all of whom were convicted. In 1969 the number of convictions dropped to nine from the total of 34 recorded in 1968. There were two convictions in 1972. While the number of persons who were charged over the period of seven decades took the form of a bell-shaped curve, low-high-low, the proportion of convictions rose steadily from 34.0 percent between 1900 and 1910 to 76.4 percent between 1951 and 1970.

The review of the Index of Cases of the Judicial District of York County from 1933 to 1975 indicated that during this 43-year period, there were 110 charges of: procuring miscarriage; an illegal operation; abortion manslaughter; giving a drug to procure an abortion; or attempted abortion. There were 68 convictions, or 61.8 percent of the individuals who were charged were convicted. None of the women who sought or had an illegal abortion or who had been involved as patients of those individuals charged with procuring an abortion were themselves charged. Of the cases involving abortionists which came before judges sitting without juries, 52.9 percent were convicted, while 37.3 percent of the individuals who were charged who appeared before juries in the Sessions Court were convicted. The 110 charges involved 97 individuals with five persons being charged twice at different times and four individuals being charged three times. The majority of the persons charged (94.8 percent) were laymen. Five physicians were convicted with sentences of four months, eight months, nine months, one year, and 18 months.

There were 55 individuals charged between 1960 and 1967, or an average of seven each year. In 1968 one individual was charged and convicted, two in 1969, and two in 1971. For this judicial county as well as for the country, the number of criminal charges and convictions dropped substantially two years prior to the date when the amendments to the Criminal Code went into effect on August 26, 1969. Knowledgeable observers have suggested that this sharp decline resulted from three factors: a widely held anticipation that the Criminal Code would be amended; an increase in the number of hospitals which did therapeutic abortions and mounting pressures within the medical profession to make legal what was being done; and a redirection of the energy of enforcement agencies to other issues such as the control of drug trafficking. While the actual reasons for the decline in charges and convictions may not be fully clear, there is no doubt that after reaching a peak between 1966 and 1967, a sharp decrease did occur during 1968. Representing only one measure, an incomplete one if taken by itself of the extent of illegal abortion, the trends in charges and convictions for this offence has involved only a handful of cases since 1971.

TABLE 4.6

CRIMINAL CHARGES AND CONVICTIONS FOR INDUCED ABORTION: JUDICIAL COUNTY OF YORK, 1933-1975*

Year	Charges	Convictions	Percent Convictions/ Charges
1933-39	9	8	88.9
1940-49	24	13	54.2
1950-59	17	11	64.7
1960-67	55	31	56.4
1968	1	1	100.0
1969	2	2	100.0
1970	-	-	-
1971	2	2	100.0
1972-75	-	-	-
TOTAL	110	68	61.8

*Source: Index of Cases of the Judicial District of York, 1933-1975.

Listed Therapeutic Abortions in Non-Committee Hospitals. Because the analysis of the information on the distribution of patients related to the hospitals with committees and hospitals without committees required an extensive re-working of the statistical records maintained by Statistics Canada, this analysis was only done for four provinces (New Brunswick, Quebec, Saskatchewan, and British Columbia) in different regions of the country. The purpose of the analysis was to determine the proportion of women who had this procedure done locally or in other hospitals in a province.

This analysis indicated that a number of abortions which were coded as therapeutic abortions (codes 640-641 of the *International Classification of Diseases*) were listed as having been done in hospitals without committees. In compiling its hospital morbidity records, Statistics Canada reports directly the coding of diseases provided by hospitals. Operating under the terms of the *Statistics Act, 1971,* Statistics Canada in its handling of information adheres to Section 16(1)(b) which stipulates:

> No person who has been sworn under section 6 shall disclose or knowingly cause to be disclosed, by any means, any information obtained under this Act in such a manner that it is possible from any such disclosure to relate the particulars obtained from any individual return to any identifiable individual person, business or organization.

In the context of these regulations, no identification by the Committee was possible of the hospitals involved to determine whether the cases reported were errors in the coding of these abortions or whether these were illegal abortions. **A total of 42 reported therapeutic abortions were done in hospitals without therapeutic abortion committees in four provinces in 1974.** There has been no review of the distribution of these reported induced abortions by provincial health authorities or Statistics Canada. The extent to which this listing occurs in the other six provinces and the two territories is unknown.

Volume of Illegal Abortion. Four sources of information were used to develop estimates of the extent of illegal abortion. These sources were: (1) information obtained from site visits to 140 hospitals by the Committee; (2) estimates of the prevalence of illegal abortion by physicians based on their own experience in medical practice; (3) the prior experience with induced abortion of patients in the national patient survey in Canada and a small group of Canadian women who had abortions in the United States; and (4) individuals reporting they had had illegal abortions who were interviewed in the national population survey.

The administrators, senior medical staff, and obstetrician-gynaecologists whom the Committee met at 140 hospitals in all provinces and the two territories reported that while the prevalence of deaths and complications resulting from illegal abortion had been high in the 1950s and 1960s, there had been no recent deaths attributed to illegal abortion at these hospitals. The complications associated with illegally induced terminations of pregnancy had virtually disappeared. Most of the physicians at these hospitals concluded that illegal abortions either were not now being done, or if this were the case, they were done so well that there were no deaths and few associated complications.

Physicians in the survey of family doctors and obstetrician-gynaecologists were asked what proportion of women in the community where they practiced obtained illegal abortions. A majority of both medical specialties (78.4 percent family physicians, and 68.3 percent obstetrician-gynaecologists) said they knew no patients who had had illegal abortions. A slightly higher number of obstetrician-gynaecologists (31.1 percent) than family physicians (19.9 percent) estimated that between 0 and 20 percent of women seeking abortion had this operation done illegally. A small number of physicians (0.49 percent) estimated that between 80 and 100 percent of the abortions were procured from illegal sources. Most of the physicians who reported a high number of illegal abortions practiced either in Ontario (23.5 percent) or in Quebec (58.8 percent).

Canadian women who had abortions at clinics or hospitals in the United States were asked if they had had a previous abortion, and if so, where and by whom it had been done. A small number (2.9 percent) had had illegal abortions done in doctors' offices in Canada. Of the total of 4,754 women in the national patient survey, 17.9 percent had had a previous abortion. For these women 73.9 percent had had this procedure done in a Canadian hospital, 9.8 percent at a clinic in the United States, 4.0 percent in a physician's office in Canada, and 2.4 percent from non-medical sources in Canada.

Calculated on the basis of rates per 1,000 women in the national population survey, the experience of women with illegal abortion varied by their age. For teenagers between 15 and 17 years, none reported having had an illegal abortion done in a doctor's office or induced by a layman. For older women this rate rose to 3.4 per 1,000 between 18 and 23 years, 6.2 per 1,000 between 24 and 29 years, 12.6 per 1,000 between 30 and 49, and 2.2 per 1,000 over age 50. The overall rate for women in the reproductive years of 15 to 49 was 6.6 per 1,000, a rate which was divided between illegal abortions done in doctors' offices (4.3 per 1,000) and induced by laymen (2.3 per 1,000).

The Committee has found in the work done for this inquiry that abortion is not a subject about which women easily talk when it relates to their personal experience. It is for this reason that the rate of 6.6 per 1,000 women who said they had had an illegal abortion can be regarded as a minimal estimate. If these rates are projected on an age-specific basis by developing different rates for each age category, then it is estimated that 46,096 Canadian women between the ages of 15 and 49 years have had illegal abortions. This estimate excludes women who have attempted self-induction or had abortions done in the United States.

Women in the national population survey were asked whether they had tried or had a self-induction. Section 251(2) of the Criminal Code provides that:

> Every female person who, being pregnant, with intent to procure her own miscarriage, uses any means or permits any means to be used for the purpose of carrying out her intention is guilty of an indictable offence and is liable to imprisonment for two years.

For all women in the national population survey, the rate per 1,000 who reported a self-induction was 8.5 and for specific age categories the rates were:

none for teenagers between 15 and 17 years; 6.8 per 1,000 between 18 and 23 years; 15.8 per 1,000 between 24 and 29 years; 5.0 per 1,000 between 30 and 49 years; and 15.5 per 1,000 for women over age 50 years. When these rates are projected on an age-specific basis it is estimated that 55,061 women in Canada had tried or had a self-induction.

The lower rates of illegal abortions among younger women corresponds with the decline in reported deaths and complications associated with illegal abortions and the number of charges and convictions of persons procuring illegal abortions. The information obtained from women in the national patient survey, while less representative of the total population than the national population survey, found similar trends by the ages of these patients.

The terms of the amended Abortion Law went into effect on August 26, 1969. If women between 18 and 23 years are considered with the current number of teenagers between 15 and 17 years, 3.4 per 1,000 in this age category had had an illegal abortion procured by a physician or a layman. The rate of self-induction for these ages was 6.8 per 1,000. This group of women between 15 and 23 years in 1976 represents those women in the reproductive years who would be affected if they sought an abortion under the amended legislation. In contrast, for women over the age of 24 years the rate of illegal abortions was 8.3 per 1,000 and 10.2 per 1,000 had tried self-induction. Unlike these older women over the age of 24 years, most younger women (15 to 23 years) had abortions either in a Canadian hospital or went to the United States for this operation. For the women in this national population survey, **one direct consequence of the amended abortion law was the sharp reduction of illegal abortions among teenagers and young women.**

Out-of-country abortions

Where and how Canadian women have obtained induced abortions has changed during recent decades. Overall during this period there has been an absolute increase in the reported induced abortion rate. From several sources of information including personal experiences provided by women to the Committee, judicial records, and the national population survey, women seeking abortion from the time of the Great Depression of the 1930s to the mid-1950s tried self-induction, turned to untrained abortionists, or had this operation done in a physician's office. Women now in their seventies and eighties have told or written to the Committee of their anguish and fears of coping with an unexpected or unwanted pregnancy. Getting an induced abortion was expensive. Because it was considered immoral and illegal, it was not discussed publicly. Few women who had abortions by these means told their friends or relatives, often not even members of their families. The stakes were high in terms of risks to moral and social standing and to permanent injuries to a woman's health.

As the abortion laws of other nations were modified after World War II, a few Canadian women, mainly those from families with higher than average

incomes, went abroad to get abortions. During the 1950s a number of Canadian women seeking abortions were referred by their physicians for this purpose to Japan, Sweden, Poland, and the United Kingdom.

Under the 1938 Act in Sweden, induced abortion could be approved on medical grounds when childbirth would entail: serious danger to a mother's life or health; physicial defect or weakness of the woman; on social grounds involving rape, incest, or pregnancy under age 15; and on eugenic grounds. This legislation was amended in 1946 to include a socio-medical indication involving a "woman's conditions of life and her circumstances in other respects." On the basis of these changes in the Swedish legislation, some Canadian physicians counselled their patients to seek abortions in that country. The women who did so were ill-advised. Regulations established by the Swedish National Board of Health virtually precluded the authorization of abortions for aliens.

> Aliens registered at the annual census and liable to taxes in Sweden come under the abortion law and may seek permission for abortion through the counselling centers. Other aliens have little chance of getting an abortion in Sweden. Every application must be drawn up according to law, and must include a certificate from a licensed Swedish physician. The Board will not consider a written petition with a certificate from a foreign physician or institutions or help with an application. If the woman comes herself to the Board, all the Board can do is to recommend her to ask the representatives of her country in Sweden for the address of a Swedish physician or to try to get hold of one herself. When a foreign woman applies in the regular way on the purely medical grounds of disease or disability, the Board sometimes gives permission for abortion in Sweden. When she applies on other grounds, they are generally prevented from doing so, mainly because they are unable to get a true picture of the conditions under which she lives.[9]

To preclude "the heartbreak and experience of a fruitless journey to Sweden", there was consideration of this issue between the senior officials of the Department of External Affairs, the Department of National Health and Welfare, and the Canadian Medical Association. Several articles appeared in professional journals and newspapers which described the Swedish regulations as they applied to aliens. A number of Canadians who went to Sweden for induced abortions subsequently had this operation done in Poland or the United Kingdom.

Combined with the trend of more women going abroad for abortions, there was an increase at this time in the number of women who obtained illegal abortions in Canada. The highest rate known to the Committee for illegal abortions was 12.6 per 1,000 women who were between 30 and 49 years of age in 1976. When these women were in their twenties and early thirties, they had obtained abortions from laymen in their homes (3.8 per 1,000) or physicians in their offices (8.8 per 1,000). This trend coincided with an increase in the number of convictions for procuring an illegal abortion. The number of doctors

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[9] Correspondence made available to the Committee. See also: R. L. Liljeström, *A Study of Abortion in Sweden*, Stockholm, Kungl. Boktryckeriet P.A. Norstedt & Söner, 1974. A contribution to the United Nations World Population Conference.

involved in doing illegal abortion increased. At several large hospitals across the country professional review procedures, often involving senior medical staff, were established to review abortion applications. A number of physicians who were at the time involved in this procedure told the Committee that they had been prepared to risk their professional careers had they been convicted because they believed that unless adequate medical care was given, women seeking induced abortions would resort to "incompetent butchers".

Two changes which occurred within a year had a profound impact on where Canadian women went to get abortions. The amended Canadian legislation went into effect toward the end of 1969. In 1970 several states in the United States revised their abortion statutes. During the years that followed these changes in legislation in Canada and the United States, major shifts took place involving where women obtained induced abortions in Canada and abroad.

While their numbers have never been fully known, fewer Canadian women at the start of the 1970s went to Europe for abortion. The number of Canadians who obtained legal abortions in the United Kingdom declined in successive years from 376 in 1969, 297 in 1970, 67 in 1971, 52 in 1972, 34 in 1973, to 24 in 1974. As hospitals across Canada established therapeutic abortion committees, a larger number of women than before sought approval for induced abortion at these facilities. Where such committees did not exist, or for a combination of other reasons women could not obtain abortion where they lived, abortion referral pathways emerged which channelled Canadian women to abortion clinics and offices in the United States. Most of these roads initially led to New York City and upstate New York cities adjacent to the international boundary. As other states amended their abortion legislation, several major north-to-south routes emerged.

Provincial medical care insurance commissions pay for the fees involved in the abortion procedure if this operation has been done in a provincial hospital, if patients retain their provincial residence status when this procedure is done in hospitals in other provinces and if it is considered a "required" medical procedure. The regulations governing the payment of medical services which may be obtained by Canadians when they are abroad vary among the provinces. In general, the payment for elective procedures is not reimbursed. Where emergencies occur or when patients are specifically referred to foreign medical centres on the written authorization of a physician, some provinces make provisions for the payment of these services based on the approved provincial medical fee schedules. Because the number of such requests for reimbursement is limited, most provinces do not separately record these payments in their statistical classification systems.

Provincial health authorities were asked to provide the Committee with information about the number of abortion patients who were residents of the provinces for whom payment had been made for abortions obtained out of the country. This information was not available for six provinces. Between 1970 and 1975, the costs of 124 abortions which had been obtained by Canadian women outside Canada were reimbursed at provincial medical fee schedule rates by four provinces. Based on the number of women reported by Statistics

Canada to have had abortions outside Canada in 1974, a number which in terms of information obtained by the Committee is an underestimate, the 22 cases for that year for which reimbursement was made represented 0.51 percent of women who had abortions outside the country.

Reported Abortions in the United States. In 1971 Statistics Canada received information from the State of New York that 3,849 Canadian women had obtained abortions in New York City. Information for the rest of New York State for that year was not available. In 1972, 6,167 Canadians had abortions in the State of New York. Little was known about the number of Canadian women who might have obtained abortions in other states. In some instances state statutes invoked residency requirements, while in other cases no statistical records were kept concerning aliens. The Abortion Surveillance Branch, Centre for Disease Control of the U.S. Public Health Service, which coordinated the compilation of national statistics on abortion for the United States relies on state health authorities for its information about the number of aliens obtaining abortions. Based on information received from this Branch and state health authorities, Statistics Canada concluded that "because of residency requirements and other factors, the number of Canadian residents who received therapeutic abortions in other states during 1972 is thought to be very small."

From 1972 to 1974 the total number of Canadian women who had abortions in the United States listed by the U.S. Public Health Service and state health authorities dropped from 6,167 to 4,699, or by 23.8 percent.[10]

Place Abortion Performed	Number of Canadian Women, 1974
California	8
Hawaii	1
Michigan	242
Minnesota	169
New York State (excludes New York City)	2,855
New York City	1,319
South Dakota	7
Vermont	95
Virginia	3
TOTAL	4,699

While the number of Canadians getting abortions in upstate New York had risen, there was a sharp decline in the number of women going to New York City for abortions. In its report on *Abortion Surveillance 1974* the U.S. Public Health Service listed 5,339 out-of-country residents who had had abortions in the United States in 1974.

[10] Abortion Surveillance Branch, Center for Disease Control, United States Public Health Service, Atlanta, Georgia, 1976. This updated information for 1974 supersedes out-of-country listing obtained from the same source given in: Statistics Canada, *Therapeutic Abortions, Canada, 1974: Advance Information.*

The move of Canadian patients away from New York City to clinics in upstate New York represents a dispersion of abortion services in the United States resulting from amended legislation in other states. One administrator of a large abortion office in New York City estimated that between 1970 and 1972 some 40 clinics in that city provided abortion services for women who came from across the United States as well as from several Canadian provinces. As new abortion services were started elsewhere in the United States and some hospitals in Canada established therapeutic abortion committees, the volume of abortion patients who were seen in clinics in New York City decreased sharply. In 1971 there were 268,573 reported abortions done in the State of New York, a number which rose to 299,891 in 1972, and dropped to 161,521 by 1974. Between 1971 and 1974 there was a 39.9 percent decrease in the number of abortions done in the state. The number of abortions done in other states adjacent to Canada increased as for instance in Vermont, which had nine reported abortions in 1971 and 1,930 in 1974.

Migrating Pathways. The abortion clinics which were contacted in the United States were asked to provide statistics, or if these were unavailable, estimates of: the number of Canadian women who had abortions at the clinic, hospital, or office in 1975; the total number of abortions done in 1975; the residence of Canadian patients; and by whom they had been referred. The information received by the Committee from clinics in the United States was incomplete (56.1 percent replied). The reasons why some clinics did not provide information to the Committee on the number of their Canadian patients included: inadequate patient record systems; distrust of any government-sponsored study which might document the number of alien patients for income tax purposes in the United States; the preservation of special arrangements, including fee-splitting, with some Canadian-based abortion referral agencies; and an attitude that it was not in their business interest to provide information which it was felt might make the obtaining of induced abortions more accessible in Canada. A number of these centres located in New York City and upstate New York which were well known to Canadian agencies did not provide information. For these reasons the information obtained from these sources by the Committee about the number of Canadians getting abortions in the United States in 1975 was a minimal estimate.

The changes involving the places where Canadian women went to get abortions in the United States were enmeshed in a strong competition to attract these patients among some of the clinics located in states along the international boundary. At least 6 of the 40 clinics visited by the Research Staff of the Committee had been established primarily to serve Canadian patients. In one instance the attending physicians routinely flew from New York City to do abortions in an upstate clinic. At another clinic, the physician-owner who had invested over $200,000 in his facility, said it would be a disaster if the Canadian law on abortion were to become more liberal for he would be put out of business. At many of the clinics, while their staff knew little about the staffing, the facilities, or services of their competitors, their administrators and medical staff downgraded the quality of care which was given elsewhere. The fees for abortion were often set competitively.

In reviewing the work of the 40 abortion clinics in the United States used by Canadian women, four measures of the quality of care were qualitatively assessed. These measures were: (1) general appearance of facilities; (2) the training of medical staff and the training and number of support staff; (3) the facilities and/or arrangements which were made for the emergency care of patients; and (4) the patient chart procedures and record systems. The staffing and services of these clinics ranged from sparsely furnished and equipped offices staffed by a receptionist, a nurse, and a part-time physician to major clinical facilities and services operated directly by hospitals. At least two of the 40 clinics were not operating within the terms of state licensing statutes.

There were no uniform standards established for the operation of these abortion services which ranged from physicians' offices to in-patient hospital facilities. The surveillance of the clinics in the United States by state health authorities was often non-existent, or operated at minimal levels requiring the perfunctory reporting of statistical information. In 1974, 36 states collected information on induced abortions, while 15 states had less complete reporting systems. On the basis of the number of Canadian women listed as patients by clinics and the number of Canadian women reported by state and federal agencies in the United States, this statistical auditing procedure is inaccurate and incomplete. The reported abortion rates of states such as Maine, Vermont, New York, and North Dakota were substantially inflated by a proportionately large number of Canadians getting abortions in these states, while in the case of these and other states, the Committee's findings indicate that a sizeable number of Canadian patients were not recorded in official state abortion statistics.

Four of the abortion services were based in hospitals, one had a full range of clinical facilities, and seven were located immediately adjacent to a hospital. Over half (58.6 percent) of the abortion clinics used by Canadian women in the United States had no formal affiliation with a hospital to provide for emergency services for patients, if abortion operation complications arose.

Most of the Canadian patients using the abortion clinics in the United States were reported by these centres to have been referred by Canadian physicians (55.5 percent) and community referral agencies (25.8 percent). One out of five Canadian women (18.7 percent) learnt about the clinics from friends, advertisements in Canadian newspapers, or toll-free telephone directory listings. Half of the clinics (48.3 percent) did not advertise their services, while the remainder used a variety of means to solicit Canadian patients. These methods, which sometimes included more than one approach, were:

providing brochures on request	13.8 percent
letters written to Canadian doctors	34.5 percent
letters written to Canadian referral agencies	24.1 percent
listings in Canadian telephone directories	13.8 percent
visits to Canadian agencies	10.3 percent
other	3.5 percent

Staff members of a number of Canadian referral agencies from time to time visited abortion clinics in the United States to review the range of services provided for patients. On the basis of these visits patients from Canada were selectively routed to those clinics which it was felt provided a good quality of medical care. No such visits were reported to have been made by Canadian physicians who referred patients to these clinics. Their decision to refer patients to these abortion clinics was based on letters and advertisements outlining the services which were provided. With the exception of abortion clinics in New York City, 62 clinics in each of the five regions in the United States drew Canadian patients who lived in nearby provinces.

1. Maritimes to New England and New York City.

   Maine: Bangor, Bar Harbour, Brunswick, Portland.
   Massachusetts: Boston, Brighton, Springfield.

2. Quebec to Mid-Atlantic States and New York City.

   Vermont: Burlington, Morrisville, Rutland.
   Upstate New York: Albany, Dobbs Ferry, Malone, Plattsburg, Syracuse, Tarrytown, Watertown.

3. Ontario to Western Upstate New York and Great Lakes' States.

   Illinois: Chicago.

   Michigan: Ann Arbor, Detroit, Grand Rapids.

   Upstate New York: Buffalo.

4. Manitoba to Midwest States.

   Minnesota: Minneapolis, St. Louis Park.

   North Dakota: Grand Forks.

5. Western Provinces to Northwest States.

   California: Oakland, San Jose.

   Washington: Bellingham, Renton, Seattle, Spokane, Tacoma.

Information from 62 clinics in the United States indicated that an estimated 6,957 Canadian women had obtained abortions at these centres in 1975. Based on 1974 figures provided by Statistics Canada,[11] there were 48,136 abortions. Added to this number for 1974 were 4,699 Canadian women who were reported by Statistics Canada to have had abortions in the United States. In the survey done by the Committee, clinics in 12 states and the District of Columbia listed 6,957 Canadian patients whose distribution was: California (6), Illinois (33), Kansas (10), Maine (156), Massachusetts (177), Michigan (975), Minnesota (154), Montana (0), North Dakota (171), New York (3,982), Vermont (280), Washington, D.C. (1), and Washington (1,012).

Estimates on the residence of Canadian patients were derived from three types of information provided to the Committee by abortion clinics in the

[11] Information on the number of therapeutic abortions done in Canadian hospitals was not available for 1975 at the time of this inquiry.

United States. These were: (1) statistical records maintained by the clinics; (2) estimates made by clinic administrators where patients from Canada lived; and (3) when residence information was omitted about the number of Canadians listed, an estimate was based on where the clinic was located and the provincial distribution of patients was distributed on a proportional basis of other clinics within the region. These estimates are given in Table 4.7 which also lists the 1974 ratio of abortions per 100 live births by province given by Statistics Canada and this ratio recalculated to include the number of Canadian women who obtained abortions in the United States in 1975. Based on this measure the national ratio rose from 13.9 to 15.9 or by 14.4 percent. The ratio changed the least in the provinces which had the highest listed abortion ratios, and it rose the most in those provinces listed by Statistics Canada which had the lowest reported induced abortion ratios. The changes in the ratios of induced abortions (combining experience for Canada and the United States of Canadian women) per 100 live births by province were:

	Percent Change
Newfoundland	22.2
Prince Edward Island	19.2
Nova Scotia	22.0
New Brunswick	57.9
Quebec	73.1
Ontario	7.0
Manitoba	23.2
Saskatchewan	12.8
Alberta	12.9
British Columbia	3.5
CANADA	14.4

TABLE 4.7

RESIDENCE OF CANADIAN PATIENTS GETTING INDUCED ABORTIONS IN THE UNITED STATES*

SURVEY OF CENTRES IN THE UNITED STATES

Province	Number of Induced Abortions		Ratio of Induced Abortions per 100 Live Births	
	Statistics Canada Listing 1974	Canadian Residents in U.S.A. 1975	Statistics Canada Listing 1974	Revised Listing Including Out-of-Country Abortions
Newfoundland	184	42	1.8	2.2
Prince Edward Island	50	10	2.6	3.1
Nova Scotia	1,062	234	8.2	10.0
New Brunswick	440	250	3.8	6.0
Quebec	4,453	3,277	5.2	9.0
Ontario	24,795	1,795	20.0	21.4
Manitoba	1,411	334	8.2	10.1
Saskatchewan	1,176	154	7.8	8.8
Alberta	4,391	546	14.7	16.6
British Columbia	10,024	315	28.3	29.3
CANADA	48,136	6,957	13.9	15.9

*Estimates for the Yukon and Northwest Territories could not be made from information provided by clinics in the United States.

Based on the reports of community agencies referring patients to clinics in the United States and clinics visited by the research staff of the Committee which refused to provide information, but which were known to serve Canadian women, the Committee estimated that between 10 and 20 percent more Canadian women than for whom information was available had abortions in the United States. If the reported number of 6,957 patients is recalculated on this basis, the number of Canadian women who had abortions in the United States in 1975 is estimated to have been between 7,655 and 8,351, or between 15.9 percent and 17.3 percent of the total number of abortions done in Canadian hospitals in 1974. Based on these estimates between 45,930 and 50,106 Canadian women obtained induced abortions in the United States between 1970 and 1975.

These trends are confirmed but at a somewhat higher level by the findings of the *national population survey* obtained from women who said they had had induced abortions in the United States. For every four women who said they had had an abortion in Canada, one woman said she had obtained an abortion in the United States, (ratio of 4.3:1). On this basis in 1974 there would have been an estimated 11,194 Canadian women that year who had induced abortions in the United States.

These estimates of the number of Canadian women getting abortions in the United States between 1970 and 1976 were derived from different sources of information. What their general proportions indicate is that a substantial number of Canadian women each year, at least between 15.9 percent and 23.5 percent of women obtaining abortion procedures annually in Canadian hospitals, obtained induced abortions in the United States.

Volume of induced abortions

There are three known sources of induced abortions obtained by Canadian women and one potential source which may involve induced abortions. The known sources are: (1) therapeutic abortions in Canadian hospitals; (2) illegal abortions; and (3) out-of-country abortions. A fourth potential source of induced abortions may be those abortions which are classified as being neither induced nor spontaneous. Reliable information is only available for the number of therapeutic abortions done in Canadian hospitals which have been approved by therapeutic abortion committees. For the other three sources of abortions, estimates have been based on information obtained by the Committee. The base year of 1974 is used in deriving rates as this is the last year for which there was a full tabulation available of the various categories of abortion.

Based on the national population survey, age-specific ratios were calculated which derived an estimate of 46,096 illegal abortions obtained by women between the ages of 15 and 49 years. None of the women between 15 and 17 years reported having had an illegal abortion. If the experience of women between 18 and 49 years is considered, then there were on an average 1,441 illegal abortions every year. When these illegal abortions are considered in

terms of live births, they represented for 1974 a ratio of 0.4 illegal abortions per 100 live births.

A total of 6,957 abortions obtained by Canadian women were reported by clinics in the United States in 1976. The Committee estimated that the actual number of Canadian women getting abortions in the United States was between 10 and 20 percent higher, or respectively 7,655 and 8,351. In the national population survey the proportion of out-of-country abortions was 23.5 percent of induced abortions obtained in Canadian hospitals, or for 1974, 11,194 abortions. As it was known that many clinics in the United States did not provide information to the Committee, an estimate of 20 percent is taken as the basis of the number of Canadian women who obtained induced abortions in the United States. In terms of 345,645 live births in 1974 this results in a ratio of 2.8 out-of-country induced abortions per 100 live births.

When the estimates of the three known sources of induced abortion are combined, they represent a ratio of 17.1 induced abortions per 100 live births for 1974.

Type of Induced Abortion	Number	Rate per 100 Live Births
therapeutic	48,136	13.9
illegal	1,441	0.4
out-of-country	9,627	2.8
TOTAL	59,204	17.1

The estimate of 17.1 induced abortions per 100 live births is 23.0 percent higher than the number of therapeutic abortions reported to have been done in Canadian hospitals.

In 1973 there were 34,911 abortions classified by Statistics Canada as spontaneous (5,970) and abortions not specified as induced or spontaneous (28,941). The rates for these two categories of abortions varied considerably between the provinces, the size of hospitals, and the ownership of hospitals. In deriving an estimate of how many of these abortions may represent assisted or induced abortions, the Committee assumed that the ratio of these abortions per 100 live births which were reported by religious hospitals represented a minimum baseline. Because of the stated position of these hospitals on the issue of induced abortion, it was assumed that the ratio of 7.1 per 100 live births may more accurately reflect the number of abortions occurring from natural causes than may be the case in hospitals which were not known to endorse these principles. On this basis there would have been 24,276 spontaneous and other abortions in 1973 in Canada instead of the 34,911 which were reported. If the remaining 10,635 abortions which were listed for that year as spontaneous and other are considered as abortions which may have been "assisted", they would represent 3.1 induced abortions per 100 live births in 1973. When this ratio is added to the revised ratio of 17.1 per 100 live births in 1974, it results in a combined ratio of 20.2 per 100 live births.

The total number of induced abortions obtained by Canadian women in 1974 consisted of: (1) therapeutic abortions done in Canadian hospitals (48,136); (2) illegal abortions obtained in Canada (1,441); (3) induced abortions obtained in the United States (9,627); and (4) "assisted" abortions classified under other listings (10,635). The total of 21,703 induced abortions which were not obtained under the procedures set out in the Abortion Law was 45.1 percent higher than the reported number of therapeutic abortions for 1974. For every five live births in Canada in 1974, it is estimated there was one induced abortion (20.2 induced abortions per 100 live births).

Chapter 5

Provincial Requirements and Hospital Practices

Several levels of government are involved in the operation of the country's hospitals. The Government of Canada operates directly a number of hospitals through the Department of National Defence for Armed Forces personnel, the Department of Veterans' Affairs for war veterans and the Medical Services Branch for immigrants and Treaty Indians and Inuit. Joint federal-provincial measures relate to the control of communicable diseases, hospital construction, national health insurance, and the supply of certain categories of health workers. How health services operate, are paid for, and are regulated involves a network of municipal, provincial, and federal regulations. Provincial statutes establish the qualifications of the health professions and govern the operation of hospitals. Seen as a whole, this nation's health system is an interwoven mosaic of federal, provincial and municipal statutes and regulations and regional health practices which influence and determine the relative supply, mix, and distribution of personnel and facilities. It is in the context of this complex health system that the terms of the Abortion Law operate.

The Terms of Reference set for this inquiry ask if the abortion procedure is not available because: (1) "there are not enough doctors in the area to form a committee"; and (2) "hospitals cannot obtain accreditation by the Canadian Council on Hospital Accreditation or approval by the provincial minister of health owing to inadequate facilities." The *Canadian Hospital Directory 1975* of the Canadian Hospital Association listed 1,378 hospitals for the country. In terms of their location and size, these hospitals ranged from three-bed nursing outpost stations in the North to highly specialized tertiary referral hospitals in metropolitan areas. With the opening of new facilities, the phasing out of old hospitals, and the total or partial closing of some hospitals to meet provincial budget restraint programs, the actual number of hospitals and the types of beds which are available fluctuate constantly within narrow limits. Two newly built hospitals in 1976 for instance had had their bylaws approved by provincial health authorities, but they were not sufficiently staffed at the time of the inquiry to provide a full range of treatment services. Ten hospitals in Ontario were initially closed in 1976 by that province's Ministry of Health, but the subsequent re-evaluation of this decision made the exact listing of hospitals in Ontario a matter of recalculation. It is in this context that information about the two Terms of Reference is reviewed.

In terms of the size of medical staff and the type of hospital services and facilities, four sets of conditions determine whether a hospital board can establish a therapeutic abortion committee. These conditions are:

1. Criminal Code criteria;
2. Accreditation of hospitals;
3. Provincial Statutes, Directives, Regulations, or Guidelines;
4. Hospital practices and functions.

The terms of these four conditions for the size of the medical staff and the type of hospital facility are not mutually exclusive. Each condition selectively eliminates some hospitals from being eligible to do the abortion procedure. *In the context of these four conditions, an eligible hospital is defined as one which can establish a therapeutic abortion committee in terms of the size of its medical staff and the nature and the scope of its facilities.* In this respect what may be allowed under the Abortion Law is significantly influenced by established patterns of medical and hospital practice. Theoretically, all of the 1,378 treatment facilities in Canada, if they were either accredited or approved by provincial health authorities, would be eligible under the Abortion Law to do the abortion procedure.

The Abortion Law for instance does not stipulate the medical staff complement of a hospital which is necessary to do the abortion procedure. But in terms of widespread hospital practice, the Abortion Law implicitly establishes a minimum requirement of three qualified physicians to serve on a therapeutic abortion committee, plus a qualified medical practitioner who is not a member of the therapeutic abortion committee, to perform the procedure. In practice, then, hospitals without at least four physicians on their medical staff are precluded from doing the abortion procedure. In one province, Manitoba, where an alternative has been tried in the form of a province-wide Central Therapeutic Abortion Committee, only three small hospitals had taken up this option. Since 1972 when this option was established, only two applications for the performance of the abortion procedure had been reviewed. In its consequences, then, the Abortion Law can be said to establish an effective minimum requirement in terms of the number of physicians who are required on the medical staff of a hospital.

Furthermore, while the Abortion Law does not stipulate what type of work a physician can do in a hospital (admitting privileges) or the nature of his full-time or part-time appointment, in practice the Committee found from its site visits to 140 hospitals across Canada that most of the members who were appointed to therapeutic abortion committees were on the active medical staff of these hospitals. A majority of the induced abortion operations which are done in Canada are performed by obstetricians and gynaecologists, a medical practice custom which is not stipulated in the Abortion Law, but one which effectively further reduces the number of hospitals where this operation in practice can be done.

At the provincial level the approval of hospitals to establish a therapeutic abortion committee involves three components, one direct and two indirect.

Eight provinces have specific statutes, directives or guidelines which determine whether a public general hospital can establish a committee. On the basis of these criteria, a number of hospitals in these provinces cannot establish committees. Two indirect measures which determine whether hospitals can establish committees are: (1) their approved general treatment functions; and (2) whether specific treatment facilities for surgery, obstetrics and gynaecology are available or have been amalgamated in a regional health services' program.

Hospitals do not have a unilateral option to start or terminate major treatment programs. Major treatment services and facilities are specified in general hospital bylaws, an organizational plan, and medical staff bylaws which are ratified by an elected and/or appointed hospital board. When these bylaws are initially established or subsequently revised, they are reviewed, on occasion amended, and approved by an agency of the provincial government which is usually its health department. Approval designates the major services, which are permitted under specified circumstances and represents the endorsement for the payment of services under public hospital and medical care insurance programs.

A revision of bylaws with provincial approval would be required for a majority of the specialty hospitals in the nation for the abortion procedure to be done. Where an amalgamation of services has occurred between hospitals, designated facilities are expanded or closed in terms of achieving greater efficiency, specialization, or conforming to provincially set health facility guidelines. If an obstetrical or gynaecological unit is closed in one hospital, this service may be expanded in another local hospital. The first hospital for instance may be permitted to expand its urological, paediatric, or chronic care services. When this realignment in the complement of hospital services occurs, the changes must be ratified by hospital bylaws and approved by provincial authorities. For these reasons, a number of hospitals which might otherwise be assumed to meet provincial criteria to establish therapeutic abortion committees do not have the treatment facilities which would permit them to do this procedure.

Terms of the abortion law

Induced abortion cannot be legally performed unless several conditions are complied with which are set forth in the Criminal Code.[1]

1. The procedure must be done by a qualified medical practitioner, i.e., a person qualified to engage in the practice of medicine under the laws of the province.
2. The qualified medical practitioner must be a physician other than a member of a hospital's therapeutic abortion committee.
3. The abortion must be approved by a therapeutic abortion committee.

[1] The full text of the Aoortion Law is given in Appendix 3.

4. The therapeutic abortion committee for any hospital means a committee appointed by the board of that hospital for the purpose of considering and determining questions relating to the termination of pregnancy within that hospital.

5. The therapeutic abortion committee must be comprised of not less than three members, each of whom is a qualified medical practitioner appointed by the board of that hospital.

6. The procedure must be done in an accredited or an approved hospital. An accredited hospital means a hospital accredited by the Canadian Council on Hospital Accreditation in which diagnostic services and medical, surgical, and obstetrical treatment are provided. An approved hospital means a hospital in a province approved for the purposes of this section by the minister of health of that province.

7. Provincial statutes are operative as "nothing in subsection (4) shall be construed as making unnecessary the obtaining of any authorization or consent that is or may be required, otherwise than under this Act, before any means are used for the purpose of carrying out an intention to procure the miscarriage of a female person."

Each of these requirements is necessary, and it is only when all of these requirements set forth in the Abortion Law are met, that a therapeutic abortion committee, if such a decision is made, can be established and therapeutic abortions performed.

Provincial colleges of physicians and surgeons across Canada review the credentials and establish the licensing qualifications for medical practice. Under provincial statutes, only those physicians who are so licensed are eligible to practice in hospitals in each province. If established, a hospital's therapeutic abortion committee must be "comprised of not less than three members each of whom is a qualified medical practitioner." Before an application is submitted for review to such a committee, several other physicians are involved such as those practicing doctors who submit the application and the specialists to whom patients may be referred for consultation. Depending upon the procedure for induction which is used, an anaesthetist may be involved during the operation. The physician who procures a miscarriage must be "other than a member of a therapeutic abortion committee for any hospital." To be clear, the Abortion Law does not stipulate how many doctors are required to be on the medical staff of an accredited or approved hospital. In accepted hospital practice, a minimum of four qualified medical practitioners on active medical staff is required to establish the therapeutic abortion committee and to do the procedure involving the termination of pregnancy in any hospital. Based on this criterion, and if other requirements are met, the board of a hospital whose medical staff consists of four or more physicians on active medical staff can establish a therapeutic abortion committee. With the exception of the experience of the Central Therapeutic Abortion Committee in Manitoba which has proved to be an ineffective option, hospitals whose medical staff consists of three or fewer physicians are in practice ineligible to establish therapeutic abortion committees.

Accredited hospitals

The abortion procedure can only be done at accredited or approved hospitals. The Abortion Law stipulates that an "accredited hospital" means "a hospital accredited by the Canadian Council on Hospital Accreditation in which diagnostic services and medical, surgical and obstetrical treatment are provided." The members of the Board of the Canadian Council on Hospital Accreditation are appointed by the Canadian Hospital Association, the Canadian Medical Association, the Royal College of Physicians and Surgeons and l'Association des médecins de langue française du Canada. The broad intent of the Council is to promote a high quality of medical and hospital care in Canadian hospitals. To achieve this purpose, the Council was authorized when it was incorporated in 1958, to undertake an evaluation of hospitals which voluntarily agreed to participate in its program. Hospitals which met the Council's standards were designated accredited hospitals with a review undertaken every three years for each hospital of its facilities, its complement of personnel and its treatment standards.

The Council's standards until 1966 were based on the principle of "the minimum essential". Among other criteria which were then adopted were that at least three members on the active medical staff were required for a hospital to be eligible for accreditation. Accreditation standards were subsequently changed "to the level of optimum achievable". This change was incorporated in the revised *Guide to Hospital Accreditation (1972)*. To be eligible at the present time for an accreditation survey by the Council, a hospital:

1. Shall be listed as a hospital by the Canadian Hospital Association;
2. Shall have a current unconditional license to operate by provincial or federal authority;
3. Shall have been in operation under the present ownership for at least 12 months prior to the survey;
4. Shall have a governing body and an organized medical staff and nursing service, as well as adequate arrangements which ensure the availability of the following supporting elements, either within its own organization, or through the use of acceptable community or registered resources:

   Dietetic Services
   Emergency Services
   Environmental Services
   Laboratory Medicine Services
   Medical Record Services
   Nuclear Medicine Services
   Pharmaceutical Services
   Radiology Services
   Radiotherapy Services
   Rehabilitation Medicine Services
   Social Services
   Special Care Services
   Staff Library Services

5. Shall have at least one of the following clinical services:

   Medicine
   Obstetrics-Gynaecology*
   Paediatrics
   Psychiatry
   Surgery*

*Shall have anaesthesia services when either of these are present in the hospital.

The number of accredited hospitals in Canada is constantly changing as new hospitals are included, while those hospitals which do not meet the Council's standards are dropped from its annual listing. In 1975, 490 of 906 general hospitals across the country were accredited. The general hospitals in the 1975 listing included large tertiary treatment centres and small hospitals of 8, 13 or 17 beds which on occasion had a medical staff complement of as few as two physicians.

The requirement of the Abortion Law goes beyond the designation of the accreditation of a hospital as it requires that such a hospital provide diagnostic services and medical, surgical, and obstetrical treatment. There is no definition in the law of what is meant by diagnostic services, medical and surgical procedures, and in particular, of obstetrical treatment. The Glossary of the *Guide to Hospital Accreditation* of the Canadian Council on Hospital Accreditation gives no definition of obstetrics and gynaecology. The Council's hospital survey questionnaire operationally designates obstetrical and/or gynaecological services to include: one or two departments; the listing of medical staff and appointment privileges; facilities and staffing of the obstetrical suite; safety devices in the nursery; the classification of deliveries, complications of pregnancy and puerperium, live births, abortions, gynaecological conditions, gynaecological surgery, and neonatal and maternal deaths.

Obstetrics and gynaecology in terms of prevailing medical practice and how hospital facilities and services are provided are on occasion separated as two related sub-specialties. Obstetrics deals primarily with pregnancy, labour and puerperium, while gynaecology deals with the diseases of the reproductive organs and the genital tract in women. Because gynaecological treatment may involve surgery, a gynaecological service may be established in a hospital which has surgical, but no obstetrical facilities. Likewise, in practice a hospital can have an obstetrical unit, but may make no provisions for gynaecological treatment.

The changes taking place in the medical practice of obstetrics and gynaecology represent a shift in the numbers of patients and types of conditions treated by this medical specialty. As the birth rate has declined in recent decades and the life span of the average Canadian has lengthened, these demographic shifts have resulted in a gradual re-allocation in the supply of required health workers and the types of hospital facilities provided for the treatment of patients. In general, the supply of maternity beds declined across Canada from 1969 to 1974.[2] In terms of ratio of maternity beds per 1,000 population, the following changes occurred during this period. Newfoundland, 0.663 to 0.664; Prince Edward Island, 0.754 to 0.632; New Brunswick, 0.7 to 0.6; Quebec, 0.455 to 0.381; Ontario, 0.619 to 0.517; Alberta, 0.733 to 0.617; and British Columbia, 0.57 to 0.51. In several provinces there has been a trend toward the consolidation of obstetrical-gynaecological services in hospitals. Nova Scotia for instance has established guidelines for the use of obstetrical beds by non-obstetrical patients. There was a move toward the separation of

[2] Based on replies from provincial health authorities. No information was available at the time of the inquiry on this point for Nova Scotia, Manitoba and Saskatchewan.

obstetrical and gynaecological services in Quebec which resulted in part from the perinatal policy of that province. Where obstetrical services were closed in 12 Quebec hospitals since 1973, they tended to be replaced by an expansion of gynaecological services. The closure of these smaller obstetrical units in Quebec, as in other provinces, resulted from findings which showed that smaller units had higher ratios of maternity care problems and higher stillbirth and neonatal death rates. In general, these units have been closed in favour of expanding the obstetrical services in larger hospital units.

The trend toward the regionalization of treatment services, and in particular for obstetrics and gynaecology, usually results in the allocation of all or a majority of a particular service to one or another hospital in a community. While one service may be discontinued, another at the same hospital is often expanded. This shift in services for obstetrics and gynaecology was described by several hospital administrators.

> As a result of regionalization, this hospital discontinued its obstetrical service in 1965. All gynaecology is done at the _____ hospital. This hospital was allowed to specialize in paediatrics.
>
> • • •
>
> This hospital provides long term care for chronic patients and rehabilitation services. All ob/gyn is regionalized at _____ hospital.
>
> • • •
>
> In 1973 obstetrical services were amalgamated at _____ hospital. This agreement made provision for a therapeutic abortion unit at that hospital and that this hospital would not be required to permit therapeutic abortions.
>
> • • •
>
> No obstetrical/gynaecological cases are admitted here. All cases are sent to _____ hospital. This hospital specializes in urology which is not done at the _____ hospital.
>
> • • •
>
> This hospital serves as the obstetrical facility and conversely, _____ hospital serves as the special gynaecology facility. This mutually advantageous arrangement has been feasible because the hospital boards have approved special admitting privileges to the ob/gyn members of the other hospitals.

The Canadian Council on Hospital Accreditation does not maintain or publish an annual listing of hospitals with medical, surgical and obstetrical services. Information on accredited general hospitals with these services was obtained by the Committee from the *Annual Directory of the Canadian Hospital Association,* from provincial health ministries, and from the national hospital survey done for this inquiry. There were 490 *general* hospitals in Canada in 1975 accredited by the Canadian Council on Hospital Accreditation. This total of 490 accredited general hospitals consisted of 441 accredited general hospitals with medical, surgical and obstetrical services and 49 other hospitals consisting of 34 accredited general hospitals with no obstetrical

services and 15 accredited hospitals with no obstetrical services which had established therapeutic abortion committees. **A total of 251 accredited general hospitals had established therapeutic abortion committees, while 19 non-accredited general hospitals were approved by provincial health authorities to do the abortion procedure. In 1976, half (51.2 percent) of the accredited general hospitals in Canada had established therapeutic abortion committees.**[3]

TABLE 5.1

ACCREDITED GENERAL HOSPITALS WITH MEDICAL, SURGICAL AND OBSTETRICAL SERVICES BY THERAPEUTIC ABORTION COMMITTEE STATUS*

	Services and Committees				
Province	Accredited General Hospitals	Accredited General Hospitals with Medical, Surgical, & Obstetrical Services	Accredited General Hospitals with Therapeutic Abortion Committees	Accredited General Hospitals with no Obstetrical Services	Accredited General Hospitals with no Obstetrical Services, with Therapeutic Abortion Committees
Newfoundland	9	8	6	—	1
Prince Edward Island	6	6	2	—	—
Nova Scotia	27	24	12	2	1
New Brunswick	20	18	8	2	—
Quebec	78	69	29	8	1
Ontario	162	142	102	13	7
Manitoba	28	26	9	1	1
Saskatchewan	36	33	9	1	2
Alberta	64	60	25	3	1
British Columbia	57	52	47	4	1
Yukon, Northwest Territories	3	3	2	—	—
CANADA	490	441	251	34	15

*Statistics Canada. *List of Hospitals with Therapeutic Abortion Committees as Reported by Provinces in Canada, January 1, 1976* (Ottawa, May 28, 1976). The approved general hospitals and the specialty hospital are excluded for this listing. The two federal hospitals with committees are located in Manitoba and Alberta.

Under the terms of the Abortion Law, a total of 49 accredited hopitals which did not have obstetrical services were ineligible to establish therapeutic abortion committees, unless they had provincial approval. The definition of obstetrical services used here incorporates the operational listing of obstetrical-gynaecological services established by the Canadian Council of Hospital Accreditation. Thirty-four accredited hospitals without designated obstetrical services did not have therapeutic abortion committees. Two-thirds of these hospitals had gynaecologists appointed to their medical staff. Twenty-one of the 34 hospitals, or 61.8 percent, were owned by religious denominations. From the site visits made by the Committee to seven of these 21 general hospitals, the decision not to do the abortion procedure was a major factor contributing to the amalgamation of their obstetrical and gynaecological services with other regional hospitals.

[3] The 1976 Statistics Canada listed a total of 271 hospitals with therapeutic abortion committees which consisted of: 251 accredited general hospitals, 19 provincially approved general hospitals, and one specialty hospital.

Ten of the fifteen accredited general hospitals with committees, but which had no designated obstetrical services, were located in regional centres and large cities. While 15 accredited general hospitals did not have obstetrical suites, nurseries or provided services for childbirth, 11 hospitals which did all abortion procedures had gynaecologists appointed to their medical staff. In these hospitals induced abortion patients, after being approved for the procedure by a therapeutic abortion committee, were treated in the gynaecological or surgical services. In 1974, 2,758 abortions were done in 14 of these hospitals; in 1975 there were 2,699 abortions in these facilities. Eleven of the fifteen hospitals which were accredited had therapeutic abortion committees, had no obstetrical services, but did not have provincial approval to do this procedure.

The conditions of the Abortion Law that a hospital be accredited (or approved) and a therapeutic abortion committee consist of three physicians establish different criteria, one relating to the standards of quality, the second involving the minimum size of a hospital's medical staff. Each of five small hospitals in Alberta in 1975 for instance, while accredited, had a medical staff of two physicians. What constitutes obstetrical and gynaecological facilities and treatment requires clarification. Hospital privileges in maternal and child care including delivery and the induced abortion procedure can be given to family doctors as well as obstetrician-gynaecologists. Obstetrical and gynaecological services in a hospital can be: (1) united into one department; (2) provide only obstetrical treatment; and (3) provide only gynaecological treatment and/or be combined with surgery. In terms of medical practice it is the gynaecologists, anaesthetists and surgical medical staff and related facilities which are involved in the induced abortion procedure.

Provincial requirements

In addition to the terms of the Abortion Law, the provincial statutes and requirements governing health workers and hospitals determine under what circumstances and in which hospitals therapeutic abortion committees can or cannot be established. These conditions take the form of provincial health department review guidelines, requirements, or may be legislative statutes. The listing of 1,348 civilian, provincial, general, specialty and private hospitals is given in Table 5.2. In addition to 1,348 civilian hospitals there are 30 hospitals operated by the Canadian Forces Medical Services. Table 5.3 lists the provincial general hospitals which are excluded by provincial requirements from the establishing of therapeutic abortion committees, the number of hospitals with committees, and those hospitals which met these requirements and did not have committees.

Newfoundland. The Newfoundland Department of Health used the following guidelines in its review of hospitals seeking approval to establish therapeutic abortion committees:

1. Beds—approximately 100 beds or more;

2. Medical Staff—a minimum of six or more members of the medical staff who would be willing to cooperate with or recognize the existence of a therapeutic abortion committee;

3. Surgical Services—the presence of a gynaecologist (or a qualified surgeon with experience in gynaecology) on the medical staff.

Eight general hospitals in Newfoundland in 1976 met these criteria. Considering the difficulties in transportation and the relative isolation of certain regions in the province, three additional hospitals, although they did not meet all of the provincial criteria, would be considered eligible if their hospital boards requested approval to establish therapeutic abortion committees. Under the terms of these criteria, 11 hospitals met the provincial guidelines, six of which had established therapeutic abortion committees.

TABLE 5.2

DISTRIBUTION OF CIVILIAN HOSPITALS BY PROVINCE, 1975*

Province	Type of Hospital				
	General	Specialty	Private	Federal	Total
Newfoundland	46	3	—	—	49
Prince Edward Island	8	4	—	—	12
Nova Scotia	45	9	—	1	55
New Brunswick	37	4	1	—	42
Quebec	128	72	47	9	256
Ontario	205	83	35	12	335
Manitoba	78	10	—	17	105
Saskatchewan	133	10	—	2	145
Alberta	119	39	—	6	164
British Columbia	103	26	3	—	132
Yukon, North-west Territories	4	—	—	49	53
CANADA	906	260	86	96	1,348

* This listing does not include 30 hospitals operated by the Canadian Forces Medical Services.

Source: *Canadian Hospital Directory 1975* (Toronto: Canadian Hospital Association, July 1975). General hospitals include services for medicine, surgery, obstetrics, intensive care and paediatrics. Special hospitals (referred to in this Report as specialty hospitals) include the following services: psychiatric, tuberculosis, convalescent, rehabilitation, chronic, urological, gynaecological, neurosurgical, geriatric, isolation, orthopaedic, contagious, extended care, alcoholic, arthritic and respiratory.

Prince Edward Island. Of 12 hospitals in Prince Edward Island, four were specialty hospitals and two had three or fewer doctors on their medical staff. The Department of Health had no formal statement of guidelines which were used in the review to establish therapeutic abortion committees. Each application was reviewed in terms of the medical staff complement and the extent to which requisite facilities and services were available. Of the province's six hospitals which were not specialty centres and had four or more physicians, two hospitals in 1976 had therapeutic abortion committees.

Nova Scotia. The policy of Nova Scotia Health Services and Insurance Commission was that only hospitals which were accredited were eligible to establish therapeutic abortion committees. Nine of the province's 55 hospitals

provided specialty services for mental illness, chronic care, or rehabilitation. One non-military hospital was operated by the federal Department of Veterans' Affairs. Of the remaining 45 public general hospitals, 27 were accredited by the Canadian Council on Hospital Accreditation. A total of 18 public general hospitals which were not accredited were ineligible to establish therapeutic abortion committees. Of the 27 accredited public general hospitals, 12 had established committees in 1976 and 15 which met the provincial requirements did not have committees.

TABLE 5.3

PUBLIC GENERAL HOSPITALS EXCLUDED BY HOSPITAL PRACTICES AND PROVINCIAL REQUIREMENTS FROM THE ESTABLISHMENT OF THERAPEUTIC ABORTION COMMITTEES, 1976

	Therapeutic Abortion Committee Status				
	Exempt by Provincial Criteria	Exempt by Hospital Practices Criteria	Appointed Therapeutic Abortion Committee*	Eligible	Total General Hospitals
Newfoundland	35	—	6	5	46
Price Edward Island	—	2	2	4	8
Nova Scotia	18	—	12	15	45
New Brunswick	16	—	8	13	37
Quebec	33	—	31	64	128
Ontario	51	—	109	45	205
Manitoba	—	38	8	32	78
Saskatchewan	110	—	10	13	133
Alberta	38	—	26	55	119
British Columbia	16	—	53	34	103
Yukon, Northwest Territories	—	—	2	2	4
TOTAL	317	40	267	282	906

*Statistics Canada, *List of Hospitals with Therapeutic Abortion Committees as Reported by Provinces in Canada, January 1, 1976* (Ottawa, May 28, 1976).

New Brunswick. Excluding four Red Cross nursing outpost stations, New Brunswick had 42 civilian public hospitals. Of this number, four were specialty hospitals, and one was a private hospital. To establish a therapeutic abortion committee, review procedures set by the New Brunswick Department of Health required that hospitals had: obstetrical beds, an operating theatre, and a medical audit committee. Sixteen of the province's 37 public general hospitals did not meet these requirements. Eight of the remaining 21 hospitals in 1976 had therapeutic abortion committees; 13 did not have such committees.

Quebec. Excluding eight northern outpost nursing stations, there are 256 hospitals in the Province of Quebec. Of this number there were 128 public general hospitals, 72 specialty hospitals, 47 private hospitals, and nine centres were operated by the federal government. Hospitals which met the definition of accredited hospitals set out in the Abortion Law did not have to get provincial approval before setting up a therapeutic abortion committee where there were

no obstetrical or gynaecological services and for non-accredited hospitals approval could be sought from the Ministry of Social Affairs. When these hospitals requested approval from the Ministry of Social Affairs to set up a therapeutic abortion committee, each request was reviewed individually. The decision reached was based on whether the criteria set by the Ministry were met. The two basic conditions required before a hospital could or could not establish a committee were:

1. Existence of surgical service;
2. Availability of at least four physicians.

On the basis of these criteria, 33 of the 128 public general hospitals in Quebec in 1976 were ineligible to establish a therapeutic abortion committee. Of the remaining 95 hospitals, 31 were listed by Statistics Canada with committees,[4] and 64 did not have therapeutic abortion committees.

Ontario. The Ontario Ministry of Health in 1976 ordered closure of 10 hospitals, with cutbacks in the supply of beds for a number of other hospitals. Before these closures the province had 335 hospitals, including 205 general hospitals, 83 specialty hospitals, 35 private hospitals, and 12 hospitals operated by the federal government. A total of five general hospitals were closed, one specialty hospital, and four private hospitals. The province had 109 public general hospitals in 1976 with therapeutic abortion committees.[5]

Regulation 729 of 1974 adopted under *The Public Hospitals Act (Revised Statutes of Ontario, 1970,* chapter 378 as amended by *Statutes of Ontario 1972,* chapter 90, and *Statutes of Ontario 1973* chapter 164) stipulates that:

> 6—(1) The board shall pass bylaws that provide for...
> (d) the appointment of members of the medical staff on the recommendation of the medical staff or the election of such members by the medical staff, to,
> (i) a credentials committee,
> (ii) a records committee,
> and, where there are ten or more members on the active medical staff,
> (iii) a therapeutic abortion committee, where therapeutic abortions are to be performed.

Information provided by the Ontario Ministry of Health indicated that as of June 30, 1975, 51 of the province's general hospitals had fewer than 10 physicians on active medical staff. Four of these hospitals were closed and then re-opened in 1976. Of the province's public general hospitals with 10 or more physicians on active medical staff, 109 hospitals had established therapeutic abortion committees, while 45 hospitals did not have such committees.[6]

In terms of the Ontario provincial requirement that hospitals with therapeutic abortion committees have 10 or more members on active medical staff,

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[4] Statistics Canada listed 32 hospitals with therapeutic abortion committees in Quebec in 1976. One of these hospitals was a *private* general hospital.

[5] The actual number of hospitals in Ontario as well as those with therapeutic abortion committees may be altered on the basis of a re-evaluation of these hospital closures.

[6] Excludes one private general hospital with a therapeutic abortion committee.

12 hospitals with established committees in 1975 had a reported active medical staff complement of less than 10 physicians. Information obtained by the Committee from seven of these 12 hospitals in March 1976 indicated that one hospital reported 12 physicians on its active medical staff. The active medical staff of six other hospitals was: four, five, seven, eight, eight, and nine. During 1975, 35 abortions were done which had been approved by therapeutic abortion committees of these hospitals.

Manitoba. The Manitoba Health Services Commission stipulates that no hospital should establish a therapeutic abortion committee which cannot undertake to work in cooperation with a planned parenthood group as well as providing appropriate counselling and follow-up for patients who have had an abortion. The Commission stipulated that the number of hospital beds and the range of technical services provided at a hospital "are no longer relevant as many are done on an N.F.A. basis".[7]

The Manitoba College of Physicians and Surgeons established a Central Therapeutic Abortion Committee in 1972 to serve as a referral source to review applications from small regional hospitals. The terms of reference set for the Committee were:

1. Five members to be appointed by the College of Physicians and Surgeons and each, by name, to be approved and appointed to the Therapeutic Abortion Committee by each hospital board which will utilize the C.T.A.C. (Central Therapeutic Abortion Committee). Two members will be appointed for one year and three members for two years.
2. Three members will be a quorum.
3. A decision in each individual case will be arrived at by majority vote after the Committee has examined all relevant documents which shall consist of, at least, the patient's request, her physician's statement and at least one report from a licensed practitioner acting as a consultant.
4. The C.T.A.C. may temporarily defer a decision in the event that further information or interview of the physician or the consultant is necessary to reach a decision.
5. The Committee, in approving a case, will provide the physician with a certificate stating that in its opinion the continuation of the pregnancy would be likely to endanger the patient's life or health.
6. The certificate will indicate that the Committee is deliberating as the Therapeutic Abortion Committee of the hospital concerned.

By 1976 three hospitals in Manitoba had passed bylaws to use the Central Therapeutic Abortion Committee. Since it had been established in 1972, the Committee had met twice to review two applications. The three hospitals were reported as having therapeutic abortion committees in the annual listing prepared by Statistics Canada.

The total of 105 hospitals in Manitoba was made up of 78 general hospitals, 10 specialty hospitals, and 17 hospitals operated by the federal

[7] N.F.A. refers to Not for Admission, i.e, services done on a day-surgery basis.

government. Of the 78 general hospitals, 38 hospitals had less than four physicians in 1976 on their medical staff. Eight of the remaining 40 provincial general hospitals (including three hospitals using the Central Committee of the Manitoba College of Physicians and Surgeons) had therapeutic abortion committees,[8] while 32 hospitals which had four or more physicians on staff did not have committees.

Saskatchewan. The province had 145 hospitals in 1976 of which there were 133 general hospitals, 10 specialty hospitals, and two hospitals operated by the federal government. Section 52(1) of the *Saskatchewan Hospital Standards Regulation, 1975* stipulates:

> Every hospital which is accredited by the Canadian Council on Hospital Accreditation may establish a committee to be known as a Therapeutic Abortion Committee consisting of at least three members each of whom shall be a member of the medical staff of that hospital, only if the hospital has a rated bed capacity of fifty beds or more.

On the basis of this provincial regulation, 110 hospitals were ineligible to establish a therapeutic abortion committee and 94 of these hospitals had less than four members on medical staff. Of the remaining 23 general hospitals, 10 had therapeutic abortion committees, while 13 hospitals did not have committees. One of the ten hospitals with a therapeutic abortion committee had over 100 beds, but it was not accredited by the Canadian Council on Hospital Accreditation.

Alberta. Alberta's 164 hospitals were comprised of 119 general hospitals, 39 specialty hospitals, and six federal hospitals. The Alberta Hospital Services Commission set out the regulations for application for approval of provisionally accredited and non-accredited hospitals. These regulations stipulated:

> (1) A hospital meeting the following criteria may apply for approval pursuant to Section 237 of the Criminal Code of Canada,
>
> (a) Has an organized medical staff which:
>
> (1) has three or more active members,
>
> (2) meets regularly at least ten times a year and reviews the clinical work done in the hospital.
>
> (b) Is adequately equipped and staffed for major surgery and anaesthesia;
>
> (c) Has adequate arrangements and facilities for emergency transfusions immediately available;
>
> (d) Has appointed a therapeutic abortion committee which meets the specifications set out in Section 237 of the Criminal Code of Canada.

[8] Excludes one hospital with a therapeutic abortion committee which was operated by Atomic Energy of Canada Ltd.

(2) Applications for approval shall be in writing and shall be submitted to the Alberta Hospital Services Commission. Each application shall be supported by:

(a) A certified copy of the resolution of the medical staff recommending that the hospital board apply for approval of the hospital for therapeutic abortions;

(b) A certified copy of the resolution of the board authorizing an application for approval of the hospital for therapeutic abortions;

(c) An outline of facilities and personnel available for major surgery and anaesthesia;

(d) An outline of the arrangements and facilities to provide emergency blood transfusions;

(e) An outline of the hospital's program and activities in respect to regular review by the medical staff of the clinical work done in the hospital;

(f) A list of the active members of the medical staff showing the extent of their hospital privileges;

(g) The names and addresses of the members of the Therapeutic Abortion Committee and the arrangements for meeting if "out-of-town" physicians are included.

Based on the criterion of three or more active members of medical staff, 38 hospitals of the total of 119 general hospitals in the province were ineligible in 1976 to establish a therapeutic abortion committee. If the criterion of a medical staff of four or more members is used, 54 hospitals were ineligible. Of the 26 general hospitals with therapeutic abortion committees,[9] only one was a non-accredited hospital. A total of 55 provincial general hospitals which had three or more doctors did not have therapeutic abortion committees.

One hospital which established a therapeutic abortion committee in 1971 and which had done no abortions since then was not listed in the annual federal directory or by the Alberta Ministry of Health and Social Development. Special arrangements were made by two hospitals with therapeutic abortion committees. One hospital with no committee had an informal referral procedure with a hospital which had a therapeutic abortion committee. A second hospital which had a medical staff of three doctors involved a physician whose medical practice was located 25 miles away. Women applying for approval of an abortion were interviewed by the four physicians in their respective offices prior to a decision being reached on an abortion application.

British Columbia. The complement of public hospitals in British Columbia consisted of 103 general hospitals, 26 specialty hospitals, and three private hospitals. The Department of Health Services and Hospital Insurance established criteria in February 1970 for all general and specialty hospitals

[9] One hospital with a therapeutic abortion committee operated by the Department of National Health and Welfare is mentioned elsewhere in this chapter.

concerning the procedures to be followed if hospital boards decided to establish therapeutic abortion committees. These requirements stipulated *inter alia*:

> A hospital which has a relatively small medical staff will have to take particular care to comply with the statutory requirement that prohibits a member of the therapeutic abortion committee from performing a therapeutic abortion in the hospital.
>
> Each "accredited hospital", within the meaning of Section 237 (6)(a), which intends to permit therapeutic abortion to be carried out, must:
>
> (a) include in its medical staff bylaws provisions governing the establishment of a therapeutic abortion committee, membership, terms of reference, frequency of the committee's meetings and the method by which it is to report to the hospital authorities. A suggestion in this regard is attached.
>
> (b) write to the Deputy Minister of Hospital Insurance advising him of its intentions and enclosing a copy of its current medical staff bylaws which set out the foregoing provisions.
>
> A hospital which does not come within the meaning of the definition of an "accredited hospital" in Section 237 (6)(a) may apply for designation as an "approved hospital" by the Minister by making application in writing to the Deputy Minister of Hospital Insurance and enclosing therewith a copy of the current medical staff bylaws of the hospital which contain the provision referred to in the preceding paragraph.

Based on these criteria, 16 of the province's 103 general hospitals were considered to be ineligible to establish a therapeutic abortion committee by the Department of Health Services and Hospital Insurance. From the Committee's national hospital survey, it was found that 16 hospitals in British Columbia had three or fewer physicians on their active medical staff and two privately operated hospitals were also in this category. Based on the approval of the provincial health department, one of the province's 26 specialty hospitals which was maintained for the treatment of mental illness established a therapeutic abortion committee in 1970. Two hospitals in British Columbia which did not have therapeutic abortion committees had made special arrangements for patients seeking approval for abortion. One small hospital with no committee routinely referred such patients to a second hospital which had appointed jointly the members of the therapeutic abortion committee of an urban hospital as its own committee. When received, applications from both hospitals were sent for review to the committee of the urban hospital. If approval was given for an application by that hospital's committee, the procedure was then done at the smaller hospital with the established affiliation. One hospital in British Columbia which established a therapeutic abortion committee in 1973 had subsequently received no applications for induced abortion. This hospital was not listed as having a therapeutic abortion committee either by provincial health authorities or the annual federal listing of hospitals with therapeutic abortion committees.

Of the province's 103 public general hospitals, 53 had therapeutic abortion committees. One unlisted hospital had such a committee. In addition, one specialty hospital had a therapeutic abortion committee. A total of 34 public

general hospitals which conformed to provincial criteria did not have committees.

Yukon and Northwest Territories. The majority of hospitals and nursing outpost stations in these two jurisdictions were operated by the Medical Services Branch of the Department of National Health and Welfare. There were no private or specialty hospitals. Of four public general hospitals, two had established therapeutic abortion committees.

Provincial Criteria. **By themselves, provincial requirements for the establishment of therapeutic abortion committees exempted 317 general hospitals, or 35.0 percent of all general hospitals in Canada.**

Specialty and private hospitals

Specialty Hospitals. Specialty medical and surgical functions which designate special facilities or services of a hospital include services for chronic and convalescent care, mental illness, retardation, rehabilitation, and, on a more limited basis, a range of other treatment services. A limited number of hospitals across the country specialize in neurology, orthopaedics, respiratory disorders, contagious diseases, and alcoholism. Because of their specialized treatment facilities and functions, these hospitals usually do not seek the approval of their hospital boards or provincial health authorities to undertake general medical and surgical procedures. They would usually have neither the requisite facilities nor the specialized medical staff appropriate to provide broader treatment services which fall outside of their designated areas of specialization. In most instances they would not be considered for these reasons to be eligible by provincial health authorities to do the abortion procedure.

Of the total of 260 specialty hospitals, there were 108 which provided chronic and/or convalescent care, 86 mental illness and mental retardation services, 22 rehabilitation programs, and 44 other specialty treatment services. Only one public specialty hospital in Canada had established a therapeutic abortion committee.[10] Because of their changing functions and a rising age limit used in the admission of patients, in some instances up to the age of 18 or 19 years, a number of children's hospitals received applications for induced abortion. When such cases were presented, they were referred to local public general hospitals. With the exception of one specialty hospital the rest of the specialty hospitals did not have therapeutic abortion committees. Their specialty functions established in bylaws and approved by provincial authorities exempted them from doing the abortion procedure. **A total of 259 specialty treatment hospitals, or 19.2 percent of all hospitals in Canada, did not have therapeutic abortion committees.**[11]

[10] This specialty accredited hospital was not listed as having surgical or obstetrical-gynaecological services.

[11] Calculated on the basis of 1,348 civilian hospitals in Canada.

TABLE 5.4

THERAPEUTIC ABORTION COMMITTEE
STATUS OF SPECIALTY, PRIVATE, AND FEDERAL HOSPITALS

Category of Hospital	Committee Status			
	Exempt	Eligible, No Committee Appointed	Eligible, Committee Appointed	Total
Specialty Hospital	259	—	1	260
Private Hospital	78	6	2	86
Department of Veterans' Affairs	7	—	—	7
Atomic Energy Commission	—	—	1	1
Medical Services Branch				
(1) Outpost Stations	75	—	—	75
(2) Hospitals*	13	—	—	13
TOTAL	432	6	4	442

* Excludes two federal hospitals with therapeutic abortion committees listed in Table 5.3 under Alberta and Yukon and Northwest Territories.

Private Hospitals. There were 86 privately owned or proprietary hospitals in 1975 which were located in New Brunswick, Quebec, Ontario, and British Columbia. The majority of the private hospitals provided exclusively specialty services such as: chronic care (52); mental or retardation services (7); rehabilitation (3); convalescent care (2); or a range of other services (8), including programs for alcoholism, plastic surgery, or orthopaedic treatment.

Of 14 private general hospitals, six were in Quebec, six in Ontario and two in British Columbia. Two of the private general hospitals in Quebec did not meet the requirements set by the Ministry of Social Affairs to establish a therapeutic abortion committee. Of four hospitals which met Quebec's criteria in terms of medical staff and hospital facilities, one private general hospital had a therapeutic abortion committee, but since it had been established in 1974, no induced abortions had been done. One private general hospital in Ontario specialized in abdominal hernia operations, while a second had only seven physicians on its medical staff, which under the provincial statute made it ineligible to establish a therapeutic abortion committee. One private general hospital in Ontario had established a therapeutic abortion committee. Neither of the two private general hospitals in British Columbia met the provincial requirements which were necessary to establish a therapeutic abortion committee. These hospitals were not acute care centres, were staffed by one or two physicians, and had been established to provide health care coverage for company townsites.

A total of 72 private specialty hospitals were ineligible to establish a therapeutic abortion committee. Of 14 private general hospitals, six did not meet provincial requirements for this procedure, two hospitals had therapeutic abortion committees, and the remainder (six) did not have committees.

Requirements for federal hospitals and services

The Government of Canada makes provisions for medical services for various categories of federal employees and operates directly three hospital service programs. These hospital programs are run by: Department of National Defense for armed services personnel; Department of Veterans' Affairs for war veterans; and Medical Services Branch, Department of National Health and Welfare for immigrants and Treaty Indians and Inuit.

Department of National Defense. The Canadian Forces Medical Services operated 30 centres and hospitals in Canada for armed forces personnel. In addition, one hospital for the Canadian Forces was located in Lahr, in the Federal Republic of Germany. Therapeutic abortion committees were established in two military hospitals, one in Canada, the second in the Federal Republic of Germany. The number of applications referred to these committees averaged half a dozen annually. No abortions had been carried out in military hospitals. At all other locations servicewomen applying for abortions were referred to civilian medical consultants. The number of servicewomen or female dependants of male armed forces personnel obtaining induced abortions in civilian (public general) hospitals was unknown.

Department of Veterans' Affairs. This department operated seven hospitals located in five provinces in 1975. None of the hospitals had obstetricians or gynaecologists on their medical staff and none had established a therapeutic abortion committee. Women with medical or surgical problems requiring gynaecological treatment were referred to general community hospitals.

Medical Services Branch, Department of National Health and Welfare. The Medical Services Branch operated 15 hospitals and 75 outpost nursing stations in 1975, most of which were located in isolated northern centres. The typical nursing station had between three to six beds, was staffed by two or three nurse-practitioner-midwives and its treatment services were coordinated with a larger regional hospital. All of the 15 hospitals were acute care hospitals. The medical staff of these hospitals consisted of physicians who worked under contract and who often served on a rotation basis. In some instances where federal general hospitals were located in larger centres, the medical staff consisted of local general practitioners.

If approval was sought to establish a therapeutic abortion committee, the guidelines set by the Medical Services Branch required that:

> Those federal hospitals operated by the Medical Services Branch which have been accredited by the Canadian Council on Hospital Accreditation are authorized by the Branch, according to their request, to set up their own therapeutic abortion committees. This is in accordance with provincial practices and in the best interests of the patient.

The guidelines of the Medical Services Branch stipulated that in addition to having an accreditation status, the hospitals operated by this Branch prior to the establishment of the therapeutic abortion committee must have:

1. the minimum number of physicians necessary on the medical staff, one of whom has major surgical privileges;

2. facilities and staffing for major surgery, including

3. facilities for emergency blood transfusion.

Where committees had been established, the request for approval had been made by the hospital. In terms of these federal requirements to establish a therapeutic abortion committee, 13 of the 15 hospitals operated by the Branch had inadequate facilities. Seven of the federal general hospitals has less than three physicians on their medical staff.

Atomic Energy of Canada Ltd. The single hospital operated by this federal agency had established a therapeutic abortion committee adhering to the guidelines set by a provincial medical licensing authority. No abortion cases had been reviewed by the committee of this small hospital in recent years.

Committee Status of Federal Hospitals. **Of 96 non-military hospital facilities operated by the Government of Canada, four eligible hospitals had established therapeutic abortion committees.**

Hospital practices

Information on the supply of physician manpower in Canada indicates that there is no up-to-date census of doctors, no coordinated listing of the medical staff complement of hospitals, and no uniformity in the listing of hospital medical staff appointments. There is no national listing of the number of doctors on the medical staff of hospitals, their qualifications and practice privileges, or their type of medical staff appointments. Categories of appointment to a hospital's medical staff include among others: active, associate, consulting, courtesy, and honorary. In general it is recognized that the main work involving medical practice in most hospitals is done by members of its active medical staff.

With the exception of Nova Scotia and British Columbia, provincial health authorities and the federal Department of National Health and Welfare provided information on the medical staff complement of all hospitals within their jurisdictions which had 100 or less hospital beds.[12] Of the 1,348 civilian hospitals in operation in 1976, at **least 331 hospitals had less than four physicians on their medical staff. In terms of the distribution of physicians, 24.6 percent of hospitals in Canada did not have a medical staff which was large enough to establish a therapeutic abortion committee and to perform the abortion procedure.**[13] The distribution of these hospitals and for federal hospital services was:

[12] Number of physicians on the staff of hospitals in British Columbia based on Committee's national hospital survey.

[13] Calculated on a basis of 1,348 civilian hospitals.

Newfoundland	11
Prince Edward Island	2
Nova Scotia	—
New Brunswick	12
Quebec	17
Ontario	5
Manitoba	38
Saskatchewan	94
Alberta	54
British Columbia	16
Medical Services Branch	
(1) outpost Stations	75
(2) hospitals	7
CANADA	331

Seven of the eight provinces which had specific criteria on medical staff and facility requirements for abortion subsumed the federal criteria. In each instance based on their statutes or directives, more hospitals did not meet stipulated provincial requirements. An Alberta directive for instance set three physicians as the minimum number of medical staff and for that province this requirement is used. A total of 38 Alberta hospitals had less than three physicians, while 54 hospitals had under four physicians on medical staff. For Prince Edward Island and Manitoba, where there was no stipulation in provincial requirements as to the size of medical staff, the hospital practices' requirement of four physicians precluded two hospitals in Prince Edward Island and 38 in Manitoba from establishing committees.

Listing of therapeutic abortion committees

The Hospital Morbidity Section of Statistics Canada prepares annual reports providing national statistics on the number of women obtaining abortion in Canadian hospitals. In compiling these reports, Statistics Canada obtains its information from three sources. The first source is from general information collected for all medical and surgical procedures which are done in Canadian hospitals. The second source is based on information derived from a special national register maintained in accredited or approved hospitals which have therapeutic abortion committees. The third source for the annual listing of hospitals with therapeutic abortion committees is compiled from information provided each year by provincial health authorities. Statistics Canada reports directly these provincial listings.

The List of Hospitals with Therapeutic Abortion Committees as Reported by Provinces in Canada, January 1, 1976 of Statistics Canada reported 271 hospitals with committees. Information obtained by the Committee from provincial health authorities in February-March 1976 provided a listing of 268 hospitals with committees. From the survey of hospitals done by the Committee to obtain information about their experience with abortion, four hospitals

listed by provincial authorities as having therapeutic abortion committees reported such committees had never been established. None had done this procedure. Five hospitals which were not listed as having therapeutic abortion committees reported that such committees had been established. In the case of four hospitals located in Quebec, Ontario and British Columbia, the establishment of the committees had been approved by hospital boards in 1975. These decisions could not be included for the year's provincial listing.

In the 1976 federal listing by Statistics Canada which was released on May 28, 1976 of hospitals which had therapeutic abortion committees during 1975, 32 hospitals in Quebec were reported based on "information is as per report from the province". Information provided to the Committee on May 11, 1976 by the Quebec Ministry of Social Affairs listed 27 hospitals in 1975 which had therapeutic abortion committees. There was a discrepancy involving five hospitals which were listed for 1975 as having committees by Statistics Canada (32) and the Quebec Ministry of Social Affairs (27).

Two other hospitals, one in Alberta and the second in British Columbia, reported the establishment of therapeutic abortion committees in 1971 and 1973 respectively. Neither hospital was listed by provincial or federal authorities as having a committee. Since each committee was established by the two hospitals, no abortions had been done. One of the conditions set by the Abortion Law was not being met by these two hospitals. These requirements stipulate that members of a therapeutic abortion committee be appointed by a hospital board. Neither of the two unlisted hospitals with committees was accredited nor had approval been sought or given by the respective provincial health departments. Taken together, the 11 hospitals whose listing was incomplete[14] (excluding the four hospitals with newly established committees) represented 4.1 percent of the hospitals listed in 1975 as having committees.

The differences in the listing of hospitals with therapeutic abortion committees may result from the review procedures established by provincial health authorities. The Committee inquired of each province whether a review had been undertaken of hospitals with and without therapeutic abortion committees. The replies from provincial health departments were:

	Hospitals with Committees	Hospitals without Committees
Newfoundland	No	No
Prince Edward Island	No	No
Nova Scotia	No	No
New Brunswick	No	No
Quebec	Annual	No
Ontario	Periodic	No
Manitoba	No	No
Saskatchewan	No	No
Alberta	Periodic	No
British Columbia	Periodic	No

[14] These 11 hospitals consisted of: four hospitals which reported to the Committee that they had never established therapeutic abortion committees, five hospitals listed by Statistics Canada for Quebec which were not verified by that province's Ministry of Social Affairs, and two hospitals with committees which were not listed by Statistics Canada nor approved by provincial health authorities. In addition there were two military hospitals, one in Canada and one abroad with committees which were unlisted for 1976.

Of the four provinces which had reviewed hospitals with committees, Quebec did so annually in terms of formal requirements and the number of abortions which were done. Ontario, Alberta and British Columbia undertook periodic assessments. Six provinces had not reviewed the experience of hospitals with therapeutic abortion committees. None of the provinces had reviewed hospitals without committees relative to induced abortion.

Eligible hospitals

Of the total of 1,348 non-military hospitals in Canada in 1976, 789 hospitals, or 58.5 percent, were ineligible in terms of their major treatment functions, the size of their medical staff, or their type of facility to establish therapeutic abortion committees. This number of hospitals was comprised of: 317 public general hospitals excluded by provincial requirements; 40 public general hospitals excluded by hospital practices' requirements involving the size of their medical staff; 259 specialty treatment hospitals; 78 private specialty hospitals and private general hospitals excluded by provincial requirements; seven hospitals operated by the Department of Veterans' Affairs; 75 nursing outpost stations operated by the Medical Services Branch of the Department of National Health and Welfare; and 13 federal hospitals which did not meet requirements for the abortion procedure set by federal health authorities. In addition, there were 34 accredited public general hospitals which did not have obstetrical services and had not sought provincial approval. These hospitals which could be eligible if provincial approval were to be obtained were not included in the total of 789 ineligible hospitals.

Of the remaining 559 general hospitals which met the various conditions involved in the establishment of a therapeutic abortion committee, 271 hospitals had committees in 1976, and 288 hospitals did not have committees. **In terms of all civilian hospitals (1,348) in Canada in 1976, 20.1 percent had established a therapeutic abortion committee. If only those general hospitals which met hospital practices and provincial requirements and were not exempt in terms of their special treatment facilities are considered, then of these 559 hospitals, 271 hospitals, or 48.5 percent, had established therapeutic abortion committees, while 288 hospitals, or 51.5 percent, did not have these committees.**

The requirements used by federal and provincial authorities to review applications by hospitals under their jurisdictions to establish a therapeutic abortion committee included:

1. *Rated bed capacity*—50 beds, 100 beds, an undesignated number of obstetrical beds.
2. *Size of medical staff*—three physicians, six physicians, 10 physicians.
3. *Appointment of medical specialists*—a physician with major hospital privileges in surgery; a gynaecologist.

4. *Organization of medical staff*—a medical audit committee; 10 meetings annually of medical staff; family planning counselling and follow-up of patients.

5. *Treatment facilities*—an operating theatre; an operating theatre equipped for major surgery and anaesthesia; facilities for emergency blood transfusion.

Two provinces did not stipulate requirements for rated bed capacity, size or organization of medical staff, or the type of treatment facilities. The requirements reported by eight provincial health authorities and the federal Medical Services Branch were: unpublished departmental guidelines; directives sent to approved hospitals; and statutes incorporated in provincial legislation. The basis of authority for these requirements is stipulated in the Abortion Law relative to hospitals approved by provincial health departments whose authority in turn is based in provincial public hospital legislation.

There was no uniformity across the nation of the standards of medical care relating to the quality of services or the requisite facilities required to undertake the abortion procedure in a general hospital. Hospitals which would be permitted to establish a therapeutic abortion committee in some provinces would not be allowed to do so in other provinces. The requirements did not specify the services and facilities required for the abortion procedure when this operation was done on an out-patient or in-hospital basis, or by the length of a patient's pregnancy.

Chapter 6

Distribution and Availability

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

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

Distribution of eligible hospitals

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

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

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

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

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

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

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

TABLE 6.1

POPULATION SERVED BY ELIGIBLE GENERAL HOSPITALS*

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

* Based on 1971 Census and 1976 distribution of hospitals.

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

Hospitals with committees

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Eligible hospitals without committees

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

Decisions of Hospital Boards. Five categories of reasons were given by hospitals for not establishing therapeutic abortion committees.[3]

[3] Based on replies from eligible hospitals in the national hospital survey.

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

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

> Under the present circumstances, there is no longer any medical indication to justify therapeutic abortion (i.e., a direct attack on the foetus) to protect the life or physical health of the mother.
>
> • • •
>
> We are not concerned with the Abortion Law; we just do not believe in this as a modality of treatment.
>
> • • •
>
> There seems to be confusion related to therapeutic abortions. The true therapeutic abortion procedure is rarely necessary; however, if you mean for convenience, this is a very expensive means of birth control for irresponsible people.
>
> • • •
>
> Is sterilization mandatory following a therapeutic abortion? Do we solve *social* ills by this means? Should not poverty and ignorance be treated directly, thus preventing the conception of these unwanted children?

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

• • •

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

• • •

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

• • •

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

• • •

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

• • •

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

• • •

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

• • •

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

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

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

• • •

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

• • •

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

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

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

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

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

(1) *Bible Basis*—Psalm 139: 1-13 and many other Scriptures teach that human life and human personality begin at conception and continue within the mother's womb before birth; and that to deliberately destroy that life is the killing of a living person.

(2) *The Position of the Pentecostal Assemblies of Canada.* The Pentecostal Assemblies of Canada declared its position on Abortion at the 1968 General Conference at Windsor, Ontario in Resolution #18, affirming that abortion, except on strictly therapeutic grounds, is contrary to the Word of God and the sanctity of God-given life and that such intervention calls for God's strong condemnation.

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

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

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

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

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

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

3. An unborn child is a "potential person" from the moment of conception and a "potential" member of a family and of society, with spiritual, moral, and legal rights in both spheres.

4. Based on the experience of its Women's Social Service Officers, it is best, in most instances, to try and help a woman to accept the fact of an unplanned pregnancy and subject to medical advice, to allow it to go to term, while giving all possible supportive help.

5. Abortion should be granted only on adequate medical grounds after the therapeutic abortion committee has by certificate in writing stated that in its opinion the continuation of the pregnancy of such a female person would or would be likely to endanger her health, but not for social reasons. "Health" should be interpreted as soundness of mind and body, allowing for usual feelings of guilt, anxiety, and the pressures of socio-economic conditions.

In Salvation Army Hospitals it is required that:

1. Where deemed advisable by the Board of Management, and approved by Territorial Headquarters, a Therapeutic Abortion Committee be properly constituted and its members formally appointed by the Board of Management.

2. Abortions will be considered necessary only when recommended by such an Abortion Committee at a properly constituted meeting with a minimum of three doctors present.

3. The Abortion Committee should have associated with it a Salvation Army Officer and a social worker.

4. Whenever possible, qualified counselling be available to the prospective mother prior to the consideration of an application by the Abortion Committee.

5. The Abortion Committee give particular consideration to such factors as the age of the mother, her medical history in the light of any previous pregnancies or abortions, the estimated age of the fetus, and the timing of the abortion procedure.

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

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

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

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

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

Preamble

As Christians we wish to affirm:

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

We also affirm that:

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

2. *Abortion*

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

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

(*b*) The present law, which requires a hospital therapeutic abortion committee to authorize an abortion is unjust in principle and unworkable in practice.

(*c*) We do not support "abortion on demand". We believe that prior to twelve weeks of gestation, or prior to that stage of foetal development when abortion can no longer be performed by D&C suction, abortion should be a personal matter between a woman and her doctor. After that period of time, abortion should only be performed following consultation with a second doctor. We further believe that her male partner and/or other supportive people have a responsibility to both the woman and the foetus and should be involved in the decision wherever possible.

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

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

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

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

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

> Medical staff does not wish this hospital to become an "abortion mill" as it would benefit very few local residents and, if sufficient volume was present, could cause curtailment of other elective surgery.
>
> • • •
>
> In this small community of less than 25,000 people, the Right to Life group is very vocal. It intimidates local physicians with phone calls in the middle of the night. Hence, so few physicians are willing to perform the operation, that patients are referred to larger metropolitan centres. Referrals are also made to protect the anonymity of the patient.
>
> • • •
>
> Abortion Committees and abortions in general may be difficult to achieve in small hospitals and communities due to the personal involvement and relationship commonly found in smaller areas.
>
> • • •
>
> In a small community such as ours there is no possible way the Hospital Board or the Medical Staff of this Hospital would approve the procedure of therapeutic abortions. I as administrator also back the Board and the Medical Staff decision.
>
> • • •
>
> Easy and rapid availability of abortion services in _____ only 120 miles from _____, the small caseload and the social implications of performing abortions in a small community detract from creating an abortion service at this hospital.

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

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

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

• • •

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

• • •

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

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

• • •

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

• • •

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

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

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

> No requests have been brought to our attention. We presume the needs are not there yet.
>
> • • •
>
> We believe, in view of the small demand for therapeutic abortion and the difficulties involved in establishing a committee, that we can continue to refer our patients to hospital centres which provide these services.
>
> • • •
>
> The need in this community for abortions has not been made known to the hospital. However there appears to be a great need for the dissemination of family planning information to people especially those in low socio-economic groups who do not readily make themselves available to attend planned lectures, seminars, etc. The use of a mobile distribution of information system sent to communities on a regular basis might be of advantage. The use of clinics, seminars, public lectures should continue as widely as possible as education in and general acceptance of means of preventing pregnancy appears to be most important.
>
> • • •
>
> Up to this point there has been no interest indicated regarding the establishment of a committee.

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

> It was believed non-relevant for our hospital to start the necessary wheels while we do not have the necessary diagnostic equipment and while the cases presented are rare and the members of such a committee consequently, could not acquire the motivation and experience necessary to make a correct assessment.
>
> • • •
>
> The Board and Medical Staff of this Hospital, after full consideration and discussion, agreed *not* to set up an Abortion Committee. The performance of

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

• • •

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

• • •

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

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

Ownership of hospitals

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

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

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

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

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

Unlike the hospitals which for various reasons were ineligible to establish committees, **the decision of a majority (63.1 percent) of the eligible hospitals which had not established committees was based on religious morals and professional ethics.** The position of those institutions owned by religious denominations was clearly set forth and in each case generally adhered to publicly stated moral principles. There were no circumstances in the foreseeable future under which these hospitals would be prepared to establish committees or be indirectly associated with the abortion procedure. Put bluntly, as it was by the boards, the administrators and the staff of these hospitals to the Committee, these hospitals wanted no part of induced abortion. Rather than have any involvement in this procedure most of the boards of these hospitals would seek to change their ownership, close their hospitals, or transfer their services to other patient treatment programs. Expressing a view which was widely held by the boards and administrators of these hospitals, two senior administrators of religious hospitals said:

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

• • •

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

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

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

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

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

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

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

> From the moment of fertilization, that is from the earliest moment of biologic existence, the developing human being is alive, and entirely distinct from the mother who provides nourishment and protection.
>
> From fertilization to old age, it is the same living human being who grows, develops, matures and eventually dies. This particular human being with his or her characteristics is unique and therefore irreplaceable.
>
> Just as medicine is at the service of life when it is failing so too it should service life from its beginning. It should have absolute respect for human life regardless of age, illness, disability or degree of dependence.
>
> When confronted with tragic situations, it is the duty of the doctor to do everything possible to help both the mother and her child. The deliberate killing of an unborn human to solve social, economic or eugenic problems is directly contradictory to the role of the doctor.

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

[4] Canadian Council on Hospital Accreditation, *Guide to Hospital Accreditation*, Toronto, 1972, page 24.

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

> will on the patient's request, assist him by supplying the information required to enable the patient to receive any benefits to which the patient may be entitled;
>
> shall except in an emergency, have the right to refuse to accept a patient;
>
> will allow death to occur with dignity and comfort when death of the body appears to be inevitable.

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

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

Public knowledge of induced abortion

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

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

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

Where persons lived in Canada and their social circumstances were related to whether they felt obtaining an abortion was legal or illegal. In regions where there were higher rates of therapeutic abortions than the national average such as in British Columbia and Ontario, more women and men said that it was legal to obtain an induced abortion. Where the reported rates for therapeutic abortions were lower in the country, fewer people in these regions such as in the Maritimes or Quebec said this was the case. There was no variation in these responses by the size of the community where people lived. More young adults than either persons who were much younger or older said induced abortions could be legally obtained. **Some six years after the federal abortion legislation was amended to allow induced abortions to be obtained under stipulated circumstances, 2 out of 3 persons in the 1976 national population survey did not know it was legal under any circumstances to obtain a therapeutic abortion.** This lack of knowledge which varied by the circumstances of individuals did not preclude some persons from having definite views on what they thought the law was about, whether it was too liberal or too restrictive, or about the circumstances under which a therapeutic abortion might be obtained.

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

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

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

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

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

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

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

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

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

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

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

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

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

TABLE 6.2

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

NATIONAL POPULATION SURVEY

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

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

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

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

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

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

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

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

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

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

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

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

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

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[5] *Appendix I: Statistical Notes and Tables*, see Note 3 and Tables 15, 18 and 19. The results of factor analysis and multiple regression analyses are the basis of these findings.

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

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

Physicians doing induced abortions

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

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

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

TABLE 6.3

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

PROVINCIAL HEALTH DEPARTMENTS

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

*Newfoundland total includes out-of-province procedures, excludes abortion procedures done by salaried physicians, and accounts for therapeutic abortions and hysterotomies.
**Nova Scotia tariff fee code 2403 includes abortion, incomplete, including D&C.
***New Brunswick, code 1401 with information for 1974.
****Quebec, information given for specialists, 1974.
*****Manitoba, procedures done by 106 physicians in 1974.

TABLE 6.4

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

PROVINCIAL HEALTH DEPARTMENTS

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

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

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

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

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

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

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

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

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

TABLE 6.5

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

Fiscal Year 1974-75*

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

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

* Health Insurance and Resources Directorate, Department of National Health and Welfare, June 1976.
** Total obstetrician-gynaecologists in eight provinces—1,076.
*** Fiscal year 1973-74.

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

Distribution of accessible services

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

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

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

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

TABLE 6.6

DISTRIBUTION OF HOSPITAL SERVICES FOR THERAPEUTIC ABORTION BY REGION

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

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

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

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

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

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

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

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

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

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

Coupled with the personal decisions of obstetrician-gynaecologists, half of whom (48.9 percent) in eight provinces did not do the abortion procedure in 1974-75, the combined effects of the distribution of eligible hospitals, the location of hospitals with therapeutic abortion committees, the use of residency and patient quota requirements, the provincial distribution of obstetrician-gynaecologists, and the fact that the abortion procedure was done primarily by this medical specialty resulted in sharp regional disparities in the accessibility of the abortion procedure. In addition to the fact of what moral and profes-

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

The relative accessibility of these resources were related to one or more of three outcomes. These were: (1) the length of time between an initial medical consultation by a woman and when the abortion operation was done in a Canadian hospital; (2) the number of abortions done in Canadian hospitals compared to the number of Canadian women going to the United States for this purpose; and (3) changes in the volume of illegitimate births in a region.

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

Chapter 7

Patient Pathways

In the reporting of vital statistics about births and infant deaths, outcomes are given; not the rates of conception and how many women may have been pregnant. It is sometimes thought that these are synonymous events, a fact which is belied when the issue of abortion is considered. For this reason while there is an accurate listing of births in Canada, there is little information on the actual extent of pregnancy. The Committee estimated that of every 100 pregnancies, 77.4 percent resulted in live births, with some of these infants dying shortly after birth or within the first year of their lives. The other pregnancies, or 22.6 percent, either terminate spontaneously or are induced. Of this number, 1.4 percent are stillbirths which occur after 20 weeks of pregnancy, 7.9 percent are spontaneous abortions and abortions designated as neither spontaneous nor induced, and 13.3 percent are induced abortions, both legally done, illegally obtained, or performed for Canadian women outside Canada.[1]

For many Canadian women the birth of a child is a happy and wanted event. But with changing ideas about the size of families, the birth rate in recent decades has declined along with the average size of families. While it is unknown how many unwanted pregnancies there may have been in the past, this fact now involves a sizeable number of Canadian women. How women see pregnancy before and after conception takes place may change, with no firm decision being reached until a definite outcome—a birth, a stillbirth, or an abortion—occurs. On the basis of its findings the Committee estimates that at least 1 out of 6 women who consider an induced abortion change their minds before this operation is obtained. About half of these women initially wanted to become pregnant, but after much consideration they subsequently decided to terminate their pregnancy. The second group consists of women who did not initially want to conceive, sought an abortion, and prior to a scheduled operation withdrew and subsequently gave birth to a child.

[1] Calculated for 1974 on the basis of: 345,646 live births; 6,345 stillbirths; 35,158 spontaneous abortions and other abortions; 48,136 therapeutic abortions in Canadian hospitals; an estimated 1,441 illegal abortions in Canada; and an estimated 9,627 abortions obtained by Canadian women in the United States. There were 5,192 infant deaths in Canada in 1974. See Statistics Canada, *Vital Statistics 1974*, Ottawa, Information Canada, May 1976.

Decisions about unwanted pregnancies involve heightened emotions and considerable stress. After an unwanted conception has occurred, women may follow one of several courses which in part depend upon their social situation, what they know about different options, and the availability of the health services where they live. Some women obtain directly an abortion in a Canadian hospital. Others who are less familiar with health services turn to community agencies for counsel. Some women by-pass Canadian medical care services altogether and go to the United States. In decreasing numbers a smaller group of women turn for assistance to maternity homes.

In reviewing these options which are taken following conception, three other courses are not dealt with in detail in the Report. Little is known about how many women had unwanted pregnancies, whether they were single or married, or if they gave birth to a child, but at no time sought the assistance of community agencies. Another group about whom little is known are the women who had abortions in Canadian hospitals which were listed as being neither spontaneous nor induced. Finally, a group whose numbers are diminishing are the women who obtain illegal abortions in Canada.

The general pathways which are taken by women who have unwanted pregnancies are: (1) women who are referred directly for abortions in Canadian hospitals; (2) women who turn, or who are referred, to community resources for counsel who may subsequently get an abortion in Canada, go to the United States for this procedure, or may carry their pregnancy to term; (3) women who turn to college and university health services; (4) women who go directly to the United States for an abortion; and (5) women who carry to term and who may turn for assistance to maternity homes and welfare services. The several sources of information about the work of agencies for pregnancy counselling and abortion referral were drawn from the national offices of major voluntary associations, and inquiries sent to a large number of provincial associations and independent groups. The actual work in the field of family planning and abortion counselling of the agencies which were contacted was unknown prior to this survey, and in this sense, the results which were obtained are not a sample. Out of a total of 1,005 agencies which were contacted, 483 or 48.1 percent, returned completed questionnaires.

Agencies Contacted	Information Requested	Replies	Percent Return
Public health departments	254	137	53.9
Child welfare agencies	242	84	34.7
Community agencies	125	42	33.6
Planned Parenthood	76	38	50.0
Séréna	49	18	36.7
College and university health services	211	134	63.5
Commercial agencies	13	2	15.4
Maternity homes	35	28	80.0
TOTAL	1,005	483	48.1

In considering the different routes taken by pregnant women, either seeking an abortion or going to term, information was obtained in the context of two Terms of Reference set for the Committee which stipulated: what is "the timeliness with which this procedure makes an abortion available in light of what is desirable for the safety of the applicant"; and whether applicants for abortion were "being discouraged from obtaining legal abortions in Canada because delays in obtaining medical examinations, decisions by therapeutic abortion committees, and termination of pregnancies where approval has been given, increase the risks to a point which applicants find unacceptable."

Pathway one: Abortion in Canadian hospitals

When a woman recognizes that she may be pregnant, and if she decides to seek an abortion, several factors may influence when the abortion operation is done. These factors are: (1) a woman's social circumstances and how she feels about the issue of abortion; (2) the individuals and agencies to which she may turn for assistance and the nature of the counsel which is given; and (3) the use of health services involving the decisions of physicians, the location of hospitals with committees, and what steps are taken by physicians in the review of abortion applications. These factors do not operate apart. Each to a greater or lesser extent has implications for the length of time which is involved between when a woman decides she wants to terminate her pregnancy and the speed with which this operation is done. The information drawn upon here was taken from the experience of 4,754 women getting an induced abortion who participated in the 1976 national patient survey.

Most of the women in the national patient survey said that their menstrual cycles either were usually (12.4 percent) or always (79.6 percent) regular. While little is known about the accuracy of the timing of missed menstrual periods or the speed with which delayed menses are recognized, 87.8 percent of the abortion patients in the national patient survey suspected they were pregnant before their second missed menstrual period. Some of these women experienced other symptoms associated with pregnancy such as nausea and swollen breasts.

After conception occurred, most of these patients (79.5 percent) initially discussed this fact with members of their families and their close friends. About 1 out of 5 patients (18.5 percent) spoke first about their pregnancy to a physician. Only a handful (2.0 percent) immediately sought out a community agency. Two major resources were used to confirm that conception had occurred. About 3 out of 5 women (59.0 percent) contacted a physician; most of the rest (40.5 percent) had a pregnancy test done either at a drugstore or a clinic. In the course of seeking advice some women (19.5 percent) subsequently turned to one or more community agencies or social service consultants for assistance. Among this group about 1 out of 10 (9.7 percent) met with the staff of two or more agencies.

The average length of time was 2.8 weeks from when a woman realized she was pregnant to when she consulted a physician. Almost 2 out of 5 women

(38.8 percent) said they had seen a physician within the first week of suspecting that they were pregnant; another quarter (26.0 percent) had done so within two weeks. Overall, 2 out of 3 women (64.8 percent) said they had seen a physician within the first two weeks of when they became pregnant, 1 out of 5 (21.2 percent) between 3 to 4 weeks and 1 out of 7 women (14.0 percent) took five weeks or longer to make an appointment with a physician. About half of the patients (52.4 percent) consulted their usual family doctor, a step which was more often followed by married women (61.4 percent) than single females (47.8 percent). Three other sources of medical care were turned to about equally, with 17.0 percent of the patients having first consulted a medical staff member of a hospital or a community clinic, 16.4 percent an obstetrician-gynaecologist, and 13.4 percent another family physician who was not their usual practitioner.

The reason most frequently cited by women why they had not seen a physician sooner about their pregnancy was that they had not realized they had been pregnant (35.9 percent). This reason for many of these women may have been a rationalization for why they had delayed consulting a physician or a rejection of the fact of pregnancy itself, for over 9 out of 10 (93.9 percent) women said they suspected they were pregnant within six weeks of the time of conception. [2] All other reasons were less often given. About 1 out of 10 patients (11.2 percent) were uncertain during this initial period of their pregnancy whether they wanted to have an abortion and 1 out of 12 women (8.3 percent) had initially been afraid to go through with having an abortion. Relatively few women, about 1 out of 20, attributed part of the delay to obtaining the results of their pregnancy tests (6.3 percent). Women seeking an abortion on an average saw two physicians (2.08 per patient) prior to their operation. Among the patients in the national survey, 16.5 percent said they had seen three physicians, 3.9 percent four physicians, and 1.1 percent had seen five or more physicians. Two patients had seen eight physicians.

On an average women took 2.8 weeks after they first suspected they had become pregnant to visit a physician. After this contact had been made there was an average interval of 8.0 weeks until the induced abortion operation was done. The average reported time of 10.8 weeks was somewhat larger than the actual indicated length of gestation at the time of the abortion operation which was 10.0 weeks for the average woman among the 4,754 patients. The average length of time after a physician had been contacted prior to the operation varied across the country and by the social circumstances of women. This average interval involved only those women who had the abortion operation done in a Canadian hospital. It does not take into account what happened to women who went to the United States for this purpose or the experience of women who decided to go to term.

The shortest average interval between the initial contact with a physician and when the abortion operation was done was among women in Quebec where 1 out of 5 patients (18.3 percent) had the operation done within three weeks.

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[2] The proportion of women who suspected they were pregnant by the number of weeks their period was overdue was: 35.7 percent, one week; 30.5 percent, two weeks; 9.8 percent, three weeks; 11.8 percent, four weeks; 3.0 percent, five weeks; 3.1 percent, six weeks; and 6.1 percent seven weeks and over.

This shorter interval for women in Quebec contrasted with other regions where between 3.7 percent to 6.4 percent of the women in the national patient survey had their abortions done within three weeks of their initial consultation with a physician. In keeping with this finding, relatively fewer women in Quebec in the national patient survey waited eight weeks or longer for this surgical procedure than women elsewhere in the country. While 1 out of 4 abortion patients in Quebec (23.0 percent) were in this longer time category (eight weeks or longer after an initial contact with a physician), on an average 2 out of 5 women in Ontario and the western provinces waited this length of time (between 41.9 and 43.8 percent of patients) and in the Maritimes this proportion rose to 3 out of 5 women (62.9 percent).

The average amount of time between when a woman first contacted a physician and when the abortion operation was done for the 4,754 women at 24 hospitals in eight provinces was directly related to their experience with seeking medical services and how hospital services were organized in different regions. This interval of time increased on an average by one week for each additional physician whom a woman contacted. Women who consulted one physician prior to when the final arrangements were made for the abortion operation waited on an average of between 6 to 7 weeks, while patients who had seen three or more physicians spent between 9 to 10 weeks until the operation was done. Other aspects of how health services were organized also directly influenced the length of the interval between an initial contact with a physician and when the abortion operation was done. These factors included: difficulties which women had had in getting an appointment at a hospital (11.1 percent); consulting a physician who chose not to make a referral either to another physician or to a hospital (5.2 percent); receiving no assistance from a hospital clinic, a medical practice clinic or a community clinic (0.9 percent); or not having an application for the procedure approved by a hospital therapeutic abortion committee (1.2 percent). Overall, about 1 out of 5 women (18.4 percent) in the national patient survey experienced one or more of these factors which served to lengthen their pregnancies prior to when the abortion operation was performed.

The average length of gestation of the women in the national patient survey when the abortion operation was done was 10.0 weeks. The length of gestation in terms of weeks for these patients was 38.8 percent, eight weeks or less; 45.3 percent, 9 to 12 weeks; 5.4 percent, 13 to 15 weeks; 9.9 percent, 16 to 19 weeks; and 0.5 percent, 20 weeks and longer. About two-thirds (65.0 percent) of the patients in Quebec had a gestation of seven weeks or less when they had their abortion operations. The average length of gestation of patients in other regions was between 10.1 and 11.2 weeks. In Quebec and British Columbia 7.7 percent and 7.0 percent respectively of the abortion patients had abortions when their length of gestation was 16 weeks and longer. In Ontario the proportion of patients in this category was 10.3 percent, while it was 14.9 percent among women in the Prairies and 20.8 percent in the Maritimes.

The average length of gestation among the abortion patients varied by their age, their marital status and their level of education. Regardless of what part of Canada they lived in about 1 out of 20 married women (5.5

percent) had a length of gestation of 16 weeks or more at the time of their abortion operation. The experience for single women and women who were separated from their spouses was double this level, with respectively 12.4 percent and 12.7 percent having this length of gestation at the time of the abortion operation.

There were consistent trends across the country when the abortion operation was done by the age of women and their length of gestation. In general, more older patients had a shorter length of gestation while most younger women had been pregnant longer prior to the abortion procedure. In British Columbia for instance which reflected the national trend, 17.9 percent of abortion patients 17 years and younger had their abortions at or before eight weeks of gestation and among this age group 14.7 percent had been pregnant 16 weeks or longer when the operation was done. In contrast, among patients who were 35 years or older in that province, 2 out of 5 (43.1 percent) had been pregnant eight weeks or less and there were none who had the abortion operation done who were 16 weeks or longer in their length of gestation. Similar trends occurred in all other regions. In Ontario, 17.7 percent of the women who were 17 years and younger and 47.9 percent of women who were 35 years and older had their induced abortions done at or before eight weeks of pregnancy. One out of five of these younger women in Ontario (22.6 percent), but only 1 out of 20 of the older women (4.3 percent) had abortions done when they had been pregnant 16 weeks or longer.

As with the effects of age and where women lived, their level of education was also related to when the abortion operation was done. Over half of the women who had been to college or university (52.4 percent) had their pregnancies terminated within eight weeks of the time of conception, while only a third (32.0 percent) of women who had grade 10 schooling or less were in this category. In contrast, five times as many women with less education (15.9 percent) than women who had been to college or university (3.0 percent) had their pregnancies terminated at 16 weeks or longer in their length of gestation. These trends occurred consistently across the country.

When only those patients who had abortions when they had been pregnant 16 weeks or longer are considered, many of these patients (10.4 percent), had had the abortion operation delayed because of difficulties which they had had with finding medical services which would have facilitated their requests for induced abortion. **Among women who had been pregnant 16 weeks or longer when they had an induced abortion, 1 out of 5 of these women said there was no therapeutic abortion committee at the hospital in the community where they lived. Among the small group of women who had induced abortions whose previous applications had not been approved by a hospital therapeutic abortion committee, 1 out of 4 (27.9 percent) had been pregnant for 16 weeks or longer. While 5.2 percent of patients said the physician whom they initially contacted did not refer them to another physician, 1 out of 5 of these patients (19.0 percent) subsequently had abortions when they had been pregnant for 16 weeks or longer. Among the 1 out of 10 patients (11.1 percent) who had had difficulties in arranging a hospital appointment, 1 out of 5 (20.0 percent) subsequently had an induced abortion when they had been pregnant 16 weeks or longer.**

There were two groups of patients among the women who had induced abortions when they had been pregnant for 16 weeks or longer. The first group had seen a physician at least eight weeks before the abortion operation was done. **Three out of four of the women (75.7 percent) who had an induced abortion done between 13 to 15 weeks of gestation had initially consulted a physician at least eight weeks earlier. An equal proportion (76.7 percent) of women who had their abortions when they had been pregnant 16 weeks or longer had also seen a physician some two months prior to the abortion operation.** These women who had a longer length of gestation when they had induced abortions had been seen by physicians in ample time to have had this operation done considerably earlier in their pregnancies. **The average interval of eight weeks resulted from direct delays in how physicians and hospitals handled these patients.**

The second group of women (21.3 percent) who had been pregnant for 16 weeks or longer when they had their induced abortions had waited on an average for eight weeks or more before they had contacted a physician about their pregnancy. The applications submitted on their behalf by physicians to hospital therapeutic abortion committees were processed more rapidly than was the case for the larger group of women who had contacted physicians earlier in their pregnancies. Among the women who had not seen a physician until eight weeks after they became pregnant, and who were between 13 to 15 weeks in length of gestation, most had an induced abortion within five weeks.

Most of the women in the national patient survey (84.1 percent) had an induced abortion done when they had been pregnant for 12 weeks or less. A majority of these women spent some 6 to 8 weeks after they had first contacted a physician before the abortion operation was done. Making an early contact with physicians had not facilitated or speeded up the scheduling of the abortion operation for these patients. Coupled with this delay experienced by most induced abortion patients was the fact that the women who themselves delayed longer than the average patient in consulting a physician obtained an induced abortion faster than the majority of all patients. In these respects the health system responded faster to what was seen as a crisis situation for women who had delayed seeking medical assistance, but in the process of doing this, the needs of those women which were seen to be less immediately threatening were set aside with the accumulative level of the risk of health complications being increased for these patients.

The amount of time taken to get an induced abortion and its relation to the length of a woman's pregnancy was looked at by a different means of analysis, the statistical method of multiple regression. In this analysis the three main contributing factors which were reviewed were: (1) a woman's social circumstances; (2) the persons or agencies which she had consulted; and (3) the provision of health services in terms of the number of physicians who were seen, the length of time which was taken for medical referrals, and the amount of time which elapsed between the initial contact with a physician and when the abortion operation was performed. This analysis dealt with the question of what accounted for the different lengths of pregnancy of women getting an induced abortion. Put differently, what speeded up or what delayed the

obtaining of this operation? Items which accounted for less than 1 percent of the differences were dropped from the regression equation as having too little statistical significance[3].

What the multiple regression procedure did was to eliminate the relationship between several events which were associated with each other, such as a patient's age, her marital status, or her level of education. For young women for instance it would be expected that fewer would be married and have somewhat less education than older women. While each of these factors may be related to the length of a woman's pregnancy, they are also closely related to each other. The analysis considered the extent to which all of these factors were related to the length of a woman's pregnancy.

Three events (how much time was taken by a woman to consult a physician, how many physicians she consulted, and the length of time from the initial medical consultation to the abortion operation) accounted for 73.5 percent of the differences in the length of the pregnancies of the women in the national patient survey. While with the information which was available, it was not possible in the regression analysis to account for about a quarter (26.5 percent) of the factors associated with the length of gestation, it is unusual in considering what people do to be able to explain or to account for such a large proportion of what happened.

The decisions which patients made—their fears about abortion, their recognition that they were pregnant, and how long it took them to reach these decisions accounted for 12.3 percent of the delay. The actual time it took to reach a decision was an important factor itself, one which was little influenced by a woman's age, her family circumstances, her religion, her primary language, or where she lived. For the patients in the national patient survey, none of these other aspects of a woman's circumstances as well as the advice given by her family or the counsel which she received from community agencies speeded up or delayed the sequence of obtaining an abortion. These factors undoubtedly influenced the experience of some of these women, but in the aggregate, if the experience of all of the women in the national patient survey is considered, they had a negligible effect. The most significant factor which accounted for women having an abortion earlier or later in their pregnancies resulted from the decisions taken by physicians once these patients had contacted them to request an abortion. Medical decisions and the amount of time which was taken to process and review abortion applications accounted for 61.2 percent of the differences in the length of the patients' pregnancies. When these decisions were promptly made and the requirements of the therapeutic abortion committees were more speedily met, the length of gestation was substantially lower. Where more time was involved in these steps between a woman's initial contact with a physician and the approval of an application, the length of gestation increased.

In considering these results it is relevant to remember that they represented the experience of 4,754 women who obtained abortions in accessible

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

Canadian hospitals in 1976. These findings did not include the experience of women who tried but did not get abortions, who went abroad for an abortion, or who decided to go to term. While many physicians and nurses have voiced their deep concern about abortion patients who obtain this operation when their pregnancy is more advanced and they attribute this delay to the socially irresponsible behaviour of women seeking induced abortions, the findings are unmistakable and clear. This is not the case for most of these women who had induced abortions. In an almost self-fulfilling prophecy, because there is so much stigma involved with induced abortion and because so many physicians see this procedure with considerable distaste while others wish no part of the abortion procedure, it is these factors that account for most of the delay experienced by women who had induced abortions when they had been pregnant for 16 weeks or longer.

Going beyond who a woman was, where she lived, or with whom she had spoken or consulted, it was medical decisions, not decisions made by patients, which made the most substantial difference in how long it took these patients to get an induced abortion and which extended the length of their pregnancies. The reasons for this delay are rooted in the diversity of views held by physicians about abortion and the amount of time which was taken to meet the various requirements set by hospital therapeutic abortion committees. If medical decisions had been more promptly made for these patients, if on an average they had seen fewer physicians, and if the time taken in the submitting and the processing of abortion applications had been shortened, most of these abortion operations could have been performed earlier and at less risk for these patients.

Pathway two: Community agencies

Approximately 1 out of 5 women in the national patient survey had contacted one of a number of community agencies about their pregnancies. This step accounted for less than 1 percent of the difference in the length of gestation of all of these patients, or in other words, for most of the patients in the survey, this step neither speeded up nor delayed their obtaining an induced abortion in a Canadian hospital. But these community agencies served a broader group of women, some of whom were advised to go to the United States to obtain an abortion, while others subsequently bore children.

The most frequently used source turned to by 1 out of 14 patients in the national patient survey (7.1 percent) were the branches of the Planned Parenthood Federation of Canada. This resource was used somewhat more by single women or women who had been previously married than by married women. The next most frequently used counselling service which had been used by the abortion patients were the various abortion referral agencies whose distribution was limited primarily to Quebec and Ontario. These agencies, used by 1 out of 15 patients (6.5 percent), drew more of their clients from among women who had a college or university education than from women with an elementary school training. The remaining sources of counsel were turned to by

only a handful of the patients, with 4.0 percent turning to general social service agencies; 2.5 percent to school nurses or counsellors; 0.9 percent to Birthright; and 0.5 percent to a religious leader such as a priest, a rabbi, or a minister. What emerges from these findings is that most of the women who decided to have an abortion in Canada did not turn to any of these community resources, but they made their decisions to obtain this operation either by themselves or through discussion with their families and friends. While the contacts made by the patients with community agencies provided some assistance, they served an "expediting" function, that of routing patients to hospitals, advising them on the selection of physicians who should be consulted about an abortion, or recommending that they go to the United States for this purpose. The type of counselling which was provided is illustrated by the experiences of women using these services—some of whom were well satisfied, while others left feeling they had not been fully or well advised.

> I was taken to a private room at the back of the offices where I was interviewed by a counsellor. I advised the counsellor that I was frightened and upset as I thought I was pregnant. The counsellor asked me whether I had had a pregnancy test. When I told her I had not, she suggested that I could go to a drugstore, the _____ Clinic (which she advised me was free), or to a doctor. She suggested I should go the next day, but from the description of my symptoms she stated that she thought that I was very likely pregnant.
>
> The counsellor asked me what I planned to do, and I replied that I did not know and that I was confused and scared. She told me that I could: (1) keep the baby, or, (2) have an abortion. I told the counsellor that I knew nothing about abortion and she then proceeded to describe what she called the two basic kinds of abortion:
>
> (a) D & C—the counsellor referred to this as "dusting and cleaning", and emphasized it was a very simple and commonly used procedure in which the womb was scraped and that there would be no serious repercussions to me.
>
> (b) Saline abortion—which is the injection of a salt solution into the fluid surrounding the baby. She stated that she would not advise this type of abortion because it was like an actual birth, as one goes into contractions, i.e., labour, but the baby is born dead and the hospital stay is longer.
>
> The counsellor urged that I shouldn't leave it too long, and that if I decided to have an abortion, I should do so very soon—before I was three months pregnant. She further advised me that I would have no problem in getting an abortion in _____ since all major hospitals, except the Catholic ones, performed abortions.
>
> I was also advised that if I went to _____ hospital, they would not use the word "abortion" on my chart, but would use the word "family planning", since she stated that abortion means "planning a family". She also stated that she thought that the _____ hospital does about twelve abortions every two weeks, and that I would be placed in the gynaecology wing and that no one would know me there.
>
> The counsellor then proceeded to fill in a questionnaire in which she recorded my birth date, address, religion, income bracket, education, profession, and type of birth control I had used.

The counsellor next explained the female anatomy and the various methods of birth control—she mentioned specifically the I.U.D., foam, jelly, condom, and the diaphragm. She showed me a chart of the female anatomy and what birth control devices looked like. I found her explanation to be somewhat less than clear. Before I left the premises, the counsellor gave me some pamphlets on birth control.

• • •

I advised the counsellor that I thought I was pregnant and wanted to talk the matter over with someone. The counsellor advised me that I could: (1) keep the baby; (2) have an abortion, and that she could not tell me what to do. I then asked the counsellor what was involved in an abortion and she stated that it was an easy operation and would only take five minutes and that, statistically speaking, it was safer than childbirth. She further stated that it was as easy as having tonsils or an appendix removed, and that my only complication might be feeling "blue" for a few days afterwards. She also stated that abortion was legal and that I did not have to feel guilty about it.

The counsellor advised me that I could either have an abortion at _____ or, at _____ in _____ where I would have to stay overnight. Or, I could go to the _____ in the United States, which she advised me would be preferable in my case since it was faster and I could be in and out in a day.

The counsellor then advised me that if I chose to have an abortion in _____ that the therapeutic abortion committees, in the aforementioned hospitals, were merely a formality and that I could obtain an abortion at _____ in three weeks or less, but at _____ it would take longer since the latter was very busy since it was doing the bulk of the abortions in _____ . I then discussed with the counsellor the question of _____ paying for the abortion and my husband finding out about the abortion. She advised me that if I had a tubal ligation performed at the same time as the abortion, the doctor would then not have to record my abortion as such, but that the _____ computer would register the abortion as a sterilization, with the result that my husband would not have to know about my abortion.

The counsellor, then, for a period of approximately 5 to 7 minutes, discussed birth control with me. She described the pill, I.U.D., diaphragm and foam. She also showed me a plastic model of the female anatomy and indicated to me how the birth control devices were used.

The counsellor then completed a form in which she recorded my name, birth date, doctor's name, income, religion, education, place of employment, and type of birth control I had been using.

The counsellor also gave me a list of doctors' names and their addresses. Apart from the time spent discussing birth control and completing the above mentioned form, the entire interview was directed to the discussion of abortion. I was never counselled about the possibility of keeping the child and no other alternative, except abortion, was discussed with me.

The services of the referral agencies were provided in most instances without charge to the women who sought them out. In the national patient survey, women who obtained abortions were asked if they had paid fees for the assistance which they had been given by community services. While most had not been charged for this assistance, 1 out of 10 women (10.7 percent) had paid

for these services, a factor which contributed to the overall expense of obtaining an abortion. Among a group of four agencies (community agencies, Planned Parenthood, Séréna, and commercial agencies), most (79.0 percent) distributed pamphlets to make their services known to the public. A second means of publicizing an agency's services was through listings in telephone directories. Three out of four (73.0 percent) agencies were listed, usually under the heading of family planning, contraception information, birth control, as well as the actual title of the agency. The heading of birth control services is sometimes given in the yellow pages of telephone directories. Advertising in newspapers and public places, such as public transit, was done by half (50.0 percent) of the community agencies. The Planned Parenthood Federation of Canada through a national birth control advertising campaign used this form of publicity. Advertisements in the personal columns of newspapers were widely used by Séréna (82.3 percent) and the commercial agencies. Commercial agencies usually paid for larger advertisements which listed their services. Public meetings including television and radio guest appearances were used by 61.2 percent of the agencies.

Many of the agencies directly contacted other community services to make known their availability and the types of services which they offered. Two-thirds (64.8 percent) of the Planned Parenthood groups, many of the Séréna groups (58.8 percent), and approximately half of the community agencies (42.5 percent) had contacts with other community resources. Additional resources most frequently contacted were social and family service agencies. Of these agencies, 51.0 percent had contacts with social agencies, while 39.0 percent had regular contacts with health agencies including family planning clinics and public health agencies. Other community resources including ministers, churches, Birthright, Children's Aid societies were routinely contacted by 29.0 percent of the agencies.

These centres were asked what difficulties had been encountered by the women seeking abortions who had used their services. Among the 214 agencies the problems listed were: 82.2 percent, length of gestation set by the hospitals; 75.0 percent, consent of minors or spouses; 73.9 percent, requirements set by hospital therapeutic abortion committees; 68.1 percent, the financial difficulties of women; 64.3 percent, obtaining an appointment with a physician or involving the advice given by a physician; and 57.8 percent, the distance travelled by the women seeking an abortion.

> In our province many women live in rural areas where they are isolated from access to the therapeutic abortion committee or in many cases isolated from information. Even in 1975 women still called asking if abortion is legal.
>
> • • •
>
> Hospital _____ in our city treats all therapeutic abortion applications as emergencies, but this is just not the case in the other hospitals. For example, Hospital _____ requires all patients to consult a psychiatrist prior to making application.
>
> • • •
>
> In this province the abortion law is not operating. Only a minute minority of hospitals have set up therapeutic abortion committees. Actually, no such

committee has been set up outside of _____. And in City _____ itself, only one hospital performs a sizeable number of abortions.

• • •

Over the last year we have had two instances of local M.D.s telling clients some pretty gross misinformation about abortions. One M.D. told a patient that she would bleed to death if she had an abortion. Another M.D. told a patient that she would be sterile if she had an abortion.

• • •

Women do not even know what the legal procedures are or how involved they are. Learning about the red tape and following along it is one more difficulty for a woman with already more difficulties than she can handle.

• • •

The _____ Hospital has placed geographic and residency restrictions on therapeutic abortion cases. This has put a great hardship on women in the south of the province as the committees in _____ have always been extremely harsh in their judgments. Many _____ women have found it necessary to give a false residence and apply through the _____ committee or to fly to the United States after having spent prior time unsuccessfully applying to the _____ committee.

• • •

Our follow-up on abortions shows that in general women who have abortions are placed on the maternity ward and that they are treated unsympathetically, if not downright ignored by nursing and service staff.

• • •

We have found that in general, M.D.s are reluctant to discuss abortion as an alternative to unplanned/unwanted pregnancy, either because of moral stance or lack of time.

• • •

Quite a few of the social agencies and doctors we have talked with are very concerned about the "blacklash" they are expecting from hospitals in _____. That hospital is starting to resent being called an "abortion mill", and rightfully so. The hospital committee in _____ is, at best, a hit and miss effort, depending on the personal beliefs of whatever doctors happen to be on the committee in any three month period. As all doctors are required to serve at one time or another, it is conceivable to have a couple of anti-abortionist doctors serving together, thereby allowing no abortions for a three month period. _____ doctors don't use _____ Hospital.

• • •

We have learned directly of one doctor in particular in this province who forced his abortion patients to sign sterilization papers, or no abortion.

• • •

We have found women who come in for an abortion past 12 weeks are invariably from out-of-town, particularly from _____. Several

of these women have talked about the difficulty getting an abortion in that city, i.e., doctor will not refer, doctor refers to another doctor who will not perform the abortion, doctor charges $250 for a D&C (although this is covered by _____).

• • •

This Hospital has geographical limits and out-of-town women must lie about their address to be considered by the therapeutic abortion committee. There is only one doctor that I am aware of, that does abortion past 12 weeks . . . he will perform prostaglandin abortions.

The 214 agencies which variously provided for pregnancy and abortion counselling (125 community agencies, 76 Planned Parenthood, and 13 commercial agencies) were located in 86 cities across Canada.

TABLE 7.1

POPULATION SERVED BY COMMUNITY RESOURCES
FOR PREGNANCY COUNSELLING AND ABORTION REFERRAL*

COMMUNITY AGENCY SURVEY

Province	Number of Resources	Number of Communities Served	Proportion of Population Served*
			percent
Newfoundland	8	4	20.2
Prince Edward Island	1	1	17.1
Nova Scotia	7	4	31.0
New Brunswick	12	10	33.1
Quebec	32	11	52.5
Ontario	62	24	60.4
Manitoba	15	2	57.3
Saskatchewan	18	9	40.6
Alberta	13	3	54.2
British Columbia	38	15	55.9
Yukon	5	1	61.0
Northwest Territories	3	2	25.3
CANADA	214	86	53.2

* Based on the size of the communities in which the agencies were located; 84.3 percent of the individuals who were served came from within a radius of 20 miles. These resources were located in communities which made up 53.2 percent of the population and their distribution varied from province to province. The proportion of the Canadian population that had immediate access to these agencies was the highest in Ontario. It was below the national average in the Maritimes. There were 62 agencies in 24 Ontario communities serving 60.4 percent of that province's population. In New Brunswick, 12 agencies in 11 communities reached an estimated 33.1 percent of the population. Seven of these agencies in four communities in Nova Scotia served 31.0 percent of its population. In Prince Edward Island, an agency operated in one city which had 17.1 percent of the province's population. Newfoundland had eight community agencies in four cities which totalled 20.2 percent of its population. The proportion of the population in the western provinces which had immediate access to these agencies for abortion counselling and referral varied little from the national average. In British Columbia, 55.9 percent of the population had access to 38 resources in 15 centres. In Alberta, 13 programs operated in three cities which had 54.2 percent of the population. With 18 agencies in nine cities, 40.6 percent of Saskatchewan's population had immediate access to these agencies.

The majority of the community agencies were located in large cities where hospitals had established therapeutic abortion committees, while their distribution was negligible in cities where no abortions were done by local hospitals, except in Quebec where most therapeutic abortions were done in two cities and the agencies were located in 11 centres. As a rule counselling and referral agencies served their local community first. On the average 84.3 percent of their clientele came from within 20 miles, while the remainder (15.7 percent) came from smaller towns in the immediate vicinity. There were no significant provincial variations in this respect. Only one agency in Saskatchewan and four in Quebec reported there was a trend involving more women coming from other large centres.

When the profile of the women who were served by these agencies is seen from the perspective of the full range of their clients, a somewhat comparable trend emerges which is similar to the experience of the women in the national patient survey. Among the women who had contacted an agency in 1975, 63.8 percent were single and most were young women; 72.9 percent of the women seen by the agencies were under 25 years, and 1.2 percent were under 15 years. Two out of five (38.8 percent) were between 15 and 19 years; 32.9 percent, between 20 and 24 years; and 27.1 percent were 25 years and older.

Among the community referral agencies surveyed by the Committee, 45 agencies had referred a total of 4,700 women to Canadian hospitals in 1975. This group included some of the larger referral agencies which accounted for two-thirds of the abortion referrals to Canadian hospitals. These agencies may have made an estimated total of 7,500 referrals for abortion in 1975 to Canadian hospitals. Among the agencies which provided family planning information, 83.7 percent routinely referred women to hospitals in the communities where they were located. The level of contact between community agencies and local resources for abortion was the same across Canada, except in Quebec and Saskatchewan where the rates were slightly lower. In Quebec 62.5 percent of the agencies had contacts with local resources and among the agencies in Saskatchewan, 66.7 percent referred women to local hospitals. Among all of these agencies, 47.8 percent had no contact with hospitals in other areas, while 52.2 percent dealt occasionally with out-of-town physicians or hospitals.

Most of the community agencies (66.1 percent) at least occasionally referred women to out-of-country abortion facilities. Compared to the national average, fewer agencies in the western provinces, where the reported rates of therapeutic abortions were higher, followed this procedure. In comparison, community agencies in Ontario, Quebec and the Maritimes more often referred women to clinics in the United States. In British Columbia 55.5 percent of the agencies which were surveyed directed clients to clinics in the United States, and this was done by 40.0 percent of the agencies in Alberta, 37.5 percent of the agencies in Saskatchewan, and 40.0 percent of the agencies in Manitoba. In Ontario, 82.4 percent of the agencies referred women across the border, as did a similarly high proportion of all of the agencies in Quebec and the Maritimes.

Pathway three: Student health services

About 1 out of 5 Canadians between the ages of 18 and 24 years are students in post-secondary institutions and about 40.0 percent of this number are women who are studying at colleges or universities. The student health services of 211 post-secondary institutions (56 universities and 155 community colleges) were surveyed, with replies being received from 75.0 percent of the university health services and from 59.3 percent of the community colleges. While most academic institutions had standard health services, 12 of the colleges and universities in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario and Newfoundland had one or more additional clinical or counselling services for female students administered by students' councils.

The majority of the student health services (86.5 percent) operated during regular office hours. A few (11.6 percent) could be reached in the evening, and the remainder were available on a part-time basis. Their services included: 82.8 percent, pregnancy counselling; and 80.6 percent, abortion referral. Among the health services which were reported to be inadequate were: 44.4 percent, abortion facilities; 27.8 percent, pregnancy counselling; 22.2 percent, sexual and contraceptive information; and 5.5 percent, abortion counselling. The majority of the schools (76.4 percent) suggested that such services should be paid for by government. Approximately one-fifth (28.6 percent) felt that these services were best provided by trained volunteer counsellors in a family planning centre. Three out of four of the colleges and universities had made some abortion referrals during 1975. Most of these referrals were made by student health services in 26 large universities in British Columbia, Alberta, Ontario, and Quebec, and community colleges in two metropolitan centres. These schools accounted for 78.0 percent of all referrals for abortion in Canada reported by student health services. The results of the national patient survey found that a minority (7.4 percent) of the students who had an induced abortion in Canadian hospitals had gone to these health services and twice as many (16.7 percent) had contacted a community referral agency. The majority had directly contacted a physician.

Among the students who said they had seen a college or university counsellor about their pregnancy, the largest group was between 20 and 24 years (54.9 percent), followed by students between 18 and 19 years (37.3 percent). Students over age 25 were the group which least used these services (7.8 percent). The reluctance of students to use student health services for abortion counselling and referral stems from a concern to preserve their privacy and from fear that their academic standing may be affected. In particular, students attending small institutions may prefer to discuss their pregnancy elsewhere. For students attending larger institutions, the health services of these universities may be one of a number of sources of referral for abortion which are available.

> It is my impression that fewer students are using university resources in the last two years. In that time period, community resources have become more numerous and more visible.

In 1975 I received approximately 15 requests for information about abortion facilities. I know and hear of many students who have taken action on their own. It is very difficult to assess the numbers of women at this university who have sought an abortion from just official reports.

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My experience has been that a community referral agency in our city does an excellent job. I know that there are less reputable referral sources that the students use. I often hear about their experiences 6 or 8 months after the fact. That is why I believe it is extremely important that abortion be readily obtainable. One of the major difficulties I have with students is their concern over parental reactions. Because of this, they sometimes refuse to use a hospital in our province, because of fears with billing and therefore possible information to their parents.

The majority of the student health services (76.0 percent) handled requests for abortion on a local basis. The remainder (24.0 percent) directed requests to out-of-town hospitals or to abortion facilities in the United States. The proportion of institutions sending students outside of their communities for an induced abortion was lower than average in the western provinces and Ontario. It rose in Quebec and New Brunswick, where over half of the institutions surveyed used facilities which were not located in their own communities. A majority of the health services of colleges and universities knew of the activities of community referral agencies in their own communities or in their region. One out of ten (9.7 percent) referred students to such agencies for abortion counselling or referral.

Based on the findings of the national patient survey, many students who had contacted their health services felt they had been given practical information about abortion or they had been sent to a physician who would refer their request to a hospital with a therapeutic abortion committee (55.8 percent). For 16.2 percent of the students, arrangements had been made at a hospital by the student health services. Approximately 1 out of 7 of the students were referred to a community agency for counselling and referral.

Approximately 2 out of 3 academic health services (66.2 percent) mentioned the length of gestation and the requirements set by hospital therapeutic abortion committees as problems which they routinely encountered. Over half (58.1 percent) of the referring health services said there were financial problems for the students seeking an induced abortion. Two out of five of the institutions complained about the distribution of resources for abortion (41.8 percent) or their lack of availability (40.5 percent), although some of these universities were affiliated with teaching hospitals which did a sizeable proportion of all abortions which were performed each year. The need for consent from a husband or a parent ranked lowest in the listing of difficulties which were cited, with 39.4 percent of the academic institutions reporting it caused problems when abortion referrals were made.

Pathway four: To the United States

Two-thirds (66.1 percent) of the community agencies surveyed by the Committee had advised some of their clients to get an abortion in the United States. Community agencies recommended this course to women if: (1) they felt their pregnancy exceeded the gestation limits of local Canadian hospitals (77.8 percent); (2) their application had been refused by a therapeutic abortion committee (75.8 percent); and (3) they did not want to be identified by staff or other patients in a hospital (71.4 percent). Other reasons which were less often cited for these out-of-country referrals were: 67.6 percent, faster procedure and close to the United States; 53.3 percent, problems of consent; 53.1 percent, repeat abortion; 47.1 percent, difficulty in obtaining a medical appointment; 40.0 percent, financial difficulties; and 39.4 percent, no therapeutic abortion committee established at local hospitals.

Those women who go by referral from us do so because:

(a) they have already had an abortion and are afraid to apply again.

(b) they have enough money and prefer to avoid the time and inconvenience involved in seeing three doctors and awaiting a Committee decision.

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It is impossible for one hospital in a province to handle the total number of requests. A great number of women in our province are forced to seek abortions in the U.S. This is costly and excludes the women under a certain income.

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Women who choose not to submit to the humiliation and red tape, and who have funds, often opt for a clinic in the United States. Women who were turned down by the therapeutic abortion committee here and who could afford to do so travelled to the United States. Total cost for air fare, lodging and medical fees was over $300 and could amount to $1000 in the case of saline termination requiring hospital stay.

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Since _____ abortions are only $75, it often makes sense for women who will have to pay at least $50 in our city to go to the U.S. where it is done without waiting and red tape.

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It is much easier on the woman concerned to go to the States which is probably why the law exists the way it is anyway. Statistics don't look so bad for Canada that way. However, that discriminates against women who cannot afford an abortion outside of Canada.

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There are occasions when a patient cannot book an appointment for nearly a month because the nurse states that the doctor is too busy. Of course, the chances of the client receiving safe, early abortion then are practically zero,

and our agency has no choice but to refer the woman to a clinic in the United States. We have been experiencing these kinds of difficulties for several years but the hospitals do not appear to have any particular desire to change their procedures to lessen the time for an abortion.

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When a woman is too far advanced to go through the long process of having all the tests and filling in all the forms to be done here before she passes the time limit, we give her several referrals in the U.S. from which to choose.

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One problem we face constantly is that almost all doctors in our city doing abortions overbill the woman anywhere from $50 to $200 cash on top of medical coverage. This delays abortions, takes time and causes more risk to the woman. We have only one doctor who does not participate in this extortion.

Although to a lesser extent than community referral agencies, the health services of colleges and universities also used out-of-country abortion facilities. The circumstances when student health services referred students to the United States included: 47.5 percent, non-approval for abortion by a therapeutic abortion committee; 46.2 percent, the preservation of anonymity; 43.6 percent, difficulty in obtaining a medical appointment; 40.7 percent, length of gestation; 40.0 percent, faster procedure and close to the United States; 29.1 percent, no local hospital with a therapeutic abortion committee; 24.5 percent, consent of parents; and 23.1 percent, repeat abortion.

A portrait of Canadian women who went to the United States to get an abortion was obtained from a small number of patients who were treated at eight clinics in five states. These 237 women came from seven provinces and the Northwest Territories. In comparison with patients who had abortions in Canadian hospitals there were fewer women who were younger (16.1 percent under 18 years) or older (8.9 percent over 35 years). Most of these women were single (68.8 percent), fewer were married (18.6 percent), and some were divorced, separated, and engaged to be married. The experience of these women with induced abortion provides an insight into why a substantial number of Canadians leave the country for this procedure. While they were only a handful of the several thousand women who went abroad for this purpose each year, the information which they gave the Committee concurred well with its general findings related to induced abortion. Like other Canadian women who had had induced abortions, most of these patients found it difficult to discuss openly their experience, and some were afraid their opinions and the fact they had left the country might become known.

Among a small group of women from whom information was obtained, most (85.8 percent) who went to the United States would have preferred to have had an abortion in Canada, if they had known or had been told this option was available. Going to the United States was expensive in terms of travel costs and the fees which they were charged for an abortion. Most of the patients (94.4 percent) paid for this operation themselves. Only a few indicated that they planned to seek reimbursement under national health insurance. In some

instances the trips involved several hundred miles, sometimes several thousand miles in the case of patients in the survey who lived in Newfoundland or the Northwest Territories who went to New York City. The main reason why these Canadian women went to the United States for an induced abortion was that they did not know how to obtain an abortion in Canada. The agencies or individuals whom they contacted either dissuaded them from trying to get an abortion in this country, told them it was too difficult or illegal, or inaccurately advised them on the procedures and practices involved in getting an abortion in Canada. From the perspective of patients who went to the United States to get an abortion, the counsel they got from physicians and agencies was a mixture of professional advice, moral values, and personal opinion.

Once they had made the decision to terminate their pregnancy, most of these women had turned to physicians for further counsel and for information as to how an abortion might be obtained. Three-quarters (75.2 percent) said they had a usual family doctor, but fewer than half (40.8 percent) had consulted these physicians whom they had already known. The remainder who had seen physicians consulted other family physicians or obstetrician-gynaecologists whom they had not known before, or went to clinics.

Most of these patients (74.4 percent) had seen one or more physicians in Canada about their pregnancy. Likewise, most of the patients had asked their doctors for assistance and advice in getting an abortion. Some of the patients had consulted more than one physician about their request, with 20.0 percent having seen two physicians, 5.1 percent three physicians, and 6.0 percent four or more physicians. The opinion of their physicians and the advice they gave was the single factor most responsible for the decision by most of these women to go to the United States for an abortion. A small number had found it difficult to get appointments for this purpose at hospital clinics, and 12.0 percent said that applications made on their behalf to hospital therapeutic abortion committees had not been approved.

The counsel given by physicians to these women included a gamut of different courses of action. A fifth of the patients (22.0 percent) going to the United States said it had been difficult to make an appointment with a physician. Many physicians gave more than one piece of advice. Taking all these reasons together, **over half (53.6 percent) of this small group of women who went to the United States to obtain an abortion said that their doctors felt they had little chance of getting an abortion in Canada, were morally opposed to assisting them, or were unwilling to refer them to a hospital where this procedure was done in this country.** The specific reasons included: physicians who would not refer patients to other doctors or to hospitals (13.4 percent); told by a physician that an abortion was illegal (22.6 percent); told an abortion could not be obtained at a Canadian hospital (41.5 percent); told pregnancy was too advanced (9.2 percent); no medical reasons (10.6 percent); abortion involved a risk to health (6.5 percent); told to go to term (14.7 percent); and told there were no doctors who would do the abortion procedure (8.8 percent). While most family doctors and obstetrician-gynaecologists referred patients to hospital committees, or if they were morally opposed to abortion, made patient referrals to other physicians, some physicians wanted no involvement at any

stage in the abortion procedure. Patients who turned to this small group of physicians, not knowing beforehand their views on abortion, either were given no assistance or in some instances were inaccurately counselled.

Pathway five: Childbirth

Child welfare agencies and maternity homes across Canada were contacted to obtain information about their experience with women seeking abortions and pregnant women who went to term for whom they provided services. Out of a total of 242 regional and local branches of child welfare agencies and 33 maternity homes (two additional homes which were contacted were closing) from whom information was requested, *complete* replies were received from 56 welfare units (23.1 percent) and 27 maternity homes (81.8 percent). In addition to providing information about the scope of their services, eight of the child welfare agencies and 24 of the maternity homes participated in a survey involving 203 women for whom they were providing assistance.

Private organizations in Manitoba, Ontario, and Nova Scotia operated child welfare services. The Manitoba Department of Health and Social Development operated 12 child welfare branches; services in that province were also provided by four Children's Aid societies and the Jewish Child and Family Service. All of the 53 child welfare agencies in Ontario were run on a voluntary basis, but worked within the framework of provincial legislation. The majority of these programs were non-sectarian (49); three were affiliated with the Catholic Church of Canada, and one was a Jewish welfare agency. While 5 out of 17 agencies in Nova Scotia were privately run, the provincial Department of Social Services supervised much of the scope of their programs.

In British Columbia, Alberta, Manitoba, and Quebec, child protection services were provided together with social welfare and health activities respectively by branches of the departments of Human Resources, Social Services and Community Health, Health and Social Development, and the Ministry of Social Affairs. Traditionally, these services had been directed toward adoption programs and the assistance of pregnant women. In recent years the scope of their services has been extended to provide for the needs of youth in general.

From the information which was given by the agencies which supplied statistics, there was a decrease between 1973 and 1975 in the volume of all individuals who were being assisted. If the number of women who were seen in 1973 is taken as an index equalling 100, then there was a 16 percent drop in the number of single pregnant women between 16 and 18 years who were seen over this three-year period and a 20 percent decline among women who were 19 years or older. The proportion of infants who were given for adoption compared to the number of babies who were brought up by their mothers during this three-year period decreased from 77.5 percent in 1973, 70.4 percent in 1974, to 60.0 percent in 1975. These trends based on incomplete information suggest what many physicians and health and welfare administrators told the

Committee, namely that fewer women were giving their infants for adoption than in the past.

About half of the pregnant women who contacted provincial child welfare agencies were in the third trimester of their pregnancies. These women had decided to carry their pregnancies to full term and had contacted these resources either to make arrangements for adoption or for their support during the last phase of their pregnancy and after childbirth had occurred. Some of the directors of these agencies commented on this aspect of their work.

> Abortion is raised as an alternative plan to consider, where appropriate. Counselling involves an examination of sexual activity, goals and possible referral to family planning clinics.
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> Since the most basic right of all human beings is the right to life, it is therefore incumbent upon us to uphold this right for all children: those already born as well as those about to be born. Our Society will not give permission to one of our wards to obtain an abortion, nor will we be involved in counselling a woman to have an abortion.
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> Currently, there is no policy regarding abortion. The practice has been to discuss the matter with anyone wishing to do so, make referral and provide information as requested, stressing that decision-making rests with the individual.
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> Difficult cases involving matters such as serious marital problems, abortion and sterilization, may be referred to the Moral Issues Advisory Committee for advice and direction. Referrals for abortion by staff may not be undertaken under any circumstances.
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> We have no written policy. Our procedure is to provide professional case-work services to assist clients in reaching their own decisions about family planning. Depending on the client's needs and wishes, this could include information giving and referrals to resources such as family planning clinics.
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> Responsible family planning within the framework of Catholic moral teaching is encouraged. Abortion is not considered to be an acceptable planning alternative but the adult client's right to self-determination is respected in this regard.
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> We have a policy. Social work staff is given authority to offer counselling to any client who wishes to discuss abortion and, if the client so desires, a consultation with senior staff provides support for the need to actively support a referral to our appropriate medical or hospital resource.
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> We have a committee developing a policy. Currently, we recommend abortion in cases where the mother's situation makes it unlikely that she will be able to care for her child for physical, emotional, or mental reasons.
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> No set policy exists. We attempt to work with each pregnant client on an individual basis in order to find the best solution to her particular problem considering her social and medical conditions.

Of the 27 maternity homes (out of a total of 33 identified across Canada) which provided information on their services, two were located in British Columbia, two in each of the Prairie provinces, 12 in Ontario, four in Quebec, and three in the Maritime provinces. The first maternity homes were established toward the end of the last century to aid young pregnant women. Through the years, the Salvation Army Corps has had a strong commitment to these services. Its work has gradually been joined by other denominations in providing services to unwed mothers. Of the maternity homes in the survey, three had been founded before 1900, 10 between 1900 and 1950, and the remainder since 1950. The impetus to open maternity homes rose following World War II. In 1976, the Salvation Army operated 14 maternity homes, seven were under the auspices of other Protestant denominations, and eight were managed by the Catholic Church.

As with the child welfare agencies, the traditional role of maternity homes has changed in recent years—from providing care for women wishing to relinquish their babies for adoption to providing residential services for many other young women. For these reasons many of the maternity homes which had been established in the past either have closed or re-aligned their policies to serve other needs. Based on the reports given by the directors of these maternity homes, the decline in the use of their services by pregnant women has accelerated since 1970. There were 1,852 residents served by the 27 maternity homes in 1975. Approximately half (48.1 percent) of the homes had 50 or fewer pregnant residents during that year, while the remainder accommodated between 60 to 180 women. The average length of stay in each home ranged from 1.5 to 4 months. Most of the homes (62.9 percent) accommodated residents for more than 2.5 months. Half (51.8 percent) of the institutions accommodated only single pregnant girls and overall, most of the residents in maternity homes were single, the remainder usually had only one or two married residents and about the same number of women who were divorced, separated, or widowed. In 1975 there were 32 married and previously married women who had stayed in these homes, a proportion which never exceeded 4 percent of the total number of residents.

Most of the residents were young women who were experiencing their first pregnancy. Over half (57.5 percent) were under 17 years old and 81.9 percent were below the age of 20 years. For 6 out of 7 of these women (86.4 percent) the conception had been their first pregnancy. Of the remainder, 4 out of 5 (82.1 percent) had carried one previous pregnancy to term and 17.9 percent had had two or more childbirths. A small number of these women (3.7 percent) had had an abortion.

According to several administrators of these maternity homes, the women who carried their pregnancies to term and had come to these homes had opted for this pathway because it was the only alternative available to them. Among the factors which were seen to influence their choice, in the opinion of the administrators, their opposition to abortion was the most important consideration. The second major reason for spending the last months of their pregnancy in a maternity home was that many of these women wanted to raise a child, but could not cope with their circumstances at home or at work. A third motivation for carrying a pregnancy to term in a maternity home was seen to result from strong pressure to do so which had been voiced by a woman's partner, her family, or her close friends. Problems associated with the availability of abortion services seldom were cited by maternity home directors as reasons why these women sought out this assistance.

Information was obtained directly from 203 pregnant women living in 24 maternity homes or who were being served by eight child welfare agencies. The majority of these women (82.3 percent) were under 20 years of age; the remainder (17.7 percent) were in their twenties. Over half of the women were 17 years or younger, with 18.8 percent under 16 years and 38.1 percent between 16 and 17 years. When birth occurred a majority of these young women would be single mothers as only 17.1 percent were married when conception occurred. These women in about equal numbers were Protestant (48.2 percent) or Catholic (42.7 percent.)

When they became pregnant, 2 out of 3 of these women (68.5 percent) had been living with their parents, while a few had their own homes (16.0 percent) or lived with a male partner (15.5 percent). In the interval between when conception occurred and when they took part in the survey, most of these women had made alternative living arrangements, with 3 out of 4 (71.7 percent) residing in maternity homes, 14.1 percent living with relatives, 7.8 percent working as "live-in" help for a family, and a few (6.4 percent) living in a boarding house. The proportion of these women who had been living with their parents when conception occurred declined with their age from 97.1 percent of females under 16 years to 47.2 percent of women who were over 20 years old. Prior to their pregnancy, 42.5 percent of these women had attended school, 35.8 percent had had jobs, and 1 out of 5 had been unemployed. At the time of the survey a majority of these women were attending school (52.2 percent), 1 out of 10 was working (10.3 percent), and the remainder were unemployed.

Although all of these women had decided to carry their pregnancy to term, half of them (50.2 percent) had initially considered the possibility of an induced abortion. For these women this option had been supported by some of their close friends (43.9 percent), their parents (25.3 percent), or their male partners (22.0 percent). About 1 out of 10 (8.8 percent) said that a physician had urged them to consider an induced abortion. The influence of their parents was greater among young teenagers, with 2 out of 5 (42.1 percent) who were 16 years or younger reporting that their families had advised them to obtain an abortion. The influence of a family in this respect declined among slightly older

women, with 1 out of 4 of these women (25.6 percent) saying that their parents had urged them to get an abortion.

Among a small group of women who were carrying their pregnancies to term 1 out of 4 (27.6 percent) had at one time considered having an induced abortion, but they had not taken this course because of a lack of accessible services for therapeutic abortion or because of delays which had been involved in applications submitted on their behalf to hospitals. Some of the factors which were involved were: 25.5 percent, physicians had told these women the length of their pregnancy went beyond the limits set for this procedure by hospitals; 30.4 percent, paying the additional costs was beyond their means; 8.9 percent, a physician had refused to refer them for this procedure; and 14.3 percent, did not know how to apply for an induced abortion. One out of five of these women thought that getting an induced abortion was illegal under any circumstances.

Among the women who had once considered having an abortion, 45.2 percent were Catholic, an equal number were Protestant, and the remainder either were members of other religious faiths or gave no affiliation. There were no trends by age among the women who had considered or not considered this alternative. There was a trend by age and the length of gestation, with more younger females, in particular those who were 16 years and younger (40.9 percent), having not sought an abortion on the grounds that their pregnancies were too advanced. Among the small group of married women who were living in maternity homes or who were assisted by child welfare agencies, 2 out of 3 (64.7 percent) had rejected the possibility of an abortion on moral grounds, 29.4 percent said that they had been unable to obtain an abortion, and 5.9 percent said they had reached this decision too late in their pregnancies to make an abortion feasible.

Two-thirds of the women who had considered having an abortion (69.9 percent) planned to give their babies for adoption, a proportion higher than the half of the women (46.9 percent) who had never considered that course. Among the women who had intended but had not had an induced abortion because their pregnancy was too far advanced to apply for one, 84.6 percent had planned an adoption. In contrast, among the women who were morally opposed to abortion, 72.2 percent planned to keep their children. Of the women who had had procedural difficulties involving the abortion procedure, 66.7 percent planned adoption. Among the women who had rejected an abortion following their partner's wish, 22.2 percent planned an adoption and 77.8 percent intended to raise their child. In reaching their decisions about adoption or retaining the custody of their newborn children, these women were influenced by their families and friends about what they decided to do. More of the women who had partners who supported their decisions, had made plans to keep their children. Among the women who had this type of support, half (52.0 percent) planned to keep their children, instead of considering an adoption. In comparison with married women more single women planned to give up their children for adoption. In each instance the decisions of these women might change after childbirth.

Family income and pregnancy experience

The relation between a person's level of income and how he works and lives has been extensively documented in Canada and elsewhere. It is on the basis of reducing these distinctions and ameliorating the situation that much of the intent of social policy hinges, and such national programs as hospital and medical care insurance were enacted. In the field of health care it has long been known that the rates of infant mortality, the distribution of certain diseases, and the accessibility to health services are not the same for all individuals, but vary directly by their social circumstances and on occasion by their level of income. As the economic standard of living has risen and as broad national programs of social security have been in operation for a period of time, a number of these disparities have been narrowed, in some cases, eliminated. Despite the extensive benefits provided by national and provincial programs, sharp social and economic disparities persist. While the social meaning of poverty and the types of services mounted to serve low-income individuals and families change and reflect the social purpose of each era, the culture of poverty remains entrenched. It molds a different way of life than that experienced by middle-income Canadians and in terms of the outcomes of pregnancy contributes to different social choices being taken between seeking an induced abortion or bringing to term an unwanted pregnancy.

As the economic standard of living of Canadians has risen in recent decades, making this nation one of the most affluent countries in the world, there has been a growing search for social indicators which, it has been hoped, would document more fully the essence and quality of how Canadians live, what they seek to do, and to further our understanding of disease which can be prevented, of the nature of social alienation, and the reduction of illegal behaviour. The quest for these new measures whose clarification is still on the horizon makes no less relevant the need to understand at present how an individual's economic lot affects his usual way of life. While there is no official national statement on the concept of poverty, a number of different measures have been developed which have sought to assess the extent and the social implications of poverty in Canada. In the past decade several reports on income indicators have been put forward by groups such as the Special Senate Committee on Poverty, the Social Development Council, Statistics Canada, and the Economic Council of Canada. Because of broad regional disparities in the lifestyles of Canadians, the divided nature of civic responsibilities, and the complexity of developing appropriate quantitative measures which are socially valid, there has been no agreement as yet about the utility of these indicators, how they may be used, or their social policy implications.

Statistics Canada has developed a measure of low income for individuals and families which takes into account the number of persons who are supported in a family and the size of the community where individuals live.[4] The 1975 revised low-income cut-off levels rose with the number of individuals in

[4] Statistics Canada, *Income Distribution by Size in Canada: Preliminary Estimates, 1974* (Ottawa, October 1975), pp. 6-7, 16-18. (This report deals with *family* size.)

families and were scaled to increase by the size of communities. Individuals or families whose annual income fell below these designated cut-off levels spent on an average 62 percent or more of their incomes on food, shelter, and clothing. For this reason they were considerd to live in straitened economic circumstances.

The low-income measure developed by Statistics Canada was used in the review of the family income levels of three groups of women who had been pregnant and two groups of single women. The three groups of *females who had children* from whom information was obtained in the national population survey were: (1) all married women who had children; (2) married women who had had induced abortions and the number of their children; and (3) single or unmarried mothers and the number of their children. In addition to the three categories of women who had had children, the two groups of *single* women who were considered were: (1) single women who had no children and who had not had an abortion; and (2) single women who had no children but who had had an abortion. In the analysis of the incomes of married women, the denominator which was used was the size of the family. The experience of all five groups of women was evaluated in terms of the low-income cut-off levels developed by Statistics Canada which take into account income levels by the size of the family and the size of the community where individuals lived.

TABLE 7.2

INCOME AND ABORTION EXPERIENCE OF FEMALES WITH CHILDREN

NATIONAL POPULATION SURVEY

Level of Income	Marital Status and Abortion Experience		
	Married Women: No Abortion	Married Women: Had an Abortion	Single Mothers No Abortion
	percent	percent	percent
—$ 4,000	8.7	7.7	15.6
$ 4,000— 5,999	8.0	0.0	3.1
$ 6,000— 7,999	8.3	7.7	12.5
$ 8,000— 9,999	9.3	19.2	25.0
$10,000— 12,999	17.9	17.3	12.5
$13,000— 14,999	13.3	21.2	6.3
$15,000— 19,999	16.4	9.6	6.3
$20,000+	18.1	17.3	18.7
Total	100.0	100.0	100.0
Proportion below Low-Income Levels*	18.6	15.4	25.0

* Based on size of family and size of community of residence, according to Low Income Lines used by Statistics Canada, 1975.

Among *married women* in the 1976 national population survey *who had had children but who had not had abortions*, a quarter (25.0 percent) had

family incomes of $8,000 or less; 27.2 percent had family incomes between $8,000 and $12,999, and almost half (47.8 percent) had family incomes which were above $13,000. The distribution of family income of married women with children in this survey undertaken by the Committee closely parallelled the 1974 proportional distribution of family incomes reported by Statistics Canada which was: 23.2 percent, $8,000 or less; 25.5 percent, $8,000 to $12,999; and 51.4 percent, $13,000 or above. The average family income in 1974 was $14,485. Different population sampling procedures may account for the observed differences as well as the fact that the information for the 1976 survey was calculated on a basis of families with children, thus excluding childless couples. The married women in the 1976 survey who had not had abortions had an average of 2.2 children, while those females who were widowed, separated, or divorced had on an average 2.3 children.

Based on the 1975 revised low-income cut-off levels developed by Statistics Canada, 18.6 percent of married women with children but who had not had abortions were below these income levels. What this means was that almost a fifth of these married women spent 62 percent or more of their family incomes on food, clothing, or shelter. In terms of the standard of living of the average Canadian family, these families were the poor of the nation.

In a number of reports which were submitted to the Committee and in some of the comments made by physicians in the national physician survey, the availability of the abortion procedure and income were linked together.

> It is unfortunate that frequently the factors which determine whether or not a patient gets a therapeutic abortion are economic or geographic. It is difficult for rural dwellers and for those in the lower income levels. The economic disparity in particular is great.
>
> • • •
>
> As long as Canadian women can go to New York State ... for abortions on demand (and all wealthy women have this option), it would appear discriminatory to reject reasonable indications in Canada and make them second-class citizens.
>
> • • •
>
> Penalizes the poor—especially in "holier than thou" areas.
>
> • • •
>
> There is nothing basically wrong with the present abortion committee set-up, except that such committees should be instructed to take a serious view of repeat therapeutic abortions, and cases in which there is evidence of improvidence, carelessness or irresponsibility. Such a serious or unsympathetic view towards abortion on demand requires a parallel development of facilities for the care of children from unsuitable parents or from women who are not likely to make good mothers. At the present time we probably do not know whether children born of such poor mothers will inevitably be a liability to the state, or an asset to the country. A thorough study of this question might help clarify the position. If the record of such children is no worse than the average, we should not be tempted (as we are at present) to grant an abortion to avoid

bringing into the world children who would be unwanted and the offspring of unsuitable mothers, who would become a liability rather than an asset to the country.

• • •

Abortion as it is practiced in Canada does not deserve the notation "therapeutic" because it cures nothing. Social ills cannot be cured by abortion on demand as has been proven in other countries ... Poverty cannot be cured by killing poor people. Undesired and unwanted pregnancies are a reflection of other problems and abortion should never take the place of contraception.

• • •

Therapeutic abortion should be performed outside of prepaid health care facilities. The economic cost should be borne by those requiring it. Everyone should bear a responsibility for their own health care, and in the light of today's knowledge, abortions should not be used as a method of contraception. Society as a whole should not be expected to pay for it. It will be argued that the poor will suffer—but it must be accepted that they should be just as responsible for their health care as anyone else. I am sure that relatively painless methods of payment can be devised.

• • •

The situation at present is a disaster. People in lower socio-economic groups are often at a disadvantage with respect to obtaining abortion, other people have a physician who will not give them the option of therapeutic abortion committee review.

Among *married women with children who had had abortions*, 15.4 percent had annual family incomes of $8,000 or less; 36.5 percent were between $8,000 and $12,999; and 48.1 percent had family incomes of $13,000 or more. Because there were few married women with no children who had had abortions, this group was excluded from this review. In contrast with married women with children who had not had abortions, 9.6 percent fewer married women who had had abortions had annual family incomes of $8,000 or less. More of these women than the former group were in the middle-income category of $8,000 to $12,999, and the proportions of both groups who had family incomes above $13,000 were comparable. When the family incomes of married women with children who had had abortions were calculated on the basis of Statistics Canada low-income cut-off levels, 15.4 percent of these families were below these minimum standards.

What this information indicates for the two groups of married women with children, a sample which represented a national cross-section of the population, is that while some married women who had abortions had low family incomes, as a group more of these women were from families in the middle-income levels. Slightly fewer of the married women who had abortions than other married women were economically poor. These findings contradict the belief which is sometimes held, that it is the poor more than the rich who turn to abortion to terminate unwanted pregnancies. The reverse situation is the case. It was the married women who were economically better off who tended to have abortions more often than the married women who were poor.

The definition of the family followed in this review of income and pregnancy experience used the guidelines of Statistics Canada which considered a family as "a group of individuals related by blood, marriage, or adoption, who shared a common dwelling unit at the time of the survey".[5] Included in this definition are families consisting of both parents and children, extended families which may have grandparents or relatives, and single-parent families involving women and men who either were once married (e.g., widowed, divorced, or separated) or who were never married and who had children living with them. It is the level of family income of single women who have had children, but who have not had abortions, which is compared here with the experience of all married women who have had children and married women with children who have had abortions.

Among all single women in the national population survey who had not had an induced abortion, 10.5 percent had had one or more children. In comparison among single women who had had an abortion, 23.1 percent had had one or more children. When the average family income of *the single women who had had children* is considered, more of these women had lower family incomes than all married women who had had children and married women with children who had had abortions. Double the number of single women who had had children (15.6 percent) than the other two groups of women had family incomes of $4,000 or less. Among the women in these three groups, 31.2 percent of single women who had children had incomes which were $8,400 or less; 15.4 percent of married women who had had abortions; and 25.0 percent of all married women who had had children were in this income group. In the highest bracket of average family incomes which were above $13,000, the proportional distribution was 31.3 percent of single-parent females, 48.1 percent of married women who had had abortions, and 47.8 percent of all married women who had children.

Based on the 1974 index of low incomes of Statistics Canada, 25.0 percent of single women who had had children were below these minimum cut-off levels. In comparison with the two other groups of women, the group of single women who had had children had lower incomes and more had poverty incomes.

There were comparable trends by level of income among the two groups of single females who had not had children. Almost a fifth of single women (19.5 percent) who had not had children had annual incomes of $6,000 or less. None of the single women who had had an abortion were in this income category. In contrast, over double the proportion (36.4 percent) of the single women who had had abortions had incomes between $6,000 and $9,999 than all single females (15.3 percent). The number of women in both groups who had incomes above $10,000 was comparable. As with married women with children, fewer single women who were poor had had abortions and there was a higher number among this group in the middle-income bracket.

When the annual incomes of *single women who had had abortions* and *single women with children who had not had an abortion* are compared, there was a sharp contrast in income levels. Almost a third (31.2

TABLE 7.3

INCOME AND ABORTION EXPERIENCE
OF SINGLE WOMEN WITHOUT CHILDREN

NATIONAL POPULATION SURVEY

Level of Income	Abortion Experience of Single Women	
	No Abortion	Had an Abortion
	percent	
-$4,000	14.2	0.0
$ 4,000- 5,999	5.3	0.0
$ 6,000- 7,999	8.2	18.2
$ 8,000- 9,999	7.1	18.2
$10,000-12,999	16.0	18.2
$13,000-14,999	12.1	18.2
$15,000-19,999	17.0	9.0
$20,000+	20.1	18.2
TOTAL	100.0	100.0

[5] Ibid., page 7.

percent) of single women with children had incomes of $8,000 or less. In contrast, 18.2 percent of single women who had had an abortion had this income level. Almost equal proportions of both groups (37.5 percent and 36.4 percent respectively) had incomes between $8,000 and $12,999. Among the highest income group of $13,000 or above, there were 31.3 percent of single women who had had children and 45.4 percent of single women who had had an abortion.

The opinions of women and men about abortion across the country varied by their level of income. While just about a third (32.3 percent) of the women with family incomes of $4,000 or less said it was legal to obtain a therapeutic abortion, almost half (47.0 percent) with family incomes of $20,000 or higher gave this reply. Somewhat fewer rich women (43.5 percent) than poor women (52.0 percent) had no comment on how accessible treatment services were for abortion, while the proportion who felt it was too difficult in each income bracket was comparable (18.1 percent and 16.4 percent).

Both women and men who had higher incomes knew more women who had had an abortion than individuals with lower incomes. Slightly over a quarter (28.8 percent) of women with family incomes of $4,000 or less knew someone who had had an abortion, while somewhat less than half (44.6 percent) of women with incomes of $20,000 or more were familiar with such individuals. The proportions for men in similar income categories were 22.3 percent and 35.8 percent respectively.

Slightly fewer men than women felt the current abortion legislation was too liberal or "about right". More men than women (36.5 percent versus 26.5 percent) said this law was too restrictive. Overall, 16.2 percent of women and 12.7 percent of men said the law was too liberal and 24.9 percent and 23.0 percent respectively endorsed the status quo. The remainder of women and

men (32.4 percent and 27.7 percent) had no opinion on this point. There was little difference among women by their level of family income in the proportion who felt the law was too liberal or who endorsed the present legislation. The proportion of women who were undecided on this issue dropped substantially as family income rose from 40.0 percent of women who had incomes of $4,000 or less to 16.5 percent of women whose family incomes were $20,000 or higher. Counterbalancing this trend, twice as many women (34.0 percent versus 17.3 percent) who were rich compared to individuals who were poor said the law was too restrictive.

What these findings on the knowledge and opinion of the Abortion Law indicate is that there were consistent trends in these replies by the level of income of women and men. In each instance individuals with higher incomes, whether the basis of their knowledge was accurate or not, held more definite views on the abortion issue. More women and men with higher incomes than individuals with lower incomes said the abortion legislation was restrictive, knew someone who had had an abortion, and said it was legal to obtain an induced abortion.

The use of health services involves a number of related factors. These components include whether health personnel and facilities are available, the type of disease an individual has and the extent to which the symptoms of an illness are known or recognized, and a knowledge of how to go about using treatment services. It is in this last respect, the knowledge of the law and of other women who have had abortions, that the poor or individuals with lower incomes had less information about abortion and the treatment services than women who had higher family incomes. This difference in knowledge about abortion and the availability of treatment services represents a much broader trend involving people with different incomes in their knowledge and their use of health services.

Women as a whole in different social and economic circumstances made different choices about the outcome of pregnancy. The information requires replication; it is but a step toward the documentation of a fuller understanding of how and why these choices are made. Among married and single women in the national survey, fewer females who were poor obtained induced abortions than middle-income and rich women. It is not known how many of the single and poor women who became pregnant were married immediately before or just after childbirth. What is known from the national population survey is that **a substantially higher proportion of single women who had had children were poor. Fewer poor women who were single or married had had abortions. In contrast, more middle-income women had had abortions and fewer of these women and those females with still higher incomes were unmarried mothers.** These broad and distinctive social choices, when the trends are considered in aggregate, represent fundamentally different ways of life and of reacting to a pregnancy. In the context of the "rich-poor" issue, these social choices have profound social and ethical implications which go well beyond the scope of this inquiry.

Alternative choices

A fuller understanding of the several options which pregnant women take would require an extensive review over a longer period of time than was available to the Committee. These options include wanted and unwanted childbirth occurring within marriage. The Committee did not deal with the effects of unwanted births on children or their parents. Little is known about the childrearing of unwanted children, their emotional capabilities, the state of their physical health, what constitutes child abuse and the extent to which it occurs, or what the life chances are of these children. The potential consequences of this course when an unwanted conception occurs are a matter for a separate inquiry. Little is also known about the emotional well-being or the physical health of women who give their infants up for adoption.

When a woman has an unwanted pregnancy, she must reach a decision about one of two alternatives. Either she must go to term, or obtain an induced abortion. From the information obtained by the Committee dealing with the experience of a small group of women who were carrying their pregnancies to term and from the results of the more comprehensive national population survey, a substantial number of single mothers who had unwanted pregnancies had low incomes and many lived in poverty. Because they were less well educated and less familiar with the workings of health services, a number of these women would have preferred to have had an abortion if they had known how to proceed. In contrast to these women, a significantly higher proportion of women who had higher incomes had induced abortions when unwanted pregnancies occurred.

In taking the alternative of obtaining an abortion, women may select one of several courses. Based upon the fragmentary information obtained by the Committee, little can be concluded about women who obtain illegal abortions in Canada. The evidence which is available from the national population survey, the personal accounts of women, reports given by physicians and the prevalence of complications resulting from illegal operations indicate that in the past several years there has been a substantial decline in the volume of illegal abortions. As the occurrence of therapeutic abortions has risen coupled with a still extensive use by Canadian women of abortion facilities in the United States, fewer women now than before take this option. Because there is more public awareness of the risks involved, women if they decide upon an abortion, are now more likely to obtain this operation in a Canadian hospital or to go abroad. In the opinion of a number of senior physicians who were consulted by the Committee, most of the relatively few illegal abortions which are now done are performed during the earliest phases of a pregnancy by means of menstrual extraction in physicians' offices. This is a step about which both the patients and the physicians involved are secretive, with this procedure in many instances being done under the guise of a minor curettage. There appear to be few guidelines governing the purchase or the importing of the required medical equipment which is readily available.

The idea of gatekeepers to health care cuts across the experience of women who by various means obtain induced abortions. While the decision to

take one course or another is always a difficult and intensely personal choice, who these pregnant women turned to and what type of counsel they received profoundly affected the steps which they subsequently took. Among the sizeable number of women who obtained abortions in Canadian hospitals, the main factor which served to lenghten their pregnancies was the amount of time taken after a woman had initially contacted a physician. Many of the women who went to the United States for an abortion either had been given no assistance or had been given inaccurate information by the physicians whom they had consulted. The findings indicate that most patients and most physicians tried to resolve the difficult issue of abortion. But where this was not the case, the timing of the abortion operation was delayed or women by-passed their local physicians and went elsewhere. These delays and the advice which was given resulted in some women going to term who should have preferred to have had an abortion.

About 1 out of 5 women turned to one of a number of community agencies for assistance. The aid given by these agencies involved counsel and the expediting function of making arrangements where abortions might be obtained. Essentially, these agencies were used by women seeking abortions who did not know how to go about getting this information themselves. These agencies often knew little about each other's work. It was the exception, not the rule, when spokesmen for one or another of these programs endorsed the work of other agencies. There was little effective coordination between the efforts of these agencies, hospitals, physicians, or public health units. Each of these groups tended to establish their own domain of services and to regard the work of other agencies as an intrusion. This duplication of effort often resulted in much bitterness and hostility whose side effects meant that the women who turned to these resources were not always well served. In some instances they were given misleading advice about the accessibility of health care services for therapeutic abortion in the community or the province where they lived. For their part, local public health units by ignoring this situation did little to redress what was happening or to move toward the coordination of pregnancy and abortion counselling and referral services.

Chapter 8

Personal Experiences

In its work the Committee was aware that the information which it received from several thousand persons—patients, the public, and the health professions—in each instance represented the difficult-to-summarize views and the diverse personal experiences of women and men. This fact was true for the decisions which were made by physicians as they considered the personal and ethical implications of their work with abortion patients. This point was equally true for the women who had had an unexpected and unwanted pregnancy. National surveys are useful to assess broad trends, but they do not easily capture the deeply felt concerns or the personal anguish which women may feel in approaching this decision.

The Committee received a number of written statements from women across the country who had had induced abortions. To ensure that these personal accounts were valid, only those reports which had been written and submitted directly by women themselves and were signed were considered to be valid. Many of these statements were accompanied by sworn affidavits. In presenting excerpts from some of these personal statements, the only alterations which have been made were to ensure the absolute confidentiality of the women who provided details about their personal experiences with abortion. For the same reasons the names of physicians, other individuals, hospitals, addresses, and provincial identification have been deleted.

In their own words the personal accounts of these women "tell it like it is". These personal experiences illustrate the broader trends which emerged from the findings of the national population survey and the national patient survey. The personal accounts which have been excerpted come from women in all provinces. They are representative of the other reports which were received but which were not included. These statements are divided into five categories: (1) consideration of abortion; (2) illegal abortion before 1969; (3) illegal abortion after 1969 which includes two transcripts from court records; (4) out-of-country abortions; and (5) legal abortions after 1969.

Consideration of abortion

Personal Account 1

At the age of 38 I found myself pregnant. I had been using the diaphragm. I had two previous children, the youngest was fifteen. I was upset at the results of the positive pregnancy test and told my doctor so, vaguely hinting at abortion. He treated the matter very lightly, almost jokingly. My second child had to have a blood transfusion after birth as I am RH negative and this added to my worry about the third pregnancy. By the fifth month the antibodies had reached a high level and I was sent to _____ for pre-natal fetal blood replacement. I made three trips in all and a fourth for the delivery of the baby, which was induced six weeks early. The whole experience of this pregnancy was one of expense, pain, and anger that I had no choice (that I knew of at the time) and of being forced into motherhood. This child, now five is healthy, loved and part of our lives. However, I feel my husband and I should have had a choice of whether we wished to be parents again, and been told of the risks involved. We probably would have chosen not to have this last child.

Personal Account 2

In 1961, I got pregnant for the third time. I did not want to go through with it. I had a boy and a girl and was a career woman. I had taken every precaution for birth control but somehow it failed. I tried the potassium permanganate douche and it didn't work.

I finally had the baby. I still regret it. It may be my attitude toward her, but she was not, nor is, a wanted child. It sounds terrible for a mother, but I so resented the authorities that *forced* me into that birth that I am still bitter. The child is backward in school, whereas the other two are bright and intelligent. I have a guilty feeling because I tried to abort her and failed, and blame myself for her slightly retarded brain.

Personal Account 3

I wanted an abortion because my husband was irresponsible and didn't have any intention of working steady. How I hunted for a doctor to do an abortion! I couldn't find one—I was scared to try too much for fear of killing myself. I ended up with two unwanted children. After my second contraceptive failure, they put an IUD in me, which has worked for me. My "ex" finally got tired and left. Now I sit on welfare, bitter at being trapped and in poverty.

Personal Account 4

My story is nearly 12 years old. It is especially difficult to tell it because the fetus that I wished to abort, wasn't, and today is 11 years old, an intelligent, energetic child who I feel very close to and love very dearly. At a time when there was nowhere to turn but to quacks and charlatans, I was 22 years old, unmarried, in a semi-professional job and a year out of university. By the time I became pregnant it was apparent the relationship could not sustain itself, let alone a child. My first instinct was to terminate the pregnancy.

The sheer terror of the situation is indescribable. The ultimate shame of an illegitimate pregnancy, the loss of face, the disruption of a just-beginning working life, the pain of having to face it all alone, no matter what happened,

led me to seek out someone to abort me. My scanty knowledge of methods told me that a D&C was very dangerous, if improperly done. The child's father had home remedies for me to take—quinine, and castor oil only caused ringing in my ears and diarrhea. The next step was to have a douche—supposedly safe, sure and $150.00. A woman gave it to me in a friend's house. Then we waited. Nothing happened—not a cramp, not a drop of blood, nothing. I got back half my money with help from my "friend's friend". Then he washed his hands of me. I was on my own.

It wasn't easy to find an abortionist, but I did. This time it was a man from _____ who agreed to fly to _____ and "help" me for $200.00. I met him at the airport, drove to my friend's empty house and after a lengthy talk while he "psyched me out" he gave me a douche after giving me my first pelvic examination to determine how "far along" I was. Then he called a cab, took my money, and left me alone. Again, nothing happened.

By this time I was over two months pregnant, absolutely desperate, going through the days like a robot, almost paralyzed with fear. About two weeks later I took a friend into my confidence and told him my situation. He offered to take me to _____ to see this man again if I was determined that there was no other course I could take. I called up _____ and after a lot of difficulty got through to him and convinced him that he had to see me again because what he had done had not worked.

We drove to _____ over night because our work situation didn't allow a lot of time away. We got a room in a motel and slept the rest of the night there. In the morning I called _____ and told him where I was. He picked me up in a dirty car with a lot of paper litter inside it. It was in sharp contrast to his person—he was a very clean well-groomed man.

He took me to a basement apartment that was untidy and dirty. I remember feeling I had really reached the bottom of the barrel. He said he had to give me some pills to make me relax and then he gave me two tiny capsules to take. The feeling I recall having was a kind of giving up—of just having no choice anymore, and a terrible sense of worthlessness. Here I was in a dirty, cluttered basement apartment in a city I'd only visited, on a street I didn't even know the name of, with a sly con man who was telling me that if I wanted to end my pregnancy I must take drugs I had no way of identifying. He then told me that the time during which a woman's cervix opened up the most was during sexual arousal. The best way to succeed with the douche was to "warm up". He then told me to get on the bed with my pants off, and he proceeded to "arouse me". He removed his own pants but kept on his shirt and tie, still done up at the neck. Between the drugs and the sense of giving up, I did get a little aroused. I remember feeling I must be some kind of slut.

Suddenly he jumped off the bed, ran and got his "equipment". He came back all business. He very painfully twisted my breast to extract some colostrum. Then he said almost angrily, "you see, you're at least three months!" He then did something to me—douched or seemed to "pop" something inside me, then showed me the white enamel pan he used—with an inch or more of dark blood in it. I got dressed. He drove me back to the motel with another $100 in his pocket.

My friend drove me back to where we had come from. The next day I realized that I was still firmly pregnant. The next day I called my family doctor. I told

him why. Then I drove 90 miles alone to his office where he confirmed my pregnancy, told me I had a very mild vaginal infection, and was damn lucky to be alive. The fetus had refused to budge. I had to succumb to the inevitable.

I left my job, hid out at home, and then lived for two months in an unwed mothers' home, giving birth alone and frightened in _____ hospital. I fed and held my beautiful son until that terrible last day when I was to go home and he was to be put into the care of _____ for adoption. I will never forget sitting up in bed on a grey February morning at 6:00 a.m., holding in my arms the most beautiful person I had ever known and telling him that I would always love him and need him but had to give him to someone else to care for because I couldn't.

After seven weeks, during which time I had seen my son twice in his foster home, I drove one day to the _____ where I signed a paper that said my son was no longer mine. I was releasing him for adoption. Then I died inside.

My story takes a sudden happy turn 10 days later. My friend who had driven me to _____ asked me—no, us—to marry him. After more soul-searching I said yes. I called up the social worker and told her I wanted my baby back. She said "you can't do that". I said I could because the three week "escape clause" on the paper I had signed was not up. And I was right. We got him back and brought him home when he was two and a half months old. We married two months later. We had two more sons.

Our oldest son knows that he had a different "man who helped mummy make him". He has only one father. He knows he was loved and very much wanted when he was finally here.

It was eight years before I was able to separate my wish not to have a baby, from the baby that I had. Then I knew forever, that no woman should have to go through what I did, or the far worse experiences of other women.

Illegal abortion before 1969

Personal Account 5

Many years before 1969 I had two illegal abortions. Three other members of my family, to my knowledge, also had an abortion at various times, only one legal. All of us also had children who were planned and wanted. None of us had any regret over the abortion itself, only over the accidental factor that caused the pregnancy to occur.

At 66, I am long past child-bearing age. I have four children and seven grandchildren. At 18, I "had to get married", left two families in a devastated state, went to _____ to hide the disgrace, and then, when living in a rather ramshackle cottage in rural _____ with an income of $100 per month and a ten-month baby, found I was pregnant again—the contraceptive didn't work. Another baby meant plain disaster. A good friend had a brother who was a medical student at _____ and he found out the name of a doctor who did abortions in his house. His uncle, a well-known gynaecologist, told him.

I went to see this Dr. _____ . He told me to come back a week later and bring $150 in cash. No cash, no abortion. My young husband and I didn't even know

anyone who could lend us that kind of money. Desperation was relieved by the unexpected over-night visit of my uncle who was a physician. He understood the situation and made no effort to change my decision, merely to help me avoid a nervous breakdown, his chief concern being how competent Dr. _____ was. He gave me $100.

I was so frightened that I took a friend with me to Dr. _____ 's office. The pleasant man of the week before had become a raging bull. By the time my friend had left and I had persuaded him to go ahead with the operation (the near-hysterical crying and begging having persuaded him that neither my friend nor I was from the police) I was so distraught that I fell on the stairs following a nurse down to his basement set-up. He had my money and all he wanted was to get it over.

I was taken to one of a number of curtained beds around the sides of one big room—there were of course no windows. I undressed and put on a gown. At that time I knew no one who had had an abortion and hadn't the least idea what would happen to me. A nurse led me out and I got on an operating table at the end of the room.

The operation was a dilatation and curettage done with no anaesthetic and as fast as possible, which meant the cervix was stretched as though it were made of elastic. I would not wish such pain on the vilest criminal. I just hung on tight, not daring to make a sound for fear of making the doctor angrier than he already was. When he finished the job, he picked me up, carried me back to my bed and dropped me from shoulder height. He left, and the nurse drew the curtains and left too. All I remember doing was crying. A couple of hours later, the nurse said I was ready to go. I hailed a taxi in the street and went to my friend's apartment. I stayed there two days, my husband dropping in after work and then going home to _____ where another friend was minding the baby.

About a week after I was home I haemorrhaged. Lying in bed with bath towels wasn't enough to stop blood from soaking the bed. I went and sat on the toilet. I thought I might bleed to death. There was no hospital in the area. I knew no doctor. The nearest phone was three blocks away. My young husband was too scared to do more than mind the baby. I had had an "illegal operation" which meant I had committed a criminal offense . . . the feeling of my insides draining out of me was unforgettable.

The bleeding stopped. I never did find out what caused it. Two years later I had a planned pregnancy. The doctor didn't seem to notice anything abnormal in my condition.

Seven years after the first abortion I had another due again to the failure of birth control. This time one of our top gynaecologists told me to go to Dr. _____ , which I did. He looked like a prize-fighter but presented no problems except $250 cash in advance, which in the depression was an awful lot of money. Instead of using his basement he used his second floor, and I had a small bedroom. I again had a D & C but this time with a general anaesthetic. In a couple of hours after sitting up for some coffee, the nurse said I could leave when I wished but if I wanted a taxi would I please go across to the drugstore and order it from there. Instead, I walked the eight blocks home. The contrast from the sheer terror and brutality of the first abortion combined with a lovely July day made me feel so relieved, it was wonderful.

My husband had not come with me because he was looking after the children. He'd been going through as much strain as I had when he saw me jauntily walking down the street instead of being carried in on a stretcher or crawling out of a taxi, he had a very pleasant shock. But I was taking my kids to my parents and had to pack. So, the second day after the operation I blew a fever, It got worse. Here I was on an isolated island convinced I could be dying of peritonitis. I took one person into my confidence and she backed me up on a story to justify me leaving the children and going back to _____ the following day. I was now running a temperature of 103 degrees. I met my husband in the lobby of the Medical Arts (he looked pale green) and went to see my gynaecologist. Verdict? "If you'd had peritonitis you'd be dead by now." Operation? "Clean as a whistle. You? Sheer devastating strain and exhaustion—go home and let your husband do everything for you for three days." It was a wonderful three days.

Personal Account 6

I, _____ of _____ in the province of _____ do solemnly declare that: "I am 56 years of age. I had an abortion approximately October 1940 at which time I was about three months pregnant. I visited the office of a physician where reams of gauze were packed into my womb. I was awake during this procedure. The next day he visited my home and removed the packing and the foetus was removed. I was supposed to return to his office but did not do so. I went to live with my parents in _____. One morning I awakened and found I was bleeding profusely and called out for my parents as I could not move for fear of drenching the bed. A physician was summoned immediately. I think he removed the afterbirth. The bleeding stopped.

The second abortion occurred during the winter of 1943 to the best of my memory. I was between four and five months pregnant. No other means being available I effected it myself. This was done by inserting a solution of castile soap, cream (dairy) and lysol into my womb with a syringe. I became very weak and took to my bed. I became delirious and a physician was summoned. He pressed on my abdomen and the foetus was expelled. My pulse was very low and I was sent in an ambulance to the _____ Hospital. It was during the war and due to overcrowding I was placed, on a portable bed for moving patients, in the hallway. To the best of my memory I laid there from early afternoon until the next morning when the doctor attended me and I received intravenous and blood transfusions.

My third abortion occurred in _____ about December 1945. Two women met me at a friend's house. They inserted something in my womb twice. The first insertion was very painful and probably would have been sufficient. I don't know what it was but the extreme pain commenced immediately. I think a couple of days later the foetus was expelled. I was about three months pregnant. I was about a week in the _____ Hospital afterwards. I believe damage was done to my bladder and took physiotherapy treatments at the hospital—deep heat applied to my abdomen sometime later. I came to _____ in the winter of 1949 and visited Dr. _____, a gynaecologist. He sent me to _____ Hospital for about a week. I am all right now except that my bladder is a little weak sometimes.

Personal Account 7

I am a woman of 56 years. I am happily married. My husband and I have had two children, a girl and a boy. We have practiced birth control under

supervision of our doctor. I had my pregnancies before oral contraceptives were available. At eleven months of age my second child was diagnosed as a "severe" hemophiliac. Throughout his infancy, youth, adolescence, and manhood, he has been transfused at least twice every month and he has been hospitalized countlessly. At least five times he has been on the critical list.

In spite of my diligent use of the diaphragm (the preferred method of the time) I became pregnant again. It is very difficult to have a healthy family with one hemophiliac. My husband and I knew we could not keep our family in good mental and physical health if we had a third child—hemophiliac or carrier. I knew that we could not manage another child. We also knew that there would be a chance that this foetus could be a hemophiliac son or a carrier daughter.

At that time my daughter was a little over two years of age and my hemophiliac son was a year old. My son was hospitalized repeatedly. My husband had colitis at that time and unable to work, I was forced to get a position to support the family. . . and I was pregnant.

I appealed to my physician, to the physician attending my husband, and to the geneticist at _____ Hospital—all to no avail. No one would give me a therapeutic abortion. I persisted and was interviewed by the chairman of the medical committee set up to review the cases of women who were pregnant with special circumstances. The chairman would not forward my case for consideration because he said that he would not be 100 percent sure that the foetus, if carried to term, would be hemophilic. You see, there was a 50 percent chance that the foetus would be carrying the defective gene.

I had no alternative but to turn to a woman who provided abortions for fifty dollars. She was a distant relative of mine. She did not have any medical training or experience. What could I do? I was desperate. She used a combination of a syringe of warm soapy water and Lysol and of Exlax. After a lot of hard work, scrubbing floors, pushing furniture around and stretching, I induced an abortion. However, I bled excessively and had to go to the _____ Hospital for a D&C.

We continued to scrupulously use birth control. The second and third times I became pregnant, the situation hadn't changed. Again I had to risk the well-being of my family and my life, by self induced abortions. Both times I had to be hospitalized at the _____ Hospital for medical attention. The second time I was admitted due to excessive bleeding (the foetus had not been eliminated) and I developed an infection.

About 1966 I found a gynaecologist, Dr. _____, who was sympathetic to my situation. He did not like to recommend taking the pill because of the possible severe side effects for me. I wanted him to sterilize me but he felt I was too close to the menopause. However, he did promise to sterilize me if I became pregnant. In 1968, I was 48 years old and I became pregnant. Dr. _____ performed an abortion and sterilized me at the _____ Hospital.

Personal Account 8

In the late 1950's I faced a pregnancy which I did not wish to continue. In those days one couldn't, and didn't, talk about it. I'd never come across anyone in the same boat. I lived in _____ . I asked our family doctor if he knew where I could obtain an abortion and recall well that he replied he made a

particular point of not having such information. He said though he didn't dare interfere surgically, he'd do what he could medically. He prescribed the necessary doses to induce menstruation. Though he didn't say so, I suspect he'd done the same for other of his patients. It worked.

I've never forgotten the ghastly misery of the whole business of realizing that I was pregnant. When I knew it was all over, my emotions were those of overwhelming relief. I have never had the slightest sense of guilt whatsoever, only thankfulness coupled with a deep anger that the whole thing couldn't have been done quickly, quietly, safely, and legally.

Personal Account 9

I, _____, do solemnly declare that I know the following to be true:

At the age of 24 I became pregnant because I felt that an unmarried woman was promiscuous if she planned to have sexual intercourse. I left my home city to have the child and gave it up for adoption. The doctor who had diagnosed my pregnancy subsequently prescribed birth control pills. He also gave me long, guilt-producing lectures on self-control.

As a result of confused emotions about my sexuality, I stopped taking the pill and again became pregnant in 1968. After trying to get medical help I resorted to an illegal abortionist who used a soapy douche to induce labour. The first attempt was unsuccessful and two weeks later I had to return to the abortionist, who accused me of becoming pregnant again. She then agreed to repeat the abortion attempt for the same $300 fee. I finally aborted while at work. After several days, when the bleeding had not stopped, I went to a hospital and was given a dilatation and curettage. To this day, I don't know whether I could conceive and bear a child if I chose to.

Personal Account 10

People like me who desperately require termination of a pregnancy will do anything to terminate it. I was aware of the risks involved—unwed and from a respected family. The thought of death occurred to me but I was so upset emotionally that I did not care. As far as I was and still am concerned that "quack" did me a favour. His method was unorthodox—no anaesthetic, no reassurance, an instrument was passed into my vagina, into the cervix. Possibly fluid was introduced. Immediately my bladder filled indicating that the uterus was punctured. What happened after that I don't recall, until I was being slapped on the face to consciousness and told to pay my $400.00 and "get out". Infection and emotional strain and guilt followed, but I was grateful to be alive.

Personal Account 11

In 1963, as a student I found myself pregnant. I wished to finish my training and was in no way ready for marriage or the responsibility of parenthood. My boyfriend at the time was willing and able to marry me and support the family. He was 21 at the time; I was 20. I became pregnant in the summer (July). Since I did not wish it to be known or to tell my parents, I waited until my Christmas holidays before I had the abortion. During the fall, through a friend, I found the name of a woman in _____ who was a waitress and who would perform the abortion for $150. I went to her home on December 19 with two friends who waited in the car.

It was a pleasant, clean, expensive home in a new subdivision. I was taken into the bathroom and instructed to lie down on the floor on the bathmat with my pants off and legs apart. She inserted a hard rubber catheter into my vagina and through my cervix. She then injected a solution of lye, soap, quinine, and oil which she had boiled on the stove. There was a fair amount of cramping and a feeling of fullness but no real pain. I was told I would abort in about 24 hours. No other instructions were given. I gave her the money—cash—and was driven to a party where we spent a couple of hours, then went back to a friend's apartment.

Exactly 24 hours later—about 7.00 p.m. the next evening—I started experiencing bad cramps, nausea and backache. I was alone in the apartment and the contractions became more and more severe over the next three hours. By this time I was bleeding and vomiting. I aborted the foetus finally and panicked, pulled on the cord and probably tore the placenta, retaining a piece in the uterus.

Over the next two weeks I bled off and on, finally ending up in hospital. The gynaecologist who examined me was very angry and punitive. When he heard what I had done, he removed the tissue from my uterus in the hospital treatment room with a sponge stick—and no anaesthesia. *That* was the worst part of the whole experience plus the attitude of the hospital staff when it—inevitably—became common knowledge that I had had an illegal abortion. I had two units of blood, was placed on birth control pills and sent home after three days in hospital.

I have—luckily—been well since, suffered no ill effects physically and although I have not had children subsequently, it is only because I have chosen not to until now. I have never regretted the action I took—only that I took a grave risk with my health and fertility. I certainly suffered no great emotional trauma and then, as now, I was only greatly relieved that a pregnancy was not going to force me into a situation I was in no way prepared or ready for. It really only forced me into being more responsible for my sexual behaviour—and admitting to myself that I was sexually active and not relying on "chance" and the occasional condom.

Personal Account 12

I became pregnant in January 1965 when I was 26. I had been brought up with sex being a taboo word; nothing was therefore ever explained to me. I knew nothing about the hazards, ways of protection—the pill was very new—thus I was quite completely at the mercy of my male partner even at that age, and with a B.A. My menstrual periods had always been irregular (sometimes none for months) so that I was three months pregnant when I found out. Being healthy, and a relative newcomer to the country, I knew of no doctor who could help, or who would know me enough to trust me. The doctors I did speak to, refused to do anything. Only one suggested, that if I did get an abortion somewhere I should come right after, to make sure everything was alright.

Through a friend of my friend a nurse tried to abort me three times with soap solution—cost $100 but no result; I was four months pregnant by then. Through another friend of my friend a man from the U.S. came to that friend's place; he also tried the soap solution method; this time it did work—cost $500 and another $100 to that friend for use of his place.

I did not know the implications of an abortion and went to work the next day. Labor started at noon; I barely made it home; 24 agonizing hours followed.

Luckily my mother was on holidays. My younger brother never figured it out. My father had died in 1963. My friend's friend assisted me during the night.

I spent the next morning in bed and the afternoon washing sheets and towels and all other traces of the abortion. Next day (36 hours after the abortion was induced) I went back to work although I almost fainted on the way; the following week the Dr. said I was all right.

Today, I am enjoying the eighth year of a happy partnership with my spouse and the seventh month with a wonderful, healthy, lively and very much wanted and planned son.

Personal Account 13

Because abortions were not legal in Canada, I was taken to Japan where they were. Although I went willingly, I was rather naive. This option had not even occurred to me. I suffered mental and physical pain.

Because of the language problem, I didn't know what was happening or going to happen to me. I believe there was a balloon inserted into the womb and filled with air to simulate a larger fetus. This balloon was tied to a rope and hung out of my body. An iron weight pulled on the rope and balloon, in hopes miscarriage would begin spontaneously. When it didn't injections were given and labor induced.

Although the staff was very kind, my surroundings were unsanitary. There was bleeding, but I didn't get a change of gown. During the three days or so I spent there my sheets weren't changed.

I was going to college. I had to borrow a substantial amount for the trip. Financially, this experience set me back for a year and more.

"Abortion" was not mentioned in those days. I suffered great anxiety for years afterwards that others would find out, although I personally did not feel I had committed a moral crime. One understanding parent took me to Japan, the other threatened to kill me. Before deciding on abortion, I had almost dropped out of college so I could have the baby in another large city and give it up for adoption. I also considered suicide.

Illegal abortion after 1969

Personal Account 14

In the fall of 1974 I had an illegal abortion. Not something that I'm particularly proud of, but nothing that I'm overly ashamed of either.

When I discovered that I was pregnant I didn't delve too seriously into the possibilities of getting a legal abortion. I was mentally and physically healthy, in a fairly good income bracket and living with the father of the child. When I decided that motherhood wasn't for me, I asked my family physician how I could go about solving this problem. The only solution he could offer was for me to go to _____ for $200.00.

I decided to stay in _____ and pay a bit more if necessary than face the long bus ride before and after the operation. Through one contact and another I

was directed to a respectable doctor who would perform the abortion at the same price ($200.00), with supervised medical attention should it prove necessary. The operation was performed in his office with a nurse standing by to hold my hand. The whole thing took about 20 minutes, and then I was sent home with instructions to call at any time if there was any undue bleeding, or if an infection occurred. Fortunately only one of these happened, and when I called with a fever of 102, the instructions given were complete and proper; and the infection rapidly abated. The whole recovery period, mentally and physically, was about a month.

Don't ask me for the name of the doctor. I have honestly tried to remember it, but have drawn a complete blank. I simply blotted his name out of my mind. I did a heck of a good job—if I were to find myself in the same position that I was in in 1974, I wouldn't know who or where to turn.

Personal Account 15

I was 20 years old when I became pregnant (because of a faulty condom) in late 1969, about to enter graduate school and still financially dependent on my family. The father and I agreed that in order to continue with our education we had to put off beginning a family. We felt that at our age and with our financial situation as it was, a child would surely suffer. Our only recourse was to find a way to terminate the pregnancy. As I knew of no counselling or referral services in _____, abortion was to be found through the grapevine.

I made numerous phone calls, meeting with both rudeness and fear. Perhaps I was lucky that none of the people I contacted were "in business" any more. Through a medical student, I found a man who had European medical papers but who could not practise medicine in Canada.

This man had a fairly complete medical unit in his basement; he was clean, kind and expensive. $350 put quite a hole in a student-sized bank account.

The experience was expensive in terms of emotional costs, too. Everything was shrouded in fear and secrecy. But, I was lucky—my doctor was clean and safe.

Personal Account 16

I live at _____ with my husband and my three children. I had my last period of menstruation in January 1971 and in February when I missed my period I knew I was pregnant and became very worried. We already had three children and my husband did not make very much money. I made some enquiries about an abortion and found that we could not make the $300 to $400 payment that was required in _____ where abortions are legal.

One Saturday in February 1971 I went to _____ who is my hairdresser and I told her about my problem and she called her aunt _____ who said she could help me. I went back home to my husband. _____ came over to my place and we talked about the abortion. She told my husband that she needed $50 now to buy the medicine and my husband went over to the drug store to cash his cheque and he came back and paid Mrs. _____ $50 and she left. She said she would return on Sunday morning.

On Sunday Mrs. _____ returned to my apartment and she told my husband to take the children for a walk for about a half an hour which he did. She then pulled out a bottle of lysol and a bar of soap and asked me to give her a pot. She put soapy water in the pot and poured the lysol into it and then she took a

knife and shaved the soap into the pot. She then gave me two pills to take while she boiled up the solution on my stove. She then told me to lie down on the floor in the bedroom and she took a floor mat and put it under me. She then took a douche and put the nozzle into my vagina and forced the solution from the pot into me. She did this several times then she put all the stuff into a bag and left the rest of the solution in the pot. I put the pot with the remaining solution on the shelf in my bedroom closet. Mrs. _____ wanted another $125, but I told her we didn't have the money.

Mrs. _____ then left our place and I showed my husband the pot of solution. He took it and poured it into a ginger ale bottle. That night I became very sick and the following day my husband took me to the _____ Hospital where I was admitted and Dr. _____ looked after me. On Wednesday, February 24, they let me go home and on Friday I was still getting pains. On Saturday Mrs. _____ came in. We had an argument about the abortion. I told her that she tried to kill me, and my husband suggested that she tried to poison me. Mrs. _____ said she would do the job again but she wanted her $125 and she told me not to go to the hospital again and that I would be alright. After some more arguments she left.

My husband then took me back to the hospital and I stayed there until March 2, 1971. I was still pregnant.

Personal Account 17

I was 18 years old and lived at home with my parents. I had left school and had a job. Through this job I met a man whom I dated for about four months. I was intimate with this man starting about three months before July 20, 1970.

My regular menstrual period should have occurred on July 20 and when it did not happen I became worried that I might be pregnant. I went to my doctor just after that. He assured me I was not pregnant but I was doubtful and went to _____ and had a pregnancy test done. This was negative.

On August 4, 1970 I again went to my doctor and this time I was told I was pregnant. I called my boyfriend and he was unsympathetic but through him and others I got the name of _____ and the telephone number.

On August 28, 1970 I called this number in the evening. The woman who answered said she was _____ but seemed reluctant to speak on the phone. I added that I was a friend of _____ and this seemed to reassure her. She asked how advanced my pregnancy was and other information about myself. She said an abortion would cost $300 and that I should call her back on the Tuesday following to complete arrangements. I did not have the money that day so did not call till the Tuesday after that, which would be September 1, 1970. I said I had the $300, which I had borrowed and saved.

After some conversation she suggested I should see her on Friday, September 4, 1970. I wanted to go in the evening but she said it would be better at 1.00 p.m. She then told me how to get to her address at _____ and that after entering I should go to the third floor where she would look after me.

I had brought some sanitary pads with me at Mrs. _____ suggestion and when I saw that the door to this apartment was open I put the bag inside the door then went outside again after knocking. I heard a voice call from below saying that the caller would be up right away. A woman came up the stairs still speaking and I recognised her voice as the one I had talked to on the telephone.

I paid her $300. She went into the kitchen, turned towards the stove, and then called me into the kitchen. She explained she was heating liquid on the stove to put into me; that it always worked; that she was doing about two abortions each day; and that the girls were sent to her by a gynaecologist because she was so good.

She cleared off the kitchen table. From under the kitchen sink she took a white cloth, with a plastic covering on one side and cotton on the other. She also brought out some disposable diapers, some newspapers, and other things. She instructed me to remove my panties and lie down on the table. I did this. The white plastic cloth was under me, next to the table, then on top of that was the newspapers, then directly below me were the disposable diapers.

She then poured some liquid from the pan on the stove into a syringe. She inserted the syringe into my vagina and used about a pint of the fluid. About then I lost track of things and became sick and began to vomit. The woman fetched a pail and started to clean the articles she had used. I sat up then, feeling better.

She took me into the living room where my two friends were seated. She went back into the kitchen. She brought me a small vial of blue and white capsules that were the same as those in a large jar in the kitchen. She said there were twelve pills in the vial; that she used them for migraine; that I should take one every four hours, and to take two pills if the pain got really bad. She said she had got the pills in large quantities from her doctor for her aches after her hysterectomy operation some years before. I then went to the front door and left.

During the night the pains and cramps started. At about 4 a.m. I passed something solid and started to bleed badly. I called a girl friend and asked her to call an ambulance, which arrived shortly afterwards and took me to the _____ Hospital.

Out of country abortion

Personal Account 18

In 1970 I became pregnant. My husband and I decided together, early in my pregnancy that, because this was an unwanted child, an abortion was imperative. At that time we were living in _____ .Since we were both in therapy with a psychiatrist at that time, we approached him for assistance as he knew only too well the tenuous situation under which we were functioning.

Dealing with a judgmental physician, we were doomed. We had asked that he take our case to the abortion committee at the _____ Hospital. We were refused. We searched around _____ desperately trying to grasp the loose ends of the elusive "red tape" in order to get our case heard somewhere.

With time running out we were forced to go to _____ for we knew of nowhere closer to go for help. Having made a very personal and private decision, we were put in the position of having to expose ourselves to friends and family in an appeal for a lot of money—very quickly. We travelled to _____ where I found a doctor who would perform my abortion for $500. I was then placed in a hospital and complications ensued making it necessary for me to be

hospitalized for three days. The latter cost me an additional $500. Provincial Medicare refused to reimburse me for any of the expenses.

Personal Account 19

I was very much impressed with the kindness and respect with which I was recently treated by a doctor in _____ and his entire staff. Unable to find assistance in _____ , and unable to make a quick appointment in my home province of _____ , I was fortunate to make a very prompt appointment over the phone and acquire a therapeutic operation within one week, at the doctor's office in _____ . I received far more understanding and attention from this office, even over the telephone, than I did in my own country. Without their help, I might still be in trouble today, and I feel deeply indebted to them.

Personal Account 20

In the summer of 1972 I went to my obstetrician (of six and a half years) to seek sterilization advice. I was 32 and a half years old and had two children. Although when I went to my physician about sterilization, I was mainly interested in my husband's obtaining a vasectomy, the doctor proceeded to recommend instead his own technique of vaginal tubal ligation. I had this operation in July 1972.

On October 29, 1974, a G.P. after a lab test confirmed that I was pregnant. A phone call to my obstetrician informed me that he was not so surprised, as he'd been having poorer luck with his technique than he'd expected, and had since improved it.

I was a very stunned, trapped, human being. I felt betrayed by my physician, but worse still, I felt myself in an absolutely impossible situation, that I had done my best to avoid. Previous methods of birth control I had always treated with care and what I felt was intelligence; and they had been effective. The decision for sterilization had been one that had been made with a great deal of thought, discussion and baring of souls—but we had made a decision "for life". I had not thought that I was being careless to let my obstetrician be the judge of the most effective method of sterilization.

Although I went through the motions (in the next couple of days) of preparing myself and my family for the inevitable, it wasn't long before I realized that there wasn't one part of me that wanted another baby. In fact I was very afraid, for my own physical and psychological health, and the effects on my sons and my husband.

My neighbour sent me to _____ where my husband and I received an interview. They agreed to help me. About three days later we met again with the counsellor, who informed us that the _____ doctors working with them were willing to take on my case, but because of the great number of applications going before the Committee at the _____ Hospital, relative to the few abortions that were actually done (the committee meets only once a week), that it would be three or four weeks before I could expect an abortion in _____ . At this point I was now about eight weeks pregnant.

I realized that I would have to take the only alternate route—to _____ . I was lucky in that we could afford it. The bus fare for my husband and I (round trip) was $100; the operation was $150. A phone call from our counsellor to _____ , let the clinic know they could expect us the next morning. We left the children with neighbours and took a 9 p.m. bus to _____ , and at midnight boarded a bus to _____ .

At around 7 or 8 a.m. we arrived in the city and made our way by cab to the clinic. The clinic was clean, efficient, but busy. My husband estimated that at least 30 women were treated during the time we were there. I was asked for a brief medical history, given a tranquilizer (which in my case had little effect), and given pills for afterwards and instructions for taking them. I was also given a blood test. We waited—a not very cheerful group. Finally, around 11 a.m. I was called. My husband could not come. I went into a room with an examining table, a piece of equipment (the vacuum aspirator) and a large empty bottle which had not been rinsed clean. I was told to remove my slacks and underpants and put them on a chair. I climbed onto the examining table and put my feet in the stirrups. I do not recall a gown but rather a sheet over me. A nurse and a doctor were present—both pleasant but rushed. I assume I was given a local anaesthetic.

What I do recall is the shame, the sorrow and the bitterness that I felt. I felt like a second class citizen. In spite of the obvious cleanliness and good medical care, the personal dignity that one expects with any operation, especially one so emotional, was just not there. Because of people like myself coming from out of town and crowding clinics such as these, everything was run like an assembly line. It was sad that I should feel so degraded, simply because I wanted desperately to remain reasonably sane myself, and to be able to raise well-adjusted children. But that is what I felt—degraded, ashamed, and bitter.

I will never forget the feeling of the vaccum machine on my uterus. I was scared. I begged for a few more moments to lie there. I was given a pad and led to an adjoining room. My clothes were laid at the foot of my cot, and I was left along with about 5 other patients. For the most part we were quiet, except to reassure each other about the feelings we were experiencing physically and emotionally. We were given 10-20 minutes to rest, then we got dressed and went through the waiting room. My husband joined us at this point and we went into a sitting room where coffee, tea and a few cookies had been left.

My husband went with four of us to a neighbouring restaurant where we ate lunch and tried desperately to bolster each other's feelings. Two of the girls went to the airport but the other had been in a state of shock since the operation, so we decided to stay with her and take our time and catch the night bus back.

This was in November, 1974. I cried most of the way home. I wanted to die—not for what I had done, but for what I had had to do.

Two weeks later my husband had a vasectomy by a surgeon who has done thousands of such operations with no failures.

Legal abortion after 1969

Personal Account 21

I had an abortion in December 1975. I was pregnant as a result of pill failure; I had been on the "mini-pill". I am married. Both my husband and I feel very strongly about the responsibility involved in having a child, as we are both products of very unhappy families. We periodically discuss whether or not to have children, now or ever. We were very lucky in having done this, as we did

not then have to make a decision under emotional strain and the pressure of time when I became pregnant, we had only to re-examine our criteria. We both feel that no one has the right to have a child unless they are prepared to accept full responsibility for that child's happiness and to do the very best they can for it. Our decision not to have children at this time was based on financial, emotional and career factors.

We were lucky. I have a very good physician who realized that it would be wrong for me to have a child at this time. We were also lucky in living in a large urban centre, where an abortion is more readily available. The whole process took less than a month. All three doctors I was in contact with, the psychiatrist, the physician and the gynaecologist were very competent, and once they were sure that I was sure, very helpful. The hospital staff was very considerate. At no time was I subjected to any disapproval or criticism. My only criticism, in turn, is that I was not informed of the procedure I would be going through. Physically, I had no idea of what to expect.

Personal Account 22

On my first visit to Dr. _____ I was very concerned to have a doctor with whom I could talk. I was pregnant and in an uncertain position. On my return from a one year trip I was three months pregnant with a child not my husband's. I was vaguely contemplating an abortion, but mostly I wanted to carry the baby to term and in that time decide if I would keep the baby or give it up for adoption depending on my situation with or without my husband. I went into the doctor's office wanting to be quite honest about my circumstances. From the first he made me uncomfortable asking questions but not even listening to my answers, sometimes repeating questions twice. He seemed extremely interested in my sexual life implying that since the child was not my husband's, I must have spent my life sleeping around. He asked questions like how many men and how often after I had already told him what had happened.

During the pelvic exam I asked questions about the position of my uterus because I had had previous problems earlier on in pregnancy with my cervix putting pressure on the urethra making it impossible for me to urinate. He gave me little satisfaction never answering a question directly. He told me to come back in two weeks and I left feeling uneasy.

I returned in two weeks hoping things would go better though I was already asking around about different doctors. The experience was even worse. It was as if I hadn't been in to see him just two weeks before. He asked all the same questions over again—even questions such as when I had conceived. Somewhere along the line he asked if I did much drinking. I said no but I occasionally smoked marijuana. This opened another topic of conversation. He started asking questions. I became very nervous as he asked if when I smoked with my friends we had orgies and seemed surprised when I said no. I am not normally upset about questions about my sexual life, or the smoking of marijuana, especially with a doctor. But this man gave me the impression that he was a voyeur looking in on my life and considering me as scum, an "easy lay". My feeling of unease and nervousness was absolutely confirmed with the humiliation of that doctor rubbing my clitoris with his thumb as he was doing the pelvic exam. I've had many pelvic exams and no doctor has come close to touching my clitoris. The doctor I went to see after this doctor told me a second pelvic exam, 2 weeks after the first was not necessary, if not detrimental.

Personal Account 23

I found it expedient through undergoing mental anguish and great physical discomfort to decide against carrying my fourth pregnancy to term. This decision had been a difficult one, arrived at eventually by a consensus of opinion, in that my husband and I talked exhaustively about our decision, then took the matter to our three children for their views. Because we lived at that time in _____, we were able, with little difficulty, to obtain an abortion and we have none of us regretted that decision since.

Ours is a warm happy and loving family environment. My pregnancy was the result of an IUD failure. We could have stretched our finances to absorb yet another family member, but we felt we were unable to stretch our emotional and physical resources, enough to welcome another child.

I come from a background where my mother found herself pregnant with her first child (me) at a most inconvenient time. My mother was an immigrant as was my father and both struggled to make ends meet in an often hostile environment. The home I was raised in was never a happy one. It was an emotionally deprived situation. I am of the firm opinion that some women are not meant to be mothers. They do actual harm to society in raising children. My mother may well have been one of those women for all her children are alienated individuals in one way or another. While I give thanks to my parents for bringing me into the world, for I hold it most dear, I do believe my mother should have been given the choice to have, or not to have children.

Personal Account 24

I am writing to you about my experience with having an abortion in _____ in July 1975. I am thirty years old, single, and a university graduate. I have conscientiously practiced birth control and have subjected myself, over the past ten years to such unpleasant and perhaps dangerous methods as the pill, two different IUDs, foam, and finally a diaphragm and jelly (which I was using when I became pregnant). When on the pill I tried several different brands and they all produced in me a bloated uncomfortable body, mood swings, depression, and a general feeling of not being myself. I persevered for several years, going off occasionally.

I realized that it was certainly not conducive to leading a productive, positive life and I refused to subject myself to that again. However, I know that the pill is the safest form of birth control, but for me the price is just too high. I doubt that many men would be prepared to subject their bodies to that kind of abuse.

Next I tried an IUD (the safety coil) which I kept for four months but couldn't tolerate. It was too big, I was told by another gynaecologist, and I have a small uterus. So he removed it and inserted a Dalkon shield. The cramps and bleeding were not much better, but I reasoned that after all some people live with the pain of arthritis and so I could survive with this. I lasted eight months this time. I had the Dalkon removed when the scare of infection and several deaths in the U.S. from women pregnant with the device in place.

At the time I realized that I was pregnant I was working for the summer in a community about 150 miles from _____, and could appreciate how difficult it must be for women who live long distances from big centres and have to come down twice, once for the initial assessment and then again several weeks later. My own gynaecologist was unable to help me because he was on the

Committee at _____ Hospital and apparently that eliminated him as a doctor to administer treatment to his patients in this area. He gave me the name of several other gynaecologists at that hospital whom I called. Two of them were on holiday, one was no longer performing abortions and one had his quota filled for the following week's committee meeting. I was floored!

My faith was shattered, and when it was suggested in my search to find a doctor that I go to _____ , I was tempted to pay the $200 and go. But now it became a matter of principle. I pay my premiums, I rarely use the services I am supposed to be insured for and now I had a real need and I was being advised to go to the States, pay out of my pocket, and act like a criminal, sneaking over the border.

I must have made fifteen phone calls that afternoon to different doctors and none of them would help me. They either didn't do abortions, they were on vacation or I would have to wait two weeks. The staff at _____ Hospital told me that since I was so early (six weeks), it would be about three to four weeks before I could have the abortion because they were bogged down with cases that were 11 and 12 weeks pregnant and they too had a quota. I was shocked and deeply angered. This was forcing me to wait three to four weeks.

I finally found a doctor who practiced at _____ Hospital, who said he would do it, but I would have to wait two weeks because their committee wasn't meeting the next week because again the bloody doctors were on holidays. I decided to take it. He informed me, after an internal examination that confirmed my positive pregnancy test, that I would be required to see a social worker at the hospital, and I would be examined by another gynaecologist on staff at their hospital. As I sat in his office and he spoke to the social worker on the phone, he assured her that I had been using birth control. He repeated this several times, and seemed to be trying to convince her to see me. He said that it was important that I stress to this social worker how depressed I was and to tell her that I had been using the diaphragm when I got pregnant because her report was very important.

I swallowed my anger, saw the social worker, visited the other doctor who stuck his professional fingers inside me and nodded sagely that I was about six weeks along. This whole process wasted the time of all the people I had talked to on the phone trying to find a doctor. It wasted the time and services of a social worker and a doctor who performed an unnecessary examination on me. And it wasted my time and energy, and humiliated me unnecessarily. I had done nothing I was ashamed of and I refused to feel guilty or like a criminal. I was given no supportive counselling and the only person who spoke in an understanding, kind way was the nurse of one of the doctors at _____ Hospital, who gave me some advice and expressed concern with my situation. God bless her.

The final humiliation came two weeks later when I again returned to _____ after a nauseating bus trip and was admitted to the hospital. I was told that I would have to stay for 24 hours after the operation, which I had no intention of doing, and come in the night before. At 10 p.m. a nurse (who was also very kind) came in with a large soapsuds enema and a shave prep tray. I was to have an enema and shave prep for a first trimester abortion! I refused. The woman in the next bed was not so lucky. She was vomiting as a result of hers, and was sharing my fate the following day. But she didn't know that it wasn't necessary, and thought it was part of the procedure. When I awoke in the

recovery room with an intravenous Pitocin drip interstitially infusing into my hand, I removed it. I refused another IV and was given an injection of Pitocin IM and returned to my room which I left four hours later, against the protests of a head nurse.

Personal Account 25

Through an IUD failure, I became pregnant in January 1972. I was a student in _____ at the time, and unmarried. To undertake the role of motherhood was impossible for me at the time and I was most upset and nervous. But I was fortunate. I lived in a large metropolitan area and had relatively easy access to hospitals with therapeutic abortion committees. I had an understanding general physician who knew that I could not carry that pregnancy to term and who referred me to a gynaecologist who in turn submitted a recommendation for a therapeutic abortion to the _____ Hospital. I had a most anxious two-week waiting period before I learned that I had been accepted. I woke up in the recovery room feeling nothing but gratitude that I did not have to be forced into the role of motherhood prematurely. Today, three years later, I have graduated, have a promising career, and have married.

Personal Account 26

In mid-December 1974 I learned on a visit to my doctor that I was one month pregnant. I decided to have an abortion. Irrespective of my age, financial and marital status, I simply and very strongly did not wish to have a child at that time, nor, I quickly realized, by the man with whom I had conceived. Carrying the child for nine months and allowing it to be born seemed much more unnatural than aborting a foetus I hated. I felt that my whole body was in revolt against me; not only was there an unwanted thing in my stomach, but I was constantly nauseous, aching, and extremely tired.

My doctor composed the necessary letter to the gynaecologist who would do the abortion, should permission be granted. Although nothing in the letter was exactly a lie, much of it was slanted. The facts were true; I was 25, single, unemployed, and had split apart from the man by whom I had conceived.

During my initial interview with and examination by the gynaecologist he only once actually looked me in the face. The rest of the time I was treated as an object to be examined or a piece of meat to be prodded and probed. Had I been in a position to change doctors, I certainly would have, for he made me feel like an insignificant piece of dirt.

Dr. _____ and his committee agreed to the abortion. It was performed in mid-January, a month after my pregnancy had been confirmed, and two months after conception. I was placed in the maternity wing of the hospital. I am not so insensitive as to feel no regret, no sense of loss for the child I didn't have. Someday I should like very much to have a child, but not now, and certainly not then. My decision to abort was not made lightly. The one consolation was that the nurses on this ward were extremely kind and friendly, providing the sort of warmth and understanding that neither my own doctor nor the gynaecologist were able to (or cared) to give.

I consider that I got off very easily—I was referred promptly to a specialist; got permission to have the abortion; had my costs covered by _____ ; and suffered no complications at all. What I do object to is having to wait a month; having to agree to a letter that bordered on defamation; having to be the

patient of a doctor who was cold and insensitive in the extreme; having to be granted permission by an unseen committee for an operation I regarded as essential. I felt powerless and abused throughout the whole experience.

Personal Account 27

It was in 1972, and I was 17 years old at the time. My boyfriend and I were using contraceptives, a condom, which broke during intercourse. Perhaps he wasn't wearing it properly, perhaps it was old, I don't know. When it was confirmed I was pregnant, my doctor (a G.P.) was very helpful. She contacted another doctor for me who could perform the abortion. This was the start of the countless excuses I had to make to get time off work. The only people who knew of my pregnancy were my doctor, my boyfriend, and a very close friend. My doctor had written a very good covering letter explaining everything. Of course this doctor didn't believe a word of it and quite frankly told me so. By then I was even more humiliated. He announced that because of my age (not yet 18 he could not do the operation without parental consent. The whole purpose of the covering letter and my seeing him was so that I would not need to get my parents involved.

I had graduated from school at the age of 16 and that same year had found a very reputable job. My parents were, at that time, going through a marriage crisis and were drinking quite heavily. My older sister had moved out some two years before, and my other sister and I were having a hard time at home. We decided to leave and share an apartment together, feeling that my parents' marriage would be saved somewhat, which, incidentally, it has. I had started my job in June, we left home in October. It was December when I found I was pregnant. Our parents still were not speaking to us—it was four months before they realized the reasons for our move. I had a lot on my mind then, and could not bear to have my parents involved.

My doctor searched and finally found another doctor for me to see. He agreed to do the abortion, but his attitude was even worse than the former doctor. He admitted "I have 4 kids. I bring babies into this world, I don't like having to do abortions." I was charged $150 and had to travel out to a rather dingy hospital. I could not even tell my sister for fear of her upset. So I fabricated some story about the need for a D&C and asked her to tell my coworkers that I had the flu. At this point I was about three months pregnant. I went and returned from the hospital alone. During my stay they found that the father of the child had a positive blood type and I had a negative, resulting in numerous tests, injections and worries. The nurses in the ward knew what we were in the hospital for and treated us accordingly. One woman in my room (there were five of us crammed together) had to come from _____ and another sobbed her heart out the whole time. There was no type of counselling.

I only took three days off work, since I was a bit paranoid and thought any more time off would arouse suspicion. I really didn't think I needed more time. I was only back a week and a half when I started to hemorrhage violently at work and had to be shipped back to the hospital for another D&C to get rid of blood clots. It was at that time that my boyfriend took off, never to be seen again. It's been so long since I've spouted this story. I'd forgotten how alone and empty I'd felt. It's good to talk about it. Too bad I couldn't do this three years ago.

Personal Account 28

When I was seventeen in 1972, I had an abortion at the _____ Hospital. The only way I found out about how to go about getting one was through a

girlfriend of mine. Half a year before she had had one. I was lucky she could help me as I had never read any information about legal abortions in any doctor's office, or for that matter at school.

When she took me down to the clinic she told me I'd better act pretty desperate and young or else they might not let me have the operation. So I told them the truth: I *was* desperate. I did not think of the thing inside me as a child but as a problem I wanted to get rid of. I also told them I wanted the whole thing absolutely confidential. Since I was over 16 years old this was done.

I was given a rough, cold internal examination in a lineup of other girls who had similar problems. During my two night, two day stay at the hospital I was treated fairly. I don't know what kind of operational procedure was practiced on me. The abortion was not discussed with me at all, by nurse or doctor, before or after the abortion. I was however given a birth control prescription afterwards, and was told how to look after myself for the following two months.

Personal Account 29

My medical background as it affects the abortion:

August 1974—gave birth to my second son.

September 1974—coaxed my husband into having a vasectomy.

June 1975—had a "stripping operation" done (varicose veins) to the tune of 37 scars on my legs.

December 1975—I discovered I was pregnant. Hubby had *never* had his sperm count checked. He was fertile!

I told my doctor that I wanted an abortion. No questions were asked as his office made arrangements for me to go to Dr. _____ . I had to make three trips to _____ —all in the few days before Christmas: (1) Appointment—general examination by Dr. _____ and my only chance to give my "story" (I was told that it had to be a good one or the abortion committee at _____ Hospital would not accept it.) With the story of my husband's vasectomy and my leg operation, I was OK'd. (2) Appointment the day before the abortion (Dec. 22)—to insert an apparatus that causes the cervix to dilate. (3) _____ Hospital: Admitted 8.30 a.m.; out by 4.30 p.m. After I came out of the recovery room, I spent the rest of the day in a large room with about 10 women who had also undergone abortions that day. It was a depressing environment, believe me. I had semi-private hospital coverage but this was not used.

I was told the bleeding after the abortion would stop within five days. Mine stopped three weeks later. I finally began my first menstrual period after the abortion on Feb. 4, 1976. Unfortunately, it never stopped. In fact, it got heavier. Yesterday (Feb. 20), I had to have a D&C performed. Today, I'm recuperating, and hoping that things will start to "get right again" with my body. Was the abortion performed correctly? If so, why so much subsequent bleeding and the D&C?

Personal Account 30

In the summer of 1972 I had a Dalkon Shield inserted by my obstetrician-gynaecologist. I had no problems with it, but in November of that year I

discovered that I could no longer feel the string and went to my doctor to see if it had been expelled unnoticed. A pregnancy test came back positive. At that time I was single and unemployed and financially dependent upon the man I was living with. I asked my doctor to help. He suggested going out of town, but I felt that I should be able to have the abortion locally, and we submitted an application to the _____ Hospital. I wrote a letter outlining the various reasons I desired the abortion and also consulted a psychiatrist upon the recommendation of my doctor. My application was turned down, and my doctor remarked that one committee member had asked whether I was a "test case". A referral was made to Dr. _____ of _____ Hospital in _____ . I saw him six days after my refusal in _____ and had the abortion performed under local anesthesia three days later on December 21.

Personal Account 31

Appointment was made with Dr. _____ for one week after the pregnancy had been confirmed in _____ . Arrived in _____ . First saw the gynaecologist who referred me to a psychiatrist in the same building. Before seeing the psychiatrist I was asked to complete several forms; one was a fill-in-the-blank questionnaire and some of the questions were:

I feel _____ Mothers _____ what annoys me most _____ I wish _____ Sports _____ Most feared thing _____ Dancing _____ I hate _____ I dislike _____ People _____ I like _____ this place _____ Men _____ Reading _____ .

Then I went into the psychiatrist's office and we talked for about half an hour. He asked me several questions: Have I ever had V.D.? What would my parents think if they knew? How many men have I slept with? Why do I want an abortion? How much money do I have in the bank? How much do I earn monthly? How old is my boyfriend? Will I ever get married? Was I using birth control? Why not? What would I do if I didn't get the abortion? If I had the baby, would I keep it or give it up? Had I ever taken drugs? Did I ever try to commit suicide?

I then saw the gynaecologist. He examined me and I was finished. They said the committee would meet Friday and I'd be called. The operation was scheduled for 11.30 Tuesday. I was given my first needle at 11:00 and got to the operating room at 12:00 or 12:30. Another needle—out stone cold. Back to my room by 1:30. I slept all day. I was given intravenous immediately after my operation which lasted for about six hours. For the next few hours I was extremely tired and wanted to sleep. I was in an overflow ward with other women who were having gynaecological surgery. By Wednesday morning I was restless and more than glad to be discharged. The nurses and doctors were all nice to me. I felt no hostility or coldness from them at all.

Personal Account 32

A couple of years ago I had to give up taking the pill and due to some misinformation I became pregnant. My husband and I were in a position where we would have run into great financial difficulties had I gone through with the pregnancy and I decided to seek an abortion . . . I was put in the care of a very qualified doctor and subsequently had the operation in a _____ hospital under the proper conditions.

Personal Account 33

At 38 years of age, I had an abortion last year. Not having any particular reason for not having another child, such as poor health, financial, emotional,

family insecurity, I was very upset thinking of going through another pregnancy.

My doctor insisted there would be no problem, referred me to a gynaecologist who after a very pleasant examination, told me of my appointment in one week at the _____ Hospital where in a pleasant one night stay (sterilization included) I was relieved of all my anxiety. I have never had *one* twinge of guilt or misgiving since I am a devoted mother of two, very happy with her lot who knows there are enough (too many) children in the world.

Personal Account 34

In the Spring of 1973 I had been fitted with an intra-uterine device, the Dalkon Shield, by Dr. _____ . He had recommended the IUD as a method of birth control, following the development of side effects (severe headaches and chest cramps) on the pill, which I had used for approximately five years. I did not regard myself as being in either a financial or an emotional position to adequately maintain a child. The IUD was still implanted in my womb somewhere, and I was concerned about its potential damage to the fetus. Finally, I was pregnant *despite* having followed medical advice.

In the late summer of 1973 I had separated from my husband. During October 1973 I began to think I was pregnant. My regular doctor was away at that time and I was examined by another doctor who was unable to confirm a pregnancy. Following a two or three week delay, such a confirmation was made. Since I have a low income I requested a referral to a doctor with whom I could discuss a therapeutic abortion. An appointment was made with Dr. _____ for the second week in December. I was informed that this was the earliest possible date.

During the pre-examination interview, Dr. _____ conducted a very cursory review of my personal situation and my reasons for desiring an abortion. He attempted to discourage me from undertaking that action, arguing that economics were not a barrier to raising a healthy child and that childbearing was a beautiful and most fulfilling experience. He suggested that children could "bring together" a previously unhappy marriage. I could bear the child and put it up for adoption. Dr. _____ went to great length to describe the medical "dangers" of the therapeutic abortion procedure, such as future child-bearing difficulties and possible sterility.

A nurse was not present during the examination. The conversation escalated to a diatribic monologue. Dr. _____ claimed that doctors such as himself were being "forced" to perform therapeutic abortions by the actions of the "damn stupid" government which had relaxed the regulations surrounding this procedure. I suggested that if the procedure bothered him so much he should refer me to another doctor. He stated his opinion was the unanimous position of all doctors, so that a referral was unnecessary. He claimed this was the reason for all the gynaecologists "getting together" and setting a standard fee, which was higher than the government rate for the procedure and was directly charged to the patient. That action was the only option available to doctors to "counter" the government and to control what had become, in his opinion, an "abortion on demand" situation. Dr. _____ became quite emotional and excited, repeating many of his arguments and claims. At one point he accused me of "looking at him as though he were stupid". I assured him that I was not, but that I did not agree with many of his thoughts or opinions. All of this occurred

while I was undressed and on the examining table, and lasted for approximately 20 to 30 minutes.

After the examination, Dr. _____ agreed to perform an abortion. He said I would be required to pay the fee prior to the operation. It was, to the best of my recollection, either $120 or $160. At no time did he describe what was actually involved from a medical standpoint.

I had one examination in late January 1974 with Dr. _____ following the abortion. The latter was conducted on either December 22 or 23, 1973, and was completely straightforward, with no complications. At the time of the examination I complained of a discharge. Dr. _____ declared it to be quite normal, and declared me healthy. For approximately a month and a half I ignored the discharge, until it became quite painful. Subsequently, another doctor diagnosed it as symptomatic of extensive cervical infection. He referred me to still another doctor who performed a cervical cauterization later that spring, after a period of drug therapy.

The personal side of care

Regardless of how their pregnancies were terminated, all of the women who gave personal accounts had in common a deeply held concern about the choice which they had to make. Once they had made their decision, they had a sense of urgency to get it over, that they wanted to get the induced abortion done promptly. As the number of illegal abortions has declined and there has been a shift toward more patients obtaining this operation in Canadian hospitals, these personal accounts show that there have been changes in the outlook of women about the type of care which they expected to receive. Unlike the frightened women who got illegal abortions, often under hazardous circumstances and at considerable cost, many of the personal accounts about abortions which had been done since 1970 show that these women expected, but had not always in their judgment received, compassionate treatment from doctors and nurses.

These women felt they were entitled as patients to a degree of respect and a sensitive understanding of their situation, qualities which for a number of women had been missing when they obtained their abortions. While the technical quality of the care which they got may have been excellent, and in terms of what is known about the low rate of short-term complications associated with therapeutic abortions this seems to have been so, these women in some instances felt they had been treated with discourtesy and had been humiliated or degraded as persons.

At its nub the effectiveness of the doctor-patient relationship rests on a sense of mutual trust and respect. For those conditions which require a personal knowledge by a physician of the social circumstances of a patient, particularly when these matters involve social ethics and stigma, the give-and-take in obtaining information under these circumstances requires time, much perception, and a sense of personal tolerance by patients and physicians. Because of the important service provided by the medical profession, patients

often have a feeling of personal gratitude for the treatment and the special concern which they have received from their physicians. Patients may see their physicians as wise and understanding counsellors who are to be trusted as few others are in society with the intimate details of personal experience.

But just as there can be discrepancies between what is ideal and what is actual, there are also two sides to the treatment which is given to induced abortion patients. For many of these patients and their physicians, the customary doctor-patient relationship had broken down. In many instances mistrust had replaced trust. There was much mutual bitterness and a not always shielded antagonism. For some patients and some physicians, these situations led to strained and emotional encounters.

From the perspective of the women who had induced abortions, the personal accounts give some graphic details about how they saw their medical treatment and how they felt about it. Many of these women were angry that despite having previously visited physicians and having taken contraceptive precautions, they were seen to have been sexually irresponsible or promiscuous. They were often angry about the difficulties which had been involved and the complex manoeuvring which was required in the processing of their requests for an abortion through professional and administrative networks. They saw many doctors as roadblocks, rather than as facilitators. In their eyes some of the physicians whom they had consulted had failed the test of personal decency by insulting them, making light of what was being done, providing indifferent and impersonal care, or on occasion, giving rough physical examinations.

In some instances the pelvic examinations of these women by their physicians had not been done in the presence of a nurse or another attendant. A few patients in this situation felt that the professional care which they had received bordered on being impertinent and in one instance, lewd. The extent to which this happens is unknown. Because of the intense personal nature of this aspect of the doctor-patient relationship, which in some cases were already strained, these allegations are difficult to prove. It should be observed, however, that where the widely endorsed but not always adhered to practice was followed of having another attendant such as a nurse or an aide present during a gynaecological examination, no concern was voiced by these patients about professional improprieties. Some of the women who gave their personal accounts were upset because they had been financially gouged for a service to which they felt they were entitled under national health insurance. Constrained by the stigma associated with this operation from making formal complaints about their extra-billings, some of these women felt their physicians had taken an unfair advantage of them.

The views of the physicians who did abortion operations were on occasion in sharp contrast with those of their patients. Half of the obstetrician-gynaecologists in eight provinces did not perform this operation. Among the members of this medical specialty who did, many did so out of a sense of professional obligation. Almost without exception these specialists and many family doctors made the point that they had been primarily trained to provide therapy and to save lives, not to terminate life. With little or no formal training in the social and psychological management of the special circumstances

involving the women who were seeking abortions, these physicians had much ambivalence about their work. Adhering to the ethics of their profession, many of these physicians gave exemplary care. But the personal dislike which some doctors had about induced abortion was not always professionally shielded in their treatment of these patients. Their opinions of induced abortion such as in some of the replies which were given in the national physician survey were readily apparent to their patients.

> The women who do not take the trouble to try to prevent pregnancies are the majority of abortion cases.
>
> • • •
>
> I have seen many women who repeatedly come demanding abortions for unwanted pregnancies, but yet despite family planning counselling they "cannot be bothered" to take contraceptive measures.
>
> • • •
>
> ...someone who's doing sex liberally, without morals, not bothering (about) contraception. Having no responsibility, not willing to obey parents or school disciplines, alcoholics, school drop-outs, and welfare cheaters.
>
> • • •
>
> An easy solution to an illegitimate affair or a morning after the night before.
>
> • • •
>
> Many of us feel our practices can be ruined by the constant barrage of young irresponsible girls seeking a therapeutic abortion without a whim of regret and like it's our responsibility to perform it. I do it. But I dislike it. Our beds are filled with these patients, while others wait months for elective, needed surgery.
>
> • • •
>
> Love and sexual companionship are rights to be preserved and cherished, not treated as an offhand form of excitement as part of the day's entertainment.
>
> • • •
>
> Too liberal and readily available...the increasing number of repeaters with an increasing decline in morals leading to degradation and degeneracy.
>
> • • •
>
> Abortions are sought by women as a "back-up" to contraception and women have become careless about contraception.

Ridiculous: After 25 years of active practice—this problem did not exist 15 years ago.

What the sharp differences in the perspectives of some patients and some doctors about induced abortion highlight is that personal convictions can be, and on occasion are, intermingled with what patients may expect of physicians, and in turn, be involved in the professional judgment of physicians. Changes in legislation do not immediately alter long-held values, particularly when the medical condition poses difficult choices involving personal morals, professional ethics, and much social stigma. Unlike the practice of some other branches of medicine, there was little that was felt to be satisfying either by patients or physicians about the induced abortion operation. Both wanted to be done with it as quickly as possible. From the personal accounts given by women and the surveys done by the Committee, **an appraisal of how the optimal professional care of women who obtain induced abortions can be provided is indicated, an appraisal which takes into account their views, and the concerns of the doctors and nurses who serve them.**

Chapter 9

Medical Practice

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

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

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

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

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

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

Profile of physicians

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

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

Definition of health

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

TABLE 9.1

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

NATIONAL PHYSICIAN SURVEY

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

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

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

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

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

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

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

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

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

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

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

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

Medical indications for abortion

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

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

*From Table 9.1.

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

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

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

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

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

Interpretation of mental health

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

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

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

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

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

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

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

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

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

• • •

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

• • •

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

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

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

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

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

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

• • •

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

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

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

• • •

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

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

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

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

Length of gestation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Abortion and the value of life

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

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

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

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

• • •

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

• • •

An abortion should be the right of all females.

• • •

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

• • •

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

• • •

I do not feel it is an unqualified right.

• • •

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

• • •

There is no place for therapeutic abortion.

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

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

• • •

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

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

• • •

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

• • •

A symptom of our general moral decay.

• • •

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

• • •

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

• • •

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

• • •

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

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

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

• • •

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

• • •

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

• • •

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

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

• • •

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

• • •

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

• • •

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

• • •

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

• • •

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

Appointment to therapeutic abortion committee

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

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

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

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

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

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

• • •

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

• • •

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

• • •

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

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

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

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

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

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

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

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

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

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

• • •

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

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

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

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

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

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

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

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

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

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

• • •

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

• • •

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Contraception and sterilization

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

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

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

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

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

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

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

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

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

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

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

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

Opinions of the abortion law

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

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

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

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

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

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

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

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

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The issue as it now stands is restrictive . . .

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

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

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In my opinion the laws are too restrictive.

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

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

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

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

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

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

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