# Chapter 10

# Consent

The Criminal Code defines an assault as the intentional application of force to the person of another without his consent[1] and sets out various offences and punishments for different types of assault. The civil as opposed to the criminal law uses the technical term battery for this type of act and exposes the perpetrator to liability in damages unless he is able to show legal justification for his act. In a situation involving immediate medical urgency where the person treated is unconscious and his wishes cannot be consulted, consent may not be necessary for a successful defence to a criminal charge or a civil action. Where consent is necessary, it must be freely given by a person who is capable of understanding the nature and effect of the act involved including the risks and who is not otherwise legally incapable of giving a valid consent. In addition, he must be provided with sufficient information to enable him to make an informed decision. While there are express exceptions in the Code, provided the above requirements are satisfied consent by a person who by the civil law of the provinces is a minor is usually a defence where a person is charged with an offence under the Criminal Code which requires the absence of consent.[2]

## The requirement of consent in the abortion law

Subsection 4 of section 251 of the Criminal Code provides the "therapeutic abortion exception" to the offence of procuring a miscarriage under subsection 1. Still, without the consent of the patient even a therapeutic abortion would constitute an assault. In this case the consent of a minor alone would appear to satisfy the general criminal law requirement of consent. However, presumably to emphasize Parliament's intent not to infringe upon provincial jurisdiction over physicians and hospitals, subsection 7 of section 251 provides that:

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[1] Criminal Code, section 244(a).

[2] B. Starkman, "The Control of Life: Unexamined Law and the Life Worth Living", *Osgoode Hall Law Journal* 11 (1973): 175, note 17, p. 179.

> 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.

The effect of this subsection is to recognize all other consent requirements including those contained in the civil law of the provinces. It is not always clear under provincial law in what circumstances a valid consent to an abortion may be given by a minor and when the substituted consent of a parent or guardian must be sought. Nor does the law in the common law provinces provide any enlightenment regarding any requirements to obtain the consent of the father in addition to that of the woman seeking an abortion. Against this background, the Committee was asked to ascertain the practice of hospitals in seeking consent to abortions and to find out in accordance with its Terms of Reference whether "therapeutic abortion committees require the consent of the father, or, in the case of an unmarried minor, the consent of a parent."

## Hospital practices and consent

In practice the interpretation of the requirements governing the obtaining of consent to all types of medical treatment including therapeutic abortions is established by hospital boards and hospital administrators. On its visits to hospitals across Canada and from the results of the national hospital survey, the Committee found that in addition to variation resulting from the specific types of treatment involved such as induced abortion, sterilization and contraceptive counselling, in the case of induced abortion **there was a diversity of consent requirements relating to the age of the woman and to the father.**

*The Minor.* In seven provinces and the two territories there is no special age of consent to medical treatment. In Newfoundland, New Brunswick, Nova Scotia, the Yukon and the Northwest Territories, the age of majority is 19 years, while in Prince Edward Island, Manitoba, Saskatchewan and Alberta it is 18 years. In Quebec and Ontario the age of majority is 18 years and in British Columbia it is 19 years.[3] In these three provinces specific statutes or regulations set lower ages of consent to medical treatment at 14 years for Quebec and 16 years for Ontario and British Columbia.[4]. The provisions dealing expressly with the age of consent to medical treatment have resulted in

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[3] Newfoundland, *The Minors (Attainment of Majority) Act 1971*, S.N. 1971, No. 71, s.6; New Brunswick, *Age of Majority Act*, R.S.N.B. 1973, c.A-4, s.1; Nova Scotia, *Age of Majority Act*, S.N.S. 1970-71, c.10, s.2; Yukon, *Age of Majority Ordinance*, Y.T.O. 1972, c.A-01, s.3; Northwest Territories, *Age of Majority Ordinance*, N.T.R.O. 1974, c.A-1, s.2; Prince Edward Island, *Age of Majority Act*, R.S.P.E.I. 1974, c.A-3, s.1; Manitoba, *The Age of Majority Act*, S.M. 1970, c.91, s.1; Saskatchewan, *The Age of Majority Act*, S.S. 1972, c.1, s.2; Alberta, *The Age of Majority Act*, S.A. 1971, c.1, s.10; Quebec, Civil Code, a. 246 and 324; Ontario, *The Age of Majority and Accountability Act 1971*, S.O. 1971, c.98, s.1; British Columbia, *Age of Majority Act*, S.B.C. 1970, c.2, s.2.

[4] Quebec, *Public Health Protection Act*, S.Q. 1972, c.42, s.36; Ontario, O. Reg. 729, s.49, R.R.O. 1970, as amended by O. Reg. 100/74, s.11, under the *Public Hospitals Act*, R.S.O. 1970, c.378; British Columbia, *Infants Act*, R.S.B.C. 1960, c.193, s.23, as amended by S.B.C. 1973 (1st Sess.), c.43. In Saskatchewan and New Brunswick regulations under the *Hospital Standards Act* and the *Public Hospitals Act* dealing with consent to surgical operations use the ages of majority. The consent of the parent or guardian of a minor is required only if the patient is unmarried.

much uncertainty among hospitals and physicians concerning the nature of their obligations and the protection afforded them.

In five provinces (Prince Edward Island, Nova Scotia, New Brunswick, Manitoba and Saskatchewan) and the two territories, all of the hospitals which were visited used the age of legal majority as the required age of consent for the performance of the abortion procedure. In the remaining five provinces, the situation varied to a certain extent, particularly in the three provinces which had statutes or regulations which set lower ages of consent to medical treatment.

In Newfoundland where the age of majority is 19 years, one hospital which had a therapeutic abortion committee was prepared to approve abortion applications beyond the age of 17 years, if in the judgment of the therapeutic abortion committee a young woman was considered to be an "emancipated minor", that is, that she was living away from home and was earning her own livelihood. This practice was also followed by one of the hospitals visited by the Committee in Alberta where the legal age of majority is 18 years.

Of the 19 hospitals with therapeutic abortion committees which were visited by the Committee in Quebec, five hospitals adopted the age of 14 years in principle as the basis of consent for the abortion procedure in accordance with the provisions of the Quebec *Public Health Protection Act*. The remainder of these hospitals, most of which did no induced abortions, adopted the age of majority as the accepted level. In Ontario, 27 hospitals which did the therapeutic abortion procedure which were visited by the Committee accepted the consent of women who were 16 years or older, a decision which was based on the Regulation under the Ontario *Public Hospitals Act*. Seven of the hospitals visited by the Committee in Ontario required the consent of parents for abortion patients up to the age of 18 years, the legal age of majority in that province. All of the hospitals in British Columbia visited by the Committee with one exception required the consent of parents for women who were under 19 years, or the age of majority, despite the fact that the *Infants Act* of that province sets the age of consent to medical treatment at 16 years. In one British Columbia hospital the consent of women who were 18 years of age was accepted if these women lived away from their parents' home and if they earned their own livelihood.

*The Father.* The law in the common law provinces provides no guidance regarding any requirement to obtain the consent of the father in addition to that of the woman seeking an induced abortion. The law of Quebec deals with the general right of married women to obtain medical treatment, though it does not refer specifically to induced abortion. Section 114 of *An Act Respecting Health Services and Social Services* provides that:

> The consent of the consort shall not be required for the furnishing of services in an establishment.[5]

In five provinces (Newfoundland, Prince Edward Island, Nova Scotia, New Brunswick and Manitoba) and the two territories (Yukon and Northwest

[5] S.Q. 1971, c.48. An establishment is defined in article 1(a) to include a hospital centre.

Territories), all of the hospitals visited by the Committee which did the therapeutic abortion procedure required the signed consent of a woman's husband prior to the performance of this operation. In the remainder of the provinces among the hospitals with therapeutic abortion committees which were visited by the Committee, the proportion of hospitals requiring the consent of a woman's husband was: 68.5 percent, Quebec; 55.8 percent, Ontario; 50.0 percent, Saskatchewan; 87.5 percent, Alberta; and 70.5 percent, British Columbia. Many of these hospitals required the consent of a husband prior to the performance of the abortion procedure.[6] Only three of these hospitals required the consent of a husband from whom a woman was separated or divorced and four hospitals required the consent of the father at all times, even when the woman had never been married. In Quebec, hospitals which required the husband's consent despite the provincial law mentioned the ambiguity of the consent requirement in subsection 7 of section 251 of the Criminal Code and the fear of possible legal action against doctors and hospitals as two of the most important reasons for the requirement.

## Special provisions for lower ages of consent to medical treatment

Two prominent Canadian legal scholars, Mr. H. Allan Leal, Q.C., Chairman of the Ontario Law Reform Commission, and Professor Horace Krever, Q.C., now Mr. Justice Krever of the Ontario Supreme Court have referred to the effect of the phenomenon of teenage sexuality in attracting attention to the subject of consent to medical treatment of minors.[7] Concern about medical treatment to minors resulted in statutory enactments in Quebec and British Columbia and an amendment to a regulation in Ontario which reduced the age of consent to medical treatment for minors. None dealt expressly with induced abortion. The relevant provision of the Quebec *Public Health Protection Act* in its original Bill form was made specifically applicable to the care and treatment of a minor who is pregnant, but it was considered that this and other references to conditions requiring medical care might limit the minor's access to medical care and treatment without a requirement of parental consent to the cases provided for in the Bill.[8] On the other hand, a Saskatchewan Bill which was not enacted proposed to put the age of consent to medical treatment at 16 years and it excluded "the procurement of a miscarriage upon a female person."[9]

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[6] In the national hospital survey among the 209 hospitals which had established therapeutic abortion committees, 143 or 68.4 percent required the consent of a husband prior to the abortion procedure, and 18.4 percent, the consent of a husband from whom a woman was separated or divorced.

[7] *Proceedings of the Conference of Commissioners on Uniformity of Legislation in Canada*, 1973, Appendix H—"Report of the Ontario Commissioners on the Age of Consent to Medical, Surgical and Dental Treatment", page 228 (Leal); *Minors and Consent for Medical Treatment*—Lecture delivered at the University of Toronto, March 18th, 1974 (Krever).

[8] P.-A. Crépeau, "Le consentement du mineur en matière de soins et traitements médicaux ou chirurgicaux selon le droit civil canadien", *Canadian Bar Review* 52 (1974); 247, pp. 252-253.

[9] Schedule 2 annexed to Appendix H of *Proceedings, supra*, note 7, p. 243.

*Quebec.* The effect of the provisions of the *Public Health Protection Act* of Quebec is that a minor 14 years or older may consent on his own to any care and treatment required by his state of health. However, in two situations the physician or the establishment must inform the person having paternal authority: (1) where a minor is sheltered for more than 12 hours; and (2) in the case of extended treatment. The obligation to inform is that of the physician or the establishment and is not a condition of the validity of the minor's consent.

On the one hand the Quebec legislation creates a presumption that the minor at the age of 14 years is capable of understanding the implications of a contract for medical treatment. On the other hand it has:

> slightly modified the law's general rules by determining the precise age where a child becomes, as a rule, capable of entering into a medical contract on his own. This law has in fact limited the minor's capacity to contract. For the child less than 14 years of age, the law has taken away his capacity to enter into a medical contract on his own, even in the case where he would have sufficient discernment to weigh the implications of such a contract.[10]

*Ontario.* The amendment to the Regulation under the *Public Hospitals Act* provides for the acceptance of a consent in writing signed by a patient who is 16 years of age or over, or who is married. As in the Quebec provision, the Regulation limits the minor's capacity to consent.

> My fear is that this new amendment has given the impression and, perhaps, a false sense of security, to members of the medical profession that a consent of a child over 16 years is full authority to the physician, and that a child under 16 may, in no circumstances other than an emergency, be treated without parental consent. My own view is, as I have indicated, that the amendment accomplishes no such result.[11]

The amendment to the Regulation under the Ontario *Public Hospitals Act* appears to afford protection to hospitals which obtain the consent of a minor over the age of 16 years, but the physician is left without this protection. The omission is due to the fact that the parent statute, the Ontario *Public Hospitals Act,* deals exclusively with the regulation of hospitals. It does not directly regulate a physician's conduct or the nature of his liability. In addition the Act purports to preclude public hospitals from permitting the performance of a surgical operation upon a minor who is under the age of 16 years without obtaining the consent of the parent or guardian. If this is so, hospitals can no longer rely on the common law capacity of a minor to consent. At the same time a physician would still be free to raise the defence of the common law capacity of a minor to consent because the physician's conduct is not directly governed or regulated by provisions which are either in the statute or the regulations.

*British Columbia.* The statutory amendment to the *Infants Act* places the age of consent to medical treatment of minors at 16 years. The Bill was opposed in the legislature on the grounds that it would allow a 16 year old girl

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[10] A. Mayrand, *L'inviolabilité de la personne humaine.* (Montreal: Wilson & LaFleur, 1975), number 50, p. 62. The author is a Judge of the Court of Appeal of the Province of Quebec.

[11] *Minors and Consent for Medical Treatment, supra,* note 7.

to seek an induced abortion without her parents' consent.[12] Unlike the reference to the care and treatment of a minor who is pregnant in the original Quebec Bill, this criticism of the British Columbia Bill was based on what was presumably included in its general wording. The Act sets conditions on the effectiveness of a minor's consent (subsection 3), and provides (in subsection 5) that the person treating the minor may inform the parent or guardian. In contrast to the limitation on the general civil law capacity to contract by the Quebec legislation, subsection 4 of the *Infants Act* preserves the common law capacity of a minor to consent by providing that:

> Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.

The conditions in subsection 3 have been summarized in the *Twelfth Report of the British Columbia Royal Commission on Family and Children's Law.*[13]

> The statute has reduced the age of consent to sixteen, but a doctor is still not free to accept the young person's consent immediately. The practitioner must "first" make a "reasonable effort" to obtain the consent of the parents. In the alternative, the doctor can get a written opinion from a second practitioner. The two options are not equal choices because the attempt to get parental consent is to be undertaken "first". Both options can cause delay and may inhibit the provision of early treatment.

It has been pointed out that subsection 4 "was taken *verbatim* from its English equivalent" in the *Family Law Reform Act 1969.*[14] The English provision in turn reflected the findings of the Committee on the Age of Majority (The Latey Committee Report) which was presented to the Parliament of the United Kingdom in July, 1967.

> There is no rigid rule of English law which renders a minor incapable of giving his consent to an operation but there seems to be no direct judicial authority establishing that the consent of such a person is valid.[15]

From the findings of the Committee it would appear that British Columbia hospitals with therapeutic abortion committees as a general rule did not accept the minor's consent to medical treatment. The question of whether there could be at common law an age at which there is capacity to consent that might be lower than the age provided in the legislation would seem unimportant in practice. The preservation of any common law capacity to consent is an attempt to provide as much protection as possible to physicians, even at the expense of incorporating uncertainty into the statute. It contains additional uncertainty, for example the condition in subsection 3 which makes the effectiveness of the consent conditional on the physician first having made "a reasonable effort" to obtain the consent of the parent or guardian. The effect of this uncertainty appears to be that many British Columbia hospitals with therapeutic abortion committees have sought protection in practice by using

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12 R. Gosse, "Consent to Medical Treatment: A Minor Digression", *University of British Columbia Law Review* 9(1974): 56, at p. 73.

13 "The Medical Consent of Minors", *Twelfth Report of the British Columbia Royal Commission on Family and Children's Law*, Vancouver, August 1975, p. 4.

14 Gosse, *Supra*, note 12, p. 69. *Family Law Reform Act 1969*, c. 46.

15 Cmnd. No. 3342, p. 117.

the only certain standard they can find, the age of majority. It would appear from the Committee's findings that the Quebec statute and the Ontario regulation provide sufficient certainty to encourage hospitals to accept the consent to therapeutic abortions of minors who have reached the required age.

## The uniform act

In view of the deeply held convictions about the issue of induced abortion, it is hardly surprising that many physicians wish to have ascertainable standards for accepting the consent of minors. It is by no means certain that the following provision of a Medical Consent of Minors Act recommended for enactment as a Uniform Act by the Uniform Law Conference of Canada will be used in induced abortion cases any more than is subsection 4 of the British Columbia statute:

> 3.(1) The consent to medical treatment of a minor who has not attained the age of sixteen years (the age of consent to medical treatment contained in section 2) is as effective as it would be if he had attained the age of majority where, in the opinion of a legally qualified medical practitioner or dentist attending the minor, supported by the written opinion of one other legally qualified medical practitioner or dentist, as the case may be,
>
> (a) the minor is capable of understanding the nature and consequences of the medical treatment, and
>
> (b) the medical treatment and the procedure to be used is in the best interests of the minor and his continuing health and well-being.

A note to this recommended Uniform Act suggests that:

> 1. A jurisdiction considering enactment of this Act may wish to exclude particular kinds of procedures from its scope, e.g. contraception, sterilization, or procurement of miscarriage. In the case of any exclusions, however, consideration must also be given as to whether or not the exclusion is to apply generally or only with respect to section 3.[16]

While one can appreciate concern lest reference to specific types of treatment limit the provision of general protection in the case of consents obtained from minors, there appears to be no reason save fear of controversy not to consider the question of minors' consent to induced abortion separately from consent to any other type of medical treatment. In light of the Committee's findings that a statute which provides certainty promotes the acceptance of a minor's consent to abortion, presumably a provision which is certain and made expressly applicable to therapeutic abortion would offer more acceptable protection to physicians and hospitals reluctant to forsake the shelter of the age of majority. A provision dealing specifically with consent to induced abortion would make it unnecessary for hospitals to develop their own guidelines for accepting consents, for example, justification based on the fact that the minor

[16] *Proceedings of the Uniform Law Conference of Canada*, 1975, Appendix N, pp. 162-163.

was near the age of majority, was living away from home and was earning her own livelihood. It would also make it unnecessary for legal advisors to consider whether legal decisions in non-abortion cases where the consent of a "mature minor" was accepted[17] are applicable to the case of induced abortion. The so-called emancipated minor and mature minor exceptions seem superfluous where the common law capacity of a minor to consent remains in force.

## Consent and contract

The provision of the Quebec *Public Health Protection Act* refers to the capacity of the minor to enter into a contract for medical treatment. The Ontario and British Columbia provisions, which use consent in the context of the intentional application of force, do not mention contract. Yet it is important to appreciate that the habit of looking to the age of majority for a standard for consent has been influenced by the establishment of such an age in the law of property and its subsequent acceptance for contractual capacity. The acceptance of such an age in the law of contract made it necessary to create an exception for necessaries, including contracts for necessary medical treatment. It would be reasonable to assume that where a therapeutic abortion committee has issued the required certificate stating that the continuation of the pregnancy would be likely to endanger the life or health of the woman the contract would be one for necessary medical treatment.[18]

The common law capacity of a minor to consent survives from a time when the influence of the age of majority had not acquired its later influence as a standard for consent. If the age of 14 years in Quebec as opposed to 16 years in the other two provinces (Ontario and British Columbia) reflects the orientation of the Quebec civil law toward the lower ages traditionally accepted for the contractual capacity of minors, then recognition of a basis in the common law for the acceptance of a lower age of consent may make it possible to arrive at a uniform age for all the provinces.

In the context of its Terms of Reference relating to consent to medical care and treatment and based on its review of hospital practices in these respects, the Committee concludes that:

1. **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.**

2. **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.**

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[17] For example, *Johnston v. Wellesley Hospital*, (1971) 2 O.R. 103 (H.C.J.).

[18] See A. Mayrand, *supra*, note 10, number 51, p. 65.

3. **While there is considerable variation in the practices of hospitals with therapeutic abortion committees across the country, most of these hospitals require 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.**

4. **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 (68.4 percent) 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 (18.4 percent) and the consent of the father where the woman had never been married.**

# Chapter 11

# Hospital Committees

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

## Size and specialty

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

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

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

TABLE 11.1

MEMBERSHIP BY MEDICAL SPECIALTY OF COMMITTEES BY REGION

NATIONAL HOSPITAL SURVEY

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

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

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

## Types of appointments

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

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

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

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

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

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

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

## Interpretation of terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TABLE 11.2

STATEMENTS ON DEFINITION OF HEALTH
BY PROVINCIAL AND FEDERAL HEALTH DEPARTMENTS

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

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

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

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

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

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

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

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

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

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

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

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

## Indications for induced abortion

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

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

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

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

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

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

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

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

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

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

—to prevent the birth of an illegitimate child; and

—whenever a woman requested an induced abortion.

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

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

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

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

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

## Requirements of committees

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

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

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

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

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

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

TABLE 11.3

## COMMITTEE REQUIREMENTS PRIOR TO REVIEW OF ABORTION APPLICATIONS BY REGION

NATIONAL HOSPITAL SURVEY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TABLE 11.4

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

NATIONAL HOSPITAL SURVEY

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

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

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

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

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

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

## Reasons for approval of abortion applications

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

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

TABLE 11.5

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

NATIONAL HOSPITAL SURVEY

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

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

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

## Hospital case studies

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

MARITIMES

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

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

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

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

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

• • •

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

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

• • •

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

QUEBEC

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

• • •

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

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

• • •

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

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

• • •

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

• • •

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

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

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

• • •

The written indications of a second hospital were:

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

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

Therapeutic abortion may be considered in the following situations:

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

b. Rape and incest.

Each case must be considered on an individual basis.

• • •

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

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

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

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

• • •

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

ONTARIO

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

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

• • •

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

• • •

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

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

Another hospital had a similar policy:

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

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

• • •

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

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

• • •

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

• • •

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

• • •

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

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

• • •

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

• • •

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

• • •

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

• • •

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

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

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

### British Columbia, Yukon, Northwest Territories

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

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

• • •

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

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

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

## Disposition of patients' charts

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

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

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

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

TABLE 11.6

DISPOSITION OF CHARTS OF THERAPEUTIC ABORTION PATIENTS BY REGION

NATIONAL HOSPITAL SURVEY

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

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

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

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

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

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

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

## Interpretation of abortion law

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

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

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

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

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

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

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

# Chapter 12

# Hospital Staff

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

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

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

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

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

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

## Staff functions

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

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

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

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

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

Nursing duty at the time of the induced abortion;

Nursing care provided to women who had had therapeutic abortions;

Nursing care for women having second-trimester abortions;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Staff recruitment and work assignment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> A nurse, barred from the operating room of a _____ hospital for refusing to assist abortions, has lost her bid for financial compensation. The _____ Hospital turned down a request by the _____ Human Rights Commission to insert a "conscience clause" in their employment policy. The clause states that a nurse who on religious or moral grounds cannot participate in abortion surgery will be transferred to another area of the hospital without loss of pay. The clause also states there would be no loss of remuneration because of the transfer. The nurse's case involved loss of extra pay for being on call one weekend a month, steady day shift work and all weekends off. She now is in a medical wing doing 12 hour shifts with alternate weekends off.[1]
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> _____ had been employed in the operating room at _____ Hospital since December 28, 1974, until November 24, 1975. When _____ was hired in December of 1974 to work in the operating room, no mention was made to her by the Director of Nurses of abortion or of the necessity of assisting at such operations as a condition of employment in that department. _____ said she had been able to avoid being scheduled to assist at abortions for the first 11 months with the cooperation of the O.R. supervisor, who simply did not schedule _____ along with a few other O.R. staff who objected to assisting with abortions, by simply not booking these individual nurses as the scrub nurse for abortions. As a result of complaints from two other O.R. nurses to _____ against _____ and the abortion issue, she was transferred to the medical floor. _____ admits that she did not explain to _____ when she was hired 11 months previously that she would be required to assist in abortions.
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> I worked in the _____ Hospital operating room as a registered nurse from March 1974 to October 1974. Before I was hired I was told therapeutic abortions were being performed and was told I must scrub and circulate for these abortions if I wished to be hired.
>
> Over the 8 months I would guess around 250 abortions were done. These were mostly suction (Gompco) type, next most common would be D & C. There were several hysterotomy abortions and only one saline that I was aware of

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

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

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

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

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

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

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

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

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

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

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

## Staff opinions

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

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

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

• • •

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

• • •

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

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

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

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

• • •

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

• • •

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

• • •

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

• • •

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

• • •

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

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

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

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

• • •

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

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

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> Abortion should definitely be a decision of a woman and her physician. However, guidance to her final decision should be made available by a qualified person who is not prejudiced.
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> The committees should have stricter guidelines.
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> I do not feel that abortion should be an alternative to birth control. However, I do feel that every child should be a wanted child and that it should be a decision agreed on by husband and wife. I do not think that physicians and politicians should be "playing God" in deciding who can and who cannot have an abortion.

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

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

> I feel as if my rights are transgressed—a doctor can refuse to abort any patient he wishes—I'm forced to nurse—and deliver—the patients having abortions. Recently one of the doctors was present and helped deliver a foetus following a saline induced abortion—he now says he'll not do any more saline injections—I'm not permitted to make this choice . . . The death on our unit following a therapeutic abortion was very stressful to the staff (patient 18 years) and even now, 4 years later, that patient is still remembered. I am pleased the Committee has taken the time to question nurses. It is the first time I've been asked about my feelings. Thanks . . .
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> . . . In 1968 we were doing anywhere from 16 to 30 therapeutic abortions per month. At the present we do 1 to 2 per month . . . More staff problems with

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

• • •

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

• • •

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

• • •

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

• • •

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

• • •

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

• • •

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

• • •

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

## Staff training

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

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

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

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

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

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

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

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

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

> We feel that the present calmness of the situation arose from the decision not to do abortions beyond 12 weeks.
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> Most of our abortions are done on a day care unit; there are no problems. We did have some problems when late abortions were done. There were also more problems when the abortions were on the same unit as obstetrics.

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

> In this hospital abortion is politely ignored, as are the needs of particular patients. Another nurse and myself sat down and drew up an outline for an in-service program on therapeutic abortion and the feelings involved of staff and patient. It was quietly squelched.
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> Since this is probably the only time someone will give me the chance to express my feelings on abortion, I will take this opportunity to state that as a whole, I disagree with the procedure. Thank you for letting me express how I feel.
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> These girls may have difficulty in ever conceiving again if they marry or change partners.

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

• • •

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

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

• • •

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

• • •

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

• • •

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

• • •

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

• • •

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

• • •

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

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

# Chapter 13

# Associated Complications

In general, the term *complication* is defined as a condition following an illness or surgery which may or may not be associated with it, but which usually requires further medical care. A complication indicates a deviation from the expected progression of events during the course of a disease or condition already present and/or the occurrence of a subsequent illness or event that would not have arisen in the absence of an earlier disease or condition. Complications may take various forms, as for instance: a new disease such as pulmonary thrombosis in the post-partum period; an exaggeration of an expected event such as blood loss associated with an abortion; a prolonged and severe depression after an otherwise normal pregnancy; or bowel obstruction due to adhesions years after an abdominal operation.

The complication may become apparent soon after the onset of the original disease or condition, or it may not be evident until much later when the original illness has been long past. Complications may be regarded as minor or unimportant when they do not alter the progression of the original disease significantly. Major complications will delay a person's rate of recovery or introduce new difficulties. Some complications such as infection are common to many diseases, while others are associated with particular organs or events.

How complications are defined by attending physicians and how these events are subsequently listed for statistical classification influence what is known about their prevalence. Complications which may arise from childbirth or induced abortion may not occur until sometime after these events have occurred. As a result they may be considered and classified separately, with no indication being given in official statistical reports as to what led to their occurrence. It is for these reasons that the findings about complications associated with pregnancy and induced abortion must be seen for what they are—available, but not fully conclusive sources of information.

One of the Terms of Reference set for the Committee was to examine: "the timeliness with which this procedure makes an abortion available in light of what is desirable for the safety of the applicant." A related Term of Reference was: " . . . to what extent has permitting the pregnancy to continue affected the woman or her family . . ." In its review of these Terms, the

Committee drew upon two sources of information. At the Committee's request Statistics Canada undertook a number of special tabulations dealing with complications associated with induced abortion. This information depends upon the assumption that there is a uniform interpretation of the term *complication,* an assumption which is not wholly valid. Counterbalancing this caution which applies equally to the reporting of all other health conditions listed in hospital and medical care insurance statistics as well as to all vital statistics collected for the nation, is that these sources of information are the best which are now available. In considering the experience of large numbers of women, they are relevant and necessary sources upon which to determine if consistent trends occur. It is from this perspective that they were considered by the Committee.

A second source of information which was used in the review of complications associated with childbirth and abortion relates to the experience of women in two provinces, Saskatchewan and Alberta. Because hospital and medical care insurance programs in Saskatchewan antedated the start of these measures elsewhere in Canada, they provide an unrivalled source of information over a period of time about morbidity and utilization of health services' trends. Both of these programs in Saskatchewan were in operation prior to the 1969 changes in the Abortion Law, thus providing a means of documenting some of the legislation's effects on the incidence of and complications associated with abortion. Obtained for other purposes, the research work involving these provincial statistical records resulted in a 10 percent sample of the Saskatchewan population which brought together for these individuals information on their hospitalization experience, their use of medical care services, and their income levels. This step was done by means of an individual identification number for each person in the 10 percent sample whose overall size, allowing for population mobility or death, was augmented annually over a period of several years. In the original analysis there was no personal identification of any individual involved.

Drawing upon this source of information involving the experience of a representative 10 percent sample of the Saskatchewan population, special tabulations were made of the women in this sample who had had deliveries, spontaneous abortions, and therapeutic abortions in 1970 and 1971. The health care experience of all women in these three categories was considered for a year before and a year after their pregnancy-related experience. This information included their experience in hospital, their before-and-after use of medical services, and the reported associated health complications which they experienced. While the number of the women in each of the three categories was small, their experience was representative of what was happening in these respects to other women in Saskatchewan.

Based on a request of the Committee, the Perinatal Committee of the Alberta Medical Association, a committee approved by the Alberta Hospital Association and the University of Alberta, took two samples of women from the 1970 computer service records of the Alberta Health Care Insurance Commission. These two groups of randomly selected women consisted of 101 women who had had induced abortions in 1970 who were matched by age with 100 women who had not had induced abortions that year. The health care

experience of these two groups of women was traced over a period of five years. A major difference between the groups of women whose health experience was considered in Saskatchewan and Alberta were the characteristics of the women in each instance with whom induced abortion patients were compared. In Saskatchewan, the comparison group consisted of women who had had deliveries or spontaneous abortions, that is, they had had pregnancy-related conditions. This was not the case for the group of women with whom induced abortion patients were compared in Alberta. The comparison group in this case involved a cross-section of women, only some of whom had had pregnancies.

## Independent viability

The fertilization of a female egg cell or ovum is the result of a union with a male sperm. The engrafting of the fertilized ovum in the lining of the uterus is known as implantation. The length of an ordinary pregnancy lasts about 40 weeks of gestation. It ends with a full-term birth. This process may end anytime during the period of gestation, either spontaneously or by interruption. Independent viability is a relative term implying that the newborn is able to survive outside the womb. This viable state depends on life supports which may be available after the birth of an infant. At the present time in Canada the level of care which is needed for the optimum survival of the newborn infant varies by the level of foetal development. Warmth and nourishment in most instances are sufficient to ensure the survival of a foetus weighing 2,500 grams or more. Below this weight the premature infant requires special care, the complexity of which increases as the weight or maturity decreases. Five hundred grams is widely considered to indicate the minimum stage of maturity above which there is any possibility for the independent viability of the infant. Feasible techniques for the prediction of foetal weight, such as ultrasound, can predict within limits the defined abortion/prematurity point (500 grams) and the premature/mature infant (2,500 grams). A more easily determined measure of infant maturity is the length of gestation. Although the measure of time is not individually precise, the average stage of a pregnancy required to reach 500 grams is usually about 20 weeks and the length of the pregnancy which is needed to reach 2,500 grams is about 37 weeks. The actual determination of the time of conception is imprecise. It relies on the approximate date of the last menses and the judgment of the physician in determining the size of a pregnant woman's uterus.

*Abortion*, derived from the latin *abortio*, meaning a miscarriage, can be applied to the failure of inanimate as well as of animate beings to progress to maturity. Its most common usage is in connection with the outcome of pregnancy, where it means that a foetus has failed to achieve or has not been allowed to reach independent viability prior to separation from the uterus of a woman. By international agreement, the separation of the products of conception is called an abortion if the separation takes place some time up to 28 completed weeks of gestation—that is, the point at which an infant is considered to be viable. Beyond 28 completed weeks, infants may be referred to as

a premature or a full-term infant. Between 20 and 28 weeks the chances of survival depend upon the length of gestation.

The viability of the female germ cell after its release from the ovary is limited. If the ovum is not fertilized within a relatively short time (about 24 hours) after ovulation, it will degenerate and be re-absorbed or expelled from the uterus. The male sperm on the other hand can survive for several days within the female reproductive tract. The time of fertilization of the ovum primarily depends upon the timing of ovulation rather than on the actual time of coitus. The medical means which are available at present for the detection of ovulation are retrospective, e.g., basal body temperatures, hormone estimations.

The implantation of the fertilized ovum is delayed for up to eight days after fertilization during which time the endometrial lining of the uterus is being prepared to receive and nourish the dividing cells. The early detection of the presence of a fertilized ovum depends upon the changes it brings about on the maternal environment, or on the production of a unique hormone which is absorbed into a mother's circulation and excreted in her urine. Newer and more sensitive laboratory techniques for the assay of this hormone of pregnancy (chorionic gonadotrophin) have made it possible to detect a pregnancy as early as two weeks after fertilization, before there are any detectable physical changes in the uterus or in the other maternal organs. The usual pregnancy tests done in laboratories, however, are not reliable until at least four weeks after fertilization, or assuming a 28 to 30 day cycle, until two weeks after the first missed menstrual flow.

Although an assay will determine the presence of an early pregnancy, it does not provide a specific date upon which to base subsequent calculations of the duration of the pregnancy. This fact still depends upon the nature of each woman's menstrual cycle and upon the accuracy of her recall of the date of her last menstrual flow. A frequently used method to determine the expected time of delivery is to identify the first day of the last menstrual flow, add seven days, and count back three months (or forward nine months). This method, when applied to the 28 day cycle, over-estimates the duration of a pregnancy by about two weeks as compared to the more precise method of determining the date of ovulation and counting forward between 266 and 270 days. If the woman's cycle is shorter or longer than 28 days, the difference between the two methods becomes greater. The practical dividing line between an abortion and a premature birth depends upon the method which is used to calculate the duration of a pregnancy.

A similar issue relating to the difference between an abortion and contraception, and the role of treatments such as the "morning-after pill" and menstrual extraction revolves around the problem of determining when a pregnancy begins. The use of these techniques might involve several factors:

Prophylactic—e.g., the inhibition of ovulation, or the union of the sperm and the ovum.

Interruptive—e.g., the inhibition of the implantation or the promotion of sloughing-off of the fertilized ovum.

Unnecessary—e.g., their use in the absence of the ovum, sperm, or pregnancy.

Which of these outcomes is the case in any individual event is seldom, if ever, known with certainty. The means are unavailable to get precise answers to two basic questions: (1) When did the pregnancy begin?, and (2) When did the foetus reach independent viability? Until there are more conclusive answers to these questions, the query "What is an abortion?" can be answered in only a general way. Only the weight can be determined with finality. This fact is only known after the foetus has been delivered.

## Methods of terminating pregnancy

Induced abortions may be done by an unqualified attendant, or by qualified attendants who are able to prevent or cope safely and effectively with bleeding, infection, and tearing. Throughout a pregnancy and afterwards, there are a number of risks such as bleeding, infection, torn muscles and others which may be associated with child-bearing or which may occur at a later date. Statistics Canada lists the complications associated with therapeutic abortion as:

Haemorrhage
Infection
Laceration of the cervix
Perforation of the uterus
Retained products of conception
Death
Other

These complications are not associated solely with an abortion, whether spontaneous or induced, but can occur more or less immediately with labour, delivery at term, or in connection with other diseases. The complications which are specific to pregnancy involve the breaking down of vascular connections between a mother and the foetus before, during, or after the removal of the products of conception from the womb. This relationship is usually not disturbed at term until after a baby is delivered. Then the uterine muscle contracts on the lessened volume, the placenta is sheared off and separated cleanly as a single mass, and the maternal vessels are tightly squeezed so that bleeding is held to a minimum. There is usually no need to introduce any instrument into the uterus to assist this mechanism and the risk of infection and trauma is small.

Spontaneous abortion occurs with a similar, but less efficient sequence. There is often some placental separation before or during the contractions which are needed to bring about the dilatation of the cervix and the expulsion of the products of conception. This bleeding may be prolonged and excessive so that it becomes necessary to dilate the cervix mechanically and remove the uterine contents thus allowing the muscle to constrict the maternal vessels and reduce the bleeding. This procedure carries with it the risks of the laceration of the cervix, the perforation of the uterus and the introduction of infection. The incomplete emptying of the uterus is not unusual for two reasons:

1. The maternal/foetal division of the placenta is not mature and the placenta is more intimately connected to the uterus than it is at term.

2. The procedure is done on a blind basis. The inner surface of the uterus is not easily inspected for the removal of placental fragments.

As a result of these factors the products of conception may be left behind or retained, adding further to the risks of haemorrhage and infection.

The problems associated with induced abortion are similar to those associated with spontaneous abortion. In the absence of spontaneous contractions which cause the cervical dilatation and the spontaneous separation of the products of conception, the risks become greater.

To understand the basis for the selection of the method which may be most appropriate for emptying the uterus at different stages of pregnancy, the procedure must be seen in the context of the changing relationships between the products of conception and the uterus. The uterus has muscular and fibrous walls the inner surface of which is covered by a membranous lining (the endometrium) which in the non-pregnant state is shed and regenerated periodically. When the fertilized and developing ovum enters the cavity by either one of the two tubal openings, it adheres to and then burrows into a small spot in the endometrium, enlarging rapidly. It soon involves a large area of the endometrium. While the invasive properties of the placental tissue permit it to establish a firm connection to the uterus, it generally does not penetrate the muscle layer to any significant depth.

As the pregnancy progresses and the uterus enlarges to accommodate the foetus floating in its fluid-filled sac, the placental tissue becomes circumscribed and occupies a relatively small proportion of the uterine wall. The muscle layer of the body of the uterus thins as the pregnancy approaches maturity and the cervix becomes softer and shorter. When normal labour begins, the time required is relatively short for the muscular contractions of the body of the uterus to dilate the cervix. Following the delivery of an infant, the muscular walls contract still further so that the inner surface area becomes smaller. The placenta which is of a fixed size is sheared off and pushed out by the force of the uterine contractions. Simultaneously, the muscle fibres close down on the maternal blood vessels which were supplying the placenta so that the blood loss is minimized. In the large majority of pregnancies, this sequence progresses efficiently and it does not require any assistance or interference.

The physical and mechanical relationships are not the only changes which occur with time. The chemical and the normal changes in the uterus keep the muscle layer quiet in the early stages, so that it is difficult to produce coordinated and effective contractions by the use of drugs or other means. Later, as the pregnancy approaches the mid-point, the uterus gradually becomes more responsive to drugs such as oxytocin and prostaglandins which are used for the slow dilatation of the cervix, and to changes in the fluid around the foetus brought about by instilling hypertonic solutions of saline, glucose or urea into the amniotic sac.

These physiological changes dictate the means by which the uterus can be emptied most easily according to the stage of gestation. The pregnancy can be

terminated by the use of mechanical techniques, drugs or a combination of these two means.

*Mechanical*

1. Dilatation
2. Dilatation and curettage (D & C)
   (a) Menstrual extraction
   (b) Suction
   (c) Surgical
3. Hysterotomy
4. Hysterectomy

*Medical (Drugs)*

1. Prostaglandins
2. Oxytocin

*Combination of Mechanical and Medical*

1. Intra-amniotic injections
2. Curettage after intra-amniotic injection

The stimulation of labour by the slow dilatation of the cervix can be attempted by mechanical dilatation or through the use of a laminaria tent which is a tightly woven mesh of seaweed or cellulose which has recently regained its popularity. Upon being introduced into the cervical canal, it absorbs local fluids, swells and dilates the cervix over a period of several hours. Labour may or may not follow. The laminaria tent is usually used concurrently with other procedures to reduce the risk of tearing the cervix. Its use is associated with some risk of infection.

In the earlier weeks of pregnancy the products of conception can be removed through a small-diameter, flexible cannula or catheter. Suction from a 50 cc syringe is sufficient to remove the contents of the uterus. The technique of menstrual extraction for the removal of the endometrium from the uterus up to seven weeks may be performed before the presence of the pregnancy is confirmed. Little is known about the extent to which this procedure is used by physicians in their offices or by women themselves, although there are indications from the national population survey that both occur in Canada. This method carries with it the risk of infection and/or the risk of a perforation of the uterus which are common to all invasive techniques, particularly when they are carried out by unskilled persons under less than optimal conditions.

The very early diagnosis of pregnancy has been made possible through the use of a recently developed sensitive and specific hormonal assay which differentiates between the hormone of pregnancy (chorionic gonadotrophin) and the chemically similar gonadotrophin produced by the pituitary gland. This significant advance coupled with the use of the vacuum or suction curette may lead to a lessening of the prevalence of complications. Because both the

suction and surgical curettage techniques are done on a "blind" basis by a physician, it is not always possible to be certain when all of the products of conception have been removed. When the retained products of conception remain, they may result in prolonged bleeding and/or infection. Precautions are necessary if the complications of trauma, haemorrhage and infection are to be reduced. The dilatation of the cervical canal to a diameter which is adequate for the passage of an instrument capable of scraping out (curetting) or aspirating (sucking) the endometrium and the products of conception, is the usual method for the termination of pregnancies prior to 13 weeks in length of gestation. With the increasing mass of the pregnancy these methods become less effective and their use is associated with greater blood loss. Consequently, they are usually replaced by techniques designed to stimulate the uterus to contract.

The induction of labour during the second trimester, similar to that which occurs at term, has been attempted to avoid excessive damage to the uterus. This step has been done successfully by injecting hypertonic solutions into the amniotic fluid around the foetus or by the use of a relatively new family of drugs, the prostaglandins. These latter drugs can be given by mouth or intravenously. Although these methods are successful, they bring new problems and result in unpleasant side effects related to the drugs which are used (water intoxication secondary to hypertonic solutions; nausea, vomiting and diarrhoea associated with the prostaglandins) and to the techniques (intra-uterine infection and haemorrhage secondary to needle puncture of the uterus). There is an increased risk of having retained products of conception in these mid-trimester abortions, because the placenta is less easily separated from the wall of the uterus at this time than at term and because the process of labour is longer and less efficient. Thus it may be necessary to complete the abortion by surgical or suction curettage.

The attempts to stimulate the uterus with drugs may be prolonged and uncomfortable. Uterine and bowel cramps, nausea, vomiting and diarrhoea are minor complications which are not listed separately. Water intoxication is a rare occurrence associated with prolonged intravenous infusions and oxytocin. Infection can be associated with intra-amniotic injections. When the uterus will not respond to efforts to induce labour at this more advanced stage of pregnancy, there is only one recourse, a hysterotomy. This operation is similar to a caesarian section, but it often involves a greater blood loss. It leaves the uterus weakened by a scar so that future pregnancies are accompanied by a threat of uterine rupture which can only be circumvented by elective caesarian section. Hysterotomies are often performed electively when a concurrent surgical sterilization is to be performed. The removal of the entire uterus along with the products of conception is an uncommon method which is used only as a last resort, or when there is an accompanying condition which is an indication for the removal of the uterus. As a pregnancy progresses, the complexity of the methods required to empty the uterus becomes greater. The problems associated with the procedures which are used increase in number and severity. Conversely, the earlier the termination is carried out, the simpler are the methods which are required which in turn result in fewer immediate associated complications.

In more than three-quarters (78.4 percent) of the 209 hospitals with therapeutic abortion committees which were surveyed by the Committee, surgical dilatation and curettage was one of the procedures which was used for therapeutic abortions. Nearly two-thirds (63.5 percent) had a suction curettage available for induced abortions. In half (56.7 percent) of the hospitals hysterotomies were performed, while intra-amniotic injections were carried out in 34.1 percent of hospitals. Menstrual extractions were performed in 3.4 percent of these hospitals.

## Complications of abortion

The complications which are recorded depend upon the prevailing attitudes and customs of patients and the medical profession as well as the definitions and regulations which are involved in the classification of diseases. A haemorrhage for instance is a reportable complication, but the dividing line between the amount of bleeding which is acceptable or may be expected, and what constitutes a reportable event is a matter of subjective professional evaluation. The techniques which are used to measure the actual amount of blood which may be lost are cumbersome and unreliable, while the individual estimates which are made by physicians may be contingent upon their experience and attitudes. A temperature elevation, an increased white blood cell count, a purulent discharge, a local pain and tenderness and a rapid pulse rate are all associated with an infection. However, an infection may or may not be related to an induced abortion and an infected abortion may or may not produce all of these signs and symptoms. A simple temperature elevation which is treated immediately with antibiotics may suppress the development of other symptoms or signs. In this event it is difficult to determine whether an abortion has become infected, or whether there was an unrelated cause of the fever. Subjective evaluations cloud the reliability of reports and mask the actual incidence of the complications which are listed even under the best circumstances, their observation in hospital. When an induced abortion does not occur in hospital, there is less opportunity for professional observation and the reliability of the information which is obtained decreases. If the complication occurs following the discharge of a patient from the hospital, her treatment may be carried out in a private physician's office, or if it is more serious it may involve her re-admission to hospital.

The complications listed by Statistics Canada (haemorrhage, infection, laceration of the cervix, perforation of the uterus, retained products of conception, death and other) include the immediate events associated with induced abortion. Later complications which may be related to early difficulties include:

Infertility and tubal pregnancies secondary to tubal adhesions or to partial or complete obstruction after infection.

Premature delivery in subsequent pregnancies which may be related to the laceration of the cervix and the later inability of the uterus to retain an increasing mass of a normally developing pregnancy.

The reported prevalence of immediate and later complications associated with induced abortion and the possibility of any of them occurring can be influenced by one of several factors, including: (1) classification; (2) method of abortion; (3) gestational age of the pregnancy; (4) the chronological age of the patient; (5) previous pregnancies; and (6) the characteristics of the hospitals where induced abortions are done.

*Classification.* **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.** This decrease occurred in all provinces, but not to the same extent in each region. The initial complication rates were based upon incomplete information for the country. The range for 1972 (7.3 per 100 abortions) was based on reports from six provinces representing 13.1 percent of the induced abortions done that year in Canada. The 1972 listing included three categories which were dropped from the 1973 lists. These categories accounted for 2.8 of a total of 7.3 complications per 100 abortions. The rate of all complications for 1972 that should be used for comparative purposes is closer to 4.5 per 100 abortions, if it is restricted to the list that now is in use. This rate of 4.5 was little different from the 4.2 per 100 reported in 1973 which again was based on incomplete national information, representing some 26 percent of the therapeutic abortions done in Canada during that year. A more significant change occurred in 1974 when there was a decline to 3.1 complications per 100 abortions, a rate which was based on almost complete national information, i.e., 85.8 percent of the therapeutic abortions done in 1974. After this date, information which was not yet available to this inquiry will be complete for the nation.

The terminology which is used in the classification of complications affects the rates which may be reported in official statistics. The difference between sepsis and infection for instance is one of degree. It is open to individual professional interpretation. The term *other* in the listing of complications is a "catch-all" category which may include many deviations from the expected course of events. The recording of the complications assigned to the *other* category is left up to the individual physician and the discretion of the particular records librarian who codes the disease morbidity for a hospital. **The decline in the *other* rate from 1.6 in 1972 to 0.1 in 1974 more than accounts for the total drop in the incidence of all of the rates combined for the recorded listing of complications during this period.** For this reason, while there was an overall decline in the reported number of complications associated with therapeutic abortions, a further examination of the trends in the rates of individual complications is not indicated. Subsequent reference to complications is based on 1974 information only.

*Induction Procedures.* The initial complications associated with therapeutic abortions in 1974 listed by Statistics Canada varied by the induction method which was used and the specific risks by types of complications which resulted. In terms of the proportion of complications *per 100 therapeutic abortions*, the rates for these procedures were: 0.6, menstrual extraction; 1.4, suction dilatation and curettage; 1.6, surgical dilatation and curettage; 4.2, hysterotomy; 7.4, hysterectomy; 11.2, urea; 18.4, saline; and 25.8, other and

unrelated combinations. Overall, there were 1,295 initial complications (or 3.1 per 100) associated with the therapeutic abortions done in Canadian hospitals in 1974. Another way of looking at the prevalence of complications is by making a comparison of the extent to which an induction method was used and the overall proportional *distribution of complications which were associated with a given procedure.*

| Surgical Procedure 1974 | Percent of Therapeutic Abortions | Percent of Complications |
|---|---|---|
| Surgical D & C | 20.8 | 10.5 |
| Suction D & C | 62.6 | 28.3 |
| Hysterotomy | 3.1 | 4.1 |
| Hysterectomy | 0.4 | 1.0 |
| Saline | 8.6 | 50.7 |
| Urea | 0.7 | 2.6 |
| Prostaglandin | 0.2 | 0.9 |
| Menstrual extraction | 3.4 | 0.7 |
| Other and unrelated Combinations | 0.2 | 1.2 |
| TOTAL | 100.0 | 100.0 |

**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.** For all other methods the level of complications was higher than the extent to which the procedures were done in 1974, and in particular, **the saline procedure which was used for 8.6 percent of the therapeutic abortions accounted for over half (50.7 percent) of the associated complications. This method, used in connection with second-trimester abortions, indicates the risks associated with the increased length of gestation.** A total of 84.7 percent of the complications associated with the saline procedure involved the retained products of conception. Overall, all types of complications were: 13.4 percent, haemorrhage; 15.8 percent, infection; 10.5 percent, laceration of the uterus; 4.4 percent, perforation of the uterus; 51.8 percent, retained products of conception; 4.0 percent, other complications; and, 0.1 percent, death. The nature of these complications varied by the induction methods which were used, with 65.1 percent of the haemorrhages associated with surgical dilatation and curettage and suction dilatation and curettage, as well as these two procedures accounting for most of the lacerations of the cervix (93.3 percent) and the perforations of the uterus (87.7 percent). There was a higher rate of post-operative infections associated with hysterotomies (49.0 percent) and hysterectomies (61.5 percent) than other induction techniques.

TABLE 13.1

COMPLICATIONS OF THERAPEUTIC ABORTION BY CHRONOLOGICAL AGE, LENGTH OF GESTATION, AND SURGICAL PROCEDURE, 1974

STATISTICS CANADA

| Patient Attributes and Surgical Procedure | Therapeutic Abortions and Complications | | |
|---|---|---|---|
| | Number of Therapeutic Abortions | Abortions with Mention of Complications | Complication Rates per 100 Therapeutic Abortions |
| CHRONOLOGICAL AGE | | | |
| under 15 years | 505 | 47 | 9.3 |
| 15-19 years | 12,481 | 516 | 4.1 |
| 20-24 years | 12,081 | 334 | 2.8 |
| 25-29 years | 7,609 | 190 | 2.5 |
| 30-34 years | 4,409 | 102 | 2.3 |
| 35-39 years | 2,783 | 74 | 2.6 |
| 40-44 years | 1,217 | 30 | 2.5 |
| 45-49 years | 138 | 2 | 1.4 |
| 50 years & over | 4 | — | 0.0 |
| LENGTH OF GESTATION | | | |
| 9 weeks & under | 8,588 | 98 | 1.1 |
| 8-12 weeks | 23,901 | 383 | 1.6 |
| 13-16 weeks | 6,005 | 381 | 6.3 |
| 17-20 weeks | 2,561 | 410 | 16.0 |
| 21 weeks & over | 172 | 23 | 13.4 |
| SURGICAL PROCEDURE | | | |
| Surgical D & C | 8,554 | 136 | 1.6 |
| Suction D & C | 25,822 | 367 | 1.4 |
| Hysterotomy | 1,247 | 53 | 4.2 |
| Hysterectomy | 175 | 13 | 7.4 |
| Saline | 3,565 | 656 | 18.4 |
| Urea | 302 | 34 | 11.2 |
| Prostaglandin | 83 | 11 | 13.2 |
| Menstrual Extraction | 1,417 | 9 | 0.6 |
| Other and unrelated combinations | 62 | 16 | 25.8 |

*Gestational Age.* The majority (58.0 percent) of all reported therapeutic abortions which were done in Canada in 1974 were carried out between the ninth and twelfth weeks of gestation. One out of five (20.8 percent) were done prior to this time, 14.6 percent were done between 13 and 16 weeks, and 6.2 percent between 17 and 20 weeks. Of the 172 therapeutic abortions which were done beyond the twentieth week of gestation in 1974, 158 were done between 21 and 24 weeks, 13 were done between 25 and 28 weeks, and one was done after the twenty-eighth week. **In a majority of the 10 provinces and two territories, over three-quarters of the induced abortions were obtained before 12 weeks of gestation. The proportion of abortions done beyond 12 weeks of gestation was higher in four provinces, namely, 44.6 percent for Newfoundland; 32.0 percent, Prince Edward Island; 34.8 percent, Nova Scotia; and 32.7**

**percent, Manitoba.** These higher rates for women with longer periods of gestation were associated with a smaller proportion of eligible hospitals which had established therapeutic abortion committees.

**The reported complications associated with induced abortion rose with the increasing mass of a pregnancy.** The complication rates per 100 abortions by the length of gestation were: 1.1, under 9 weeks; 1.6, 9-12 weeks; 6.3, 13-16 weeks; 16.0, 17-20 weeks; and 13.4, 21 weeks and over. The retained products of conception was the major complication among all age groups. The rate for this problem as well as for lacerations of the cervix and for the perforation of the uterus was higher in the earlier stages of pregnancy among women who were 19 years or younger, most of whom were pregnant for the first time. This shift may be related to the technical difficulties associated with the gaining of access to the cavity of the uterus through a rigid cervix not previously dilated by an earlier delivery.

*Chronological Age.* Among women who had therapeutic abortions in 1974, the frequency of reported complications was the highest among the youngest group of females. These are women who were just about to enter into the most fertile years of their lives. The abortion rates expressed as a rate per 100,000 women in each age group were highest among females between 15 and 19 years and 20 to 24 years of age. These rates decreased steadily with increasing age. This trend is expected since the fertility rate follows much the same pattern. A more reliable picture of the trend toward the use of induced abortion to terminate unwanted pregnancies can be obtained from the abortion rate expressed as the number of abortions per 100 *live births* by age group. This rate was also high among females between 15 and 19 years, but it dropped rapidly to its lowest point among women between 25 and 29 years. It then rose steadily so that at age 40 to 44 years, the rate equalled that of women between 15 and 19 years. The pattern was similar in all provinces, but it was much less pronounced in some such as Prince Edward Island, while there was a wider disparity in others such as Ontario and British Columbia.

The complication rate, when expressed as its frequency per 100,000 women, followed the same pattern as the abortion rate expressed in the same way. A truer picture of the effects of age on the risks of abortion is obtained if the reported complications are related to the number of abortions which are done in the same age group. This comparison shows that **the risks of complications associated with induced abortion were higher in the younger age groups: 9.3 per 100 for women between 10 and 14 years, and 4.1 per 100 for women between 15 and 19 years. After this age, the ratio remained stable at between 2.3 to 2.8 per 100 until the 45 to 49 age group.** For this older group of women the number of abortions and complications were too small to attach much significance to the lower ratio of 1.4 complications per 100 abortions.

*Previous Pregnancies.* Based on information from Statistics Canada, over half of the women (57.2 percent) who had therapeutic abortions in 1974 had not had a previous delivery and 11.0 percent had had three or more deliveries. A total of 15.1 percent had had a previous abortion—7.2 percent had had spontaneous abortions, and 7.9 percent had had previous therapeutic procedures. The nulliparous women had the highest complication rates in two

of the three categories, suggesting possibly that a previous delivery or therapeutic abortion provided an element of protection, because it was easier to dilate the cervix during the therapeutic abortion procedure. On the other hand, previous spontaneous abortions appeared to increase the risk of complications associated with subsequent therapeutic abortions, particularly if there had been more than one earlier spontaneous abortion. This increase in the number of complications may be due to the more general or local causes of spontaneous abortion, such as endocrine disease, uterine tumor or malformation. In addition, there was a higher proportion of older women who had had previous spontaneous abortions (19.9 percent) compared to women who had had previous therapeutic abortions (6.7 percent). The complication rate in this age group was high—4.8 percent after two spontaneous abortions and 7.6 percent after three previous spontaneous abortions.

*Hospitals Where Abortions Were Done.* Statistics Canada classifies hospitals which perform therapeutic abortions into four groups according to the number of operations which are done annually: 0-50; 51-100; 101-400; 401 and over. The group of hospitals with the highest volume (401 or more operations) which accounted for 70.7 percent of therapeutic abortions done in Canada in 1974 consisted of the larger, **well-equipped, and more extensively staffed institutions whose number included many university-affiliated teaching hospitals.** This group of 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). Hospitals which did between 51 and 100 procedures annually had the next highest rate (5.1 per 100), while the hospitals doing 101 to 400 abortions had a rate comparable to the larger institutions (3.1 per 100).**

**The hospitals performing the largest number of abortions had the lowest complication rate in spite of carrying a larger case load of patients who were in the later stages of gestation when the complication rates for the nation were known to be higher.** The one out of five (21.7 percent) of the procedures done after the twelfth week of gestation in hospitals doing over 400 abortions contrasted to 14.9 percent among this group of patients who were treated at hospitals doing less than one abortion per week (the 0-50 category per year). The only patient who was aborted after 28 weeks of gestation was treated in one of these hospitals which did under 50 such procedures annually. However, the hospitals which did fewer induced abortions admitted more patients who were at a higher risk in terms of their chronological age, those women who were 19 years or younger, or who were over 34 years. These women accounted for 52.5 percent of the admissions to the smaller-volume hospitals compared to accounting for 38.8 percent of the abortion admissions to the larger-volume hospitals. The differences in the rates of complications between the hospitals with the largest and the smallest volume of abortions were in the three categories of haemorrhage, infection, and *other.*

*Other Complications.* Because the national and regional information from Statistics Canada was only available for the early physical complications associated with therapeutic abortions, it was only possible to consider them in detail from this source. Early and late psychiatric and social complications

were not noted in these records, but are dealt with in the analysis of the Saskatchewan and Alberta findings. Similarly, late physical sequelae associated with induced abortion in Canada have not been dealt with except by a few individual researchers who have based their findings on unrepresentative clinical groups of patients. Among the research studies which have been done, there are indications that the physical problems of infection, laceration, and repeated surgical procedures on the uterus can and do produce lasting effects on the health of some women. In addition to the consequences of hysterotomy which have been noted on the subsequent course of pregnancies, lacerations of the cervix can result in scarring and distortion. Research results which are still inconclusive suggest that these effects may lead to the inability of the uterus to retain subsequent pregnancies so that late foetal loss or prematurity may occur.

When illegal abortions were more extensively done, particularly by untrained persons, infertility and chronic pelvic pain were on occasion attributed to the infections which subsequently resulted. This complication does not occur so frequently in hospital-induced abortions, but the infection rate is still not insignificant, particularly among hospitals where the procedure was not frequently done. The obliteration of the cavity of the uterus which is secondary to infection and surgical trauma is a complication which is particularly difficult to correct. Information on a national basis about the psychiatric and social side effects of therapeutic abortions is scarce. Many abortions are done because it is considered that a continuation of the pregnancy would constitute a threat to the emotional health of a woman or affect her family. These patients are frequently not followed up by the psychiatrist who examined them before the abortion operation or by the social worker who was assigned to counsel them. Young single women make up the largest group having therapeutic abortions. It will require time and diligent research to determine what effects these events will have on their future attitudes toward marriage, the family, and child-rearing. Likewise, there is little information about the nature of the complications which may result involving Canadian women who have induced abortions in the United States.

## Before-and-after use of health services in Saskatchewan

The use of health services and the reasons why these services were used by women who had deliveries, spontaneous abortions, therapeutic abortions, and sterilizations were reviewed based on a 10 percent random sample of the Saskatchewan population for 1970 and 1971. There is no other comparable information recording system covering a large and representative group of the population in Canada assembled on this basis for this period, or subsequently, which is known to the Committee. For each of these pregnancy-related events, an assessment was made of the hospital and medical care which was received and reported for a year prior to the operation and for a year following this procedure. The sample was initially taken to study the effects of the introduction of medical care insurance in Saskatchewan between 1963 and 1971. As some persons dropped out of the original 10 percent sample, either by moving

out of the province or by death, their number was replaced on a representative sampling basis. In this sense the women in the sample were not, in the language of survey research, a cohort, but a repeated-time sample by means of which it was possible to trace their health care activities over a period of time.

This information was assembled to include the health experience of persons in the 10 percent sample up to 1971, or two full calendar years after the abortion legislation was amended. By this means, then, it was possible to review in some detail the use of health services as it related to abortion for this two-year period. The population sample included approximately 44,000 families, or about 120,000 individuals out of the provincial population of 926,245 residents in 1971. While their numbers were small, the health care experiences of women who had deliveries, spontaneous abortions, therapeutic abortions, and sterilizations can be considered to be representative of all of the women who had these experiences at that time in Saskatchewan.

The information was assembled by means of an information linkage system, which while preserving the anonymity of each person in the 10 percent sample, brought together their experience from hospital and medical care insurance records.

*Trends in Deliveries and Abortions.* The total number of deliveries with and without associated complications decreased by 36.1 percent between 1959 and 1974. During this period the rate of hospital separations for all categories of abortion declined by 17.1 percent. The steady fall in births which began in 1962 subsequently continued, while the trends in abortions which had been running parallel at that time to the curve for births reversed sharply after 1969. Although there is a minor discrepancy in the numbers of all abortions supplied by the Saskatchewan Health Services Plan and by the Medical Care Insurance Commission, the resulting trends from both sources are the same, namely a continuation of the downward curve from 1969 onward for the overall annual total of abortions. The differences in the two sets of information reflect differences in the medical and hospital records for the population but do not alter the trends in any significant manner. The decline in abortions other than those which were induced in hospital based on these sources becomes either 47.8 percent or 52.7 percent and exceeds the fall in births. These numbers represent 10.4 percent and 9.1 percent respectively of the births and are little different from the relationship which existed in 1959 (12.2 percent) or in 1969 (10.6 percent). The total number of abortions when expressed as a percentage of the births for each year between 1970 and 1974 was: 12.5 percent; 15.8 percent; 16.6 percent; 16.8 percent; and 15.9 percent. These trends indicate that the continued decline in the birth rate of Saskatchewan may have been influenced in part by the increased number of induced abortions, a trend, however, which may be offset by a displacement effect, namely a redesignation of the labelling and coding of these various abortion procedures.

*Family Size and Residence.* Among single women the number of normal deliveries increased from 0.9 percent to 6.5 percent of the total number of deliveries between 1963 and 1968. After 1968 this proportion fell to 2.6 percent and subsequently remained at about this level. Prior to 1969, induced abortions

were more common among women who had families of four or more persons. In 1969 for instance, 3 out of 5 women who had the abortion procedure were from families with three members and the remainder of these women had larger families. There was a shift which started in the early 1970s toward more single women obtaining therapeutic abortions, with their number constituting 29.4 percent of the total group in 1970, a proportion which rose to 42.1 percent in 1971. Until 1967 the largest group of women who had normal deliveries came from families consisting of four or more members, while there was a shift of the largest group involving families of three persons in 1968. Approximately a third of deliveries and abortions in 1970 and 1971 involved women who had families of five or more members.

In recent decades in Saskatchewan there has been an extensive outflow of provincial residents to other parts of Canada and a gradual shift from a rural to a more urban way of life. In 1971 over half of the provincial population lived in cities, with the two largest centres, Regina and Saskatoon accounting for 28 percent of the total population. About a fifth of the people of Saskatchewan then lived in towns and villages and about 1 out of 4 lived in rural farming areas. While women who lived in cities in Saskatchewan in 1971 accounted for about the same proportion of births as their residential distribution, almost two-thirds of the therapeutic abortions (64.9 percent) were performed for women living in urban centres.

*Use of Health Services.* The frequency with which health services are used includes: the hospitalization of patients, their consultations with physicians and the laboratory services which are prescribed for their care. In particular, the number of laboratory services can have an inflating effect when these trends are considered as units of service combined with care received from physicians. The experience of women who had deliveries, spontaneous and other abortions, therapeutic abortions and sterilizations was reviewed from 1970 and 1971 concerning their use of these services. In its work the Committee was advised by a number of experienced gynaecologists that as the professional familiarity with a procedure increased, it could be expected to be done more effectively and efficiently. If this is the case, then the 1971 information on therapeutic abortions which were done in Saskatchewan may be considered to be more representative than the 1970 treatment patterns when 75.1 percent fewer therapeutic abortions were performed (131 in 1970 and 562 in 1971). In the sample of women having therapeutic abortions, they represented 16.0 percent of the provincial total in 1970 and 13.2 percent of the 1971 total.

Differences in the prior utilization of hospital and physicians' services for 1970 and 1971 occurred for women having deliveries, spontaneous and other abortions, therapeutic abortions and sterilizations. These differences were relatively small except for the use of physicians' services by patients having therapeutic abortions. These women made the most use of physicians in each year, but the rate dropped in 1971 and approximated that of women who had spontaneous and other abortions. Both groups of women who had different types of abortions used the physicians' services more extensively than did the women who delivered babies.

TABLE 13.2

## BEFORE AND AFTER USE OF HOSPITAL SERVICES BY AGE OF WOMEN FOR SELECTED PROCEDURES: TIMES HOSPITALIZED PER PATIENT

Saskatchewan, 1971*

SASKATCHEWAN HOSPITAL SERVICES COMMISSION

| Age of Women | Use of Hospital Services: One Year Before (1970) Delivery | Therapeutic Abortion | Other Abortions | Sterilization | One Year After (1972) Delivery | Therapeutic Abortion | Other Abortions | Sterilization |
|---|---|---|---|---|---|---|---|---|
| 17 years & younger | 0.49 | 0.58 | 0.25 | — | 1.23 | 1.00 | 1.00 | — |
| 18-23 years | 0.46 | 0.39 | 0.63 | 1.00 | 1.14 | 1.23 | 1.40 | 1.00 |
| 24-39 years | 0.39 | 0.18 | 0.43 | 0.57 | 1.13 | 1.00 | 1.12 | 0.60 |
| 40 years & older | 0.58 | 0.10 | 0.36 | 0.50 | 1.31 | 1.10 | 1.21 | 0.71 |
| AVERAGE | 0.43 | 0.32 | 0.48 | 0.58 | 1.14 | 1.12 | 1.20 | 0.63 |

* The number of women in each category was: 1,537, delivery; 74, therapeutic abortion; 152, other abortions; and 231, sterilization.

TABLE 13.3

## BEFORE AND AFTER USE OF HOSPITAL SERVICES BY WOMEN: SELECTED DIAGNOSTIC CATEGORIES PER PATIENT

Saskatchewan, 1971*

SASKATCHEWAN HOSPITAL SERVICES COMMISSION

| Diagnostic Categories | Use of Hospital Services: One Year Before (1970) Delivery | Therapeutic Abortion | Other Abortions | Sterilization | One Year After (1972) Delivery | Therapeutic Abortion | Other Abortions | Sterilization |
|---|---|---|---|---|---|---|---|---|
| Complications of Pregnancy, Childbirth, & Puerperium | 0.28 | 0.12 | 0.24 | 0.33 | 1.03 | 1.05 | 1.07 | 0.33 |
| Diseases of Genito-urinary System | 0.04 | 0.04 | 0.07 | 0.07 | 0.03 | 0.03 | 0.03 | 0.08 |
| Diseases of Digestive System | 0.02 | 0.07 | 0.03 | 0.02 | 0.04 | — | 0.03 | 0.04 |
| Mental Disorders | 0.01 | 0.01 | 0.01 | 0.02 | — | — | 0.02 | 0.04 |
| Accidents, Poisonings, & Violence | 0.02 | 0.05 | 0.02 | 0.03 | 0.01 | — | 0.43 | 0.01 |

* Prior to their hospitalization, the five diagnostic categories constituted 86.2 percent of the diagnoses for women who had deliveries; 91.7 percent, therapeutic abortion; 83.1 percent, other abortions; and 79.7 percent, sterilization. In the same order, these five diagnostic categories during 1972 were: 96.5 percent, 96.4 percent, 97.8 percent, and 78.1 percent.

TABLE 13.4

## BEFORE AND AFTER USE OF PHYSICIANS' SERVICES BY AGE OF WOMEN FOR SELECTED PROCEDURES: NUMBER OF MEDICAL CONSULTATIONS AND SERVICES PER PATIENT

Saskatchewan, 1971*

SASKATCHEWAN MEDICAL CARE INSURANCE COMMISSION

| Age of Women | Use of Physicians' Services: One Year Before (1970) | | | | One Year After (1972) | | | |
|---|---|---|---|---|---|---|---|---|
| | Delivery | Therapeutic Abortion | Other Abortions | Sterilization | Delivery | Therapeutic Abortion | Other Abortions | Sterilization |
| 17 years & younger | 8.00 | 13.67 | 11.75 | — | 3.87 | 2.92 | 3.63 | — |
| 18-23 years | 9.10 | 15.57 | 14.02 | 20.38 | 3.95 | 4.77 | 5.84 | 5.25 |
| 24-39 years | 7.84 | 16.00 | 22.25 | 14.16 | 3.78 | 1.64 | 4.65 | 3.51 |
| 40 years & older | 9.09 | 13.80 | 10.71 | 13.82 | 5.64 | 2.80 | 4.50 | 3.58 |
| AVERAGE | 8.36 | 15.11 | 12.52 | 14.32 | 3.90 | 3.27 | 4.89 | 3.58 |

* The number of women in each category was: 1,525, delivery; 74, therapeutic abortion; 142, other abortions; 230, sterilization.

TABLE 13.5

## BEFORE AND AFTER USE OF PHYSICIANS' SERVICES BY WOMEN: SELECTED DIAGNOSTIC CATEGORIES PER PATIENT

Saskatchewan, 1971*

SASKATCHEWAN MEDICAL CARE INSURANCE COMMISSION

| Diagnostic Categories | Use of Physician's Services: One Year Before (1970) | | | | One Year After (1972) | | | |
|---|---|---|---|---|---|---|---|---|
| | Delivery | Therapeutic Abortion | Other Abortions | Sterilization | Delivery | Therapeutic Abortion | Other Abortions | Sterilization |
| Complications of Pregnancy, Childbirth, & Puerperium | 1.60 | 1.35 | 2.22 | 0.91 | 0.08 | 0.10 | 0.41 | 0.02 |
| Diseases of Genito-urinary System | 1.08 | 1.86 | 2.97 | 2.44 | 0.81 | 0.87 | 1.34 | 0.68 |
| Diseases of Digestive System | 0.20 | 0.23 | 0.20 | 0.67 | 0.23 | 0.01 | 0.17 | 0.17 |
| Mental Disorders | 0.25 | 0.21 | 0.67 | 0.61 | 0.16 | 0.27 | 0.30 | 0.25 |
| Accidents, Poisonings, & Violence | 0.21 | 0.49 | 0.29 | 0.25 | 0.12 | 0.16 | 0.15 | 0.20 |

* During the year before their operation, the five diagnostic categories constituted 39.9 percent of the diagnoses for deliveries; 47.4 percent, for therapeutic abortion; 50.7 percent, other abortions; and 34.1 percent, sterilization. In the same order these five diagnostic categories during the year after were: 35.8 percent, 40.5 percent, 35.1 percent, and 36.9 percent.

In the case of all of these women, the use of laboratory services is included in these rates. As well, for women obtaining therapeutic abortions two additional factors contributed to their greater use of physicians' services prior to the abortion operation. Based on the estimates of the national patient survey, in which 16.5 percent of abortion patients saw three physicians, 3.9 percent saw four physicians, and 1.1 percent saw five physicians in their seeking of a therapeutic abortion, 4.7 percent or more of the visits of Saskatchewan patients can be accounted for by visits to physicians who were not prepared to assist them. In addition, since the requirements of therapeutic abortion committees usually call for at least two medical consultations prior to the submission of an abortion application, 6.7 percent of their prior visits were involved in making these visits. If these additional steps had not been involved, then the one-year prior use of physicians' services by women who had therapeutic abortions in Saskatchewan in 1971 would be reduced by 11.4 percent or to a level (13.39 services) more comparable to women who had spontaneous and other abortions (12.52 services).

In contrast with women who had deliveries and spontaneous and other abortions, the one year prior use of hospital services by women who had therapeutic abortions was substantially lower, while the post-pregnancy use of hospital services of the groups of women was comparable. However, during the year following their pregnancy-related operations, women who had therapeutic abortions in 1971 used physicians' services 16.2 percent less than women who had childbirth and 33.1 percent less than women who had spontaneous and other abortions. What these trends indicate is that women who had therapeutic abortions had less medical follow-up care than other women who had deliveries and who had spontaneous and other abortions.

*Reasons for the use of Health Services.* Compared to the three other groups of women, the women who had induced abortions in 1971 had been *hospitalized* half as often prior to their operations for complications associated with their pregnancy, but they had had more digestive disorders and double the rate of accidents which had resulted in their hospitalization. Their prior hospitalization for mental disorders was comparable to the experience of women who subsequently had spontaneous and other abortions. During the year following their induced abortion, the hospitalization of these women was comparable in terms of complications associated with pregnancy, childbirth and the puerperium to the prevalence of these disorders among women who had deliveries and other types of abortions. Unlike the three other groups of women, none of the abortion patients were hospitalized during the year after their operation for digestive system problems, mental disorders, or as a result of accidents or violence.

In their use of *physicians' services* during the year prior to their operation, in 1970, women who had therapeutic abortions in comparison to women who had had deliveries had: fewer complications associated with their pregnancies; more genito-urinary problems; about the same number of digestive system problems; a comparable number of mental disorders; and double the number of conditions resulting from accidents or violence which required medical treatment. In contrast with women who had spontaneous and other types of

abortions, during the year prior to their operation, the reasons why abortion patients had consulted physicians were: about 40 percent less often for pregnancy-related conditions; two-thirds less often for the treatment of mental disorders; and about twice as often for visits resulting from accidents or violence.

During the year after their operation the women who had therapeutic abortions were treated about as often as women who had deliveries for pregnancy-related problems and disorders of the genito-urinary tract. But unlike the women who had deliveries, these women were diagnosed by their physicians 40.8 percent more often as having mental disorders and 25.0 percent more often for the treatment of accidents or conditions resulting from violence. In comparison to women who had spontaneous and other abortions, substantially fewer women who had induced abortions visited their physicians during the year after their operation for pregnancy-related conditions or diseases of the genito-urinary tract. During this period following the termination of their pregnancies, the experience of the two groups of women who had abortions was about comparable in terms of their use of physicians' services for mental disorders and requiring treatment for accidents.

While the number of women involved in each of the three pregnancy-related operations was small, their experience with the use of hospital and medical services and the complications which they experienced are considered to be representative of women in Saskatchewan who had similar operations. In considering these findings, it is known that they neither represent complications which may occur over a longer period of time nor the experience of Saskatchewan women who obtained induced abortions in the United States. Saskatchewan's long-established background in the public provision of hospital and medical care services may also affect the general health status of its people and how they use these services. As well there are differences among the women in the three groups in terms of their age, marital status and parity.

Within the context of these unknown factors, what the findings indicate is that **women who had therapeutic abortions appeared generally to be in good health after their operations. In a small before-and-after study in Saskatchewan 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 deliveries or spontaneous and other abortions. In terms of the health services which they obtained, their level of mental health was comparable to women who had spontaneous and other abortions, or who had been sterilized. These three groups on an average subsequently consulted physicians twice as often for reasons related to mental health than women who had term deliveries.**

## Five year follow-up in Alberta

In a five year retrospective study (1970 to 1974) a review was made of the use of health services of a group of women who had had induced abortions in

1970 compared to the experience of women who had not had this operation. Involving 101 women who had had therapeutic abortions and 100 women who were matched by age who had not had an induced abortion, the samples were drawn from the records of the Alberta Health Care Insurance Commission; a tabulation was made of the total reported use of hospital and medical services of the two groups. Omitted from the analysis of each group were those women who may have left the province during this five year interval. Because on an average younger women, more of whom are single, obtain induced abortions, this comparison involves a review of their health experience with a broader range of women more of whom may have been married. Unlike the women whose before-and-after use of health services was reviewed in Saskatchewan, the findings for Alberta did not consider the prior use of services of both groups of women, nor was there a matching of the two groups involving pregnancy-related experiences (e.g., delivery, spontaneous abortion, therapeutic abortion). It is in the context of how these findings were obtained and to whom they relate that the trends which are observed must be interpreted.

In reviewing the *hospitalization* experience over five years of the two groups of women, some of the findings from this exploratory study were:

- abortion patients had more subsequent hospitalizations (64 percent versus 52 percent).
- abortion patients had more subsequent abortions (12 percent versus 3 percent).
- fewer abortion patients were subsequently sterilized (3 percent versus 10 percent in the control group).
- hospitalization for gynaecological problems—none of the abortion patients subsequently had spontaneous abortions, while there were two in the control group; seven abortion patients versus two control group patients had subsequent gynaecological bleeding problems; the incidence of inter-menstrual bleeding was more than twice as high among abortion patients than among other women, but the incidence of pelvic inflammatory disease was greater among other women than among women who had had induced abortions.
- complications associated with pregnancy occurred among five abortion patients one of whom had pre-eclampsia.
- subsequent deliveries—22 percent, abortion patients; 32 percent, control group of women. Eight patients in each group appear to have had difficult deliveries.
- perinatal deaths—none among the control group; one stillbirth by a woman who had a therapeutic abortion.
- newborns—no premature infants were born to women in the control group, while there were two premature infants born to women who had had induced abortions.
- psychological problems—13 percent of the women who had had therapeutic abortions were subsequently hospitalized with psychological problems, four of which involved an overdose of drugs. Four percent of the women in the control group were hospitalized with psychological problems one of whom was an alcoholic.
- other reasons for admission to hospital—38 percent, abortion patients; 25 percent, control group. The reasons for these admissions ranged from tonsils to varicose veins. Four of the women who had abortions subsequently had elective plastic surgery breast operations.

In addition to the hospitalization experience of the two groups of women, their use of the *services of physicians* was documented for the five-year period. The major trends in their use of *medical services* were:

- visits to physicians—overall, a greater use by women who had an abortion (29 percent) than among the other women (13 percent).
- gynaecological problems—72 follow-up visits to physicians for women who had had abortions compared to 47 visits for this purpose by other women.
- obstetrics—in 1975, nine women who had had induced abortions had deliveries as did almost an equal number of other women (10 deliveries).
- psychological problems—women who had therapeutic abortions subsequently made more visits to psychiatrists (25 percent) than other women (3 percent).

In considering the findings obtained in this small study of Alberta women, it is important to recall that the experience of women who had induced abortions was compared with the use of health services of a cross-section of other women. The women in the matching (or the control) group were not selected on a basis of having had a pregnancy-related experience, that is, a delivery or a spontaneous and other abortion. For this reason the Committee draws no conclusions from the findings of this study.

## National trends

The studies of therapeutic abortion which were done in Saskatchewan and Alberta are a useful beginning, but just that. A fuller understanding of what might be involved will require a prospective analysis, one which in addition to reviewing the use of health services considers the experience over a period of time of women who had: (1) deliveries; (2) therapeutic abortions in Canada; (3) induced abortions in the United States; (4) spontaneous and other abortions; (5) unwanted pregnancies; and (6) single mothers. For each group of these women such a prospective study should consider in more detail than was possible in the Saskatchewan and Alberta studies their social circumstances and how they usually obtain health care. It is apparent for instance that women who obtain therapeutic abortions are predominantly young and single. Many of these women have difficulties in obtaining physician referrals for the procedure or experience delays once such consultations have been made. In addition to affecting their prior use of health services as well as influencing the diagnoses which may be made by physicians (e.g., the widespread use of the medical diagnosis of reactive depression), the stigma associated with induced abortion can be expected to influence the subsequent use of hospital and medical services of women who have therapeutic abortions and in turn, it may affect how physicians whom these women consult provide treatment and the types of diagnoses which may be used. Studies are needed which would provide information to some of these questions. Such studies are methodologically feasible. In terms of their costs such studies would constitute a fraction of the health costs now spent directly on the treatment services for these problems.

Based on the information collected by Statistics Canada certain trends emerge involving the early physical complications of therapeutic abortion. These trends are:

1. The risk of early physical complications increased:
   - with the gestational age of pregnancy;
   - if the woman was pregnant for the first time;
   - if the woman had previous spontaneous abortions;
   - among the youngest and oldest age groups;
   - when the procedure was carried out in a hospital doing fewer than two abortions per week.

2. There was no national information available to determine the nature and frequency of the long-term physical complications and of the emotional and social problems associated with therapeutic abortion. Such information is not readily accessible by means of the current national reporting system.

**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 specially trained nurses and medical personnel.** The information which is available about therapeutic abortions and the complications associated with this procedure represent a minimal reporting system, but it is a largely unused resource for the surveillance of complications, their regional distribution, their extent by the types of procedures used and by the size of the hospitals doing these procedures. If these complex issues and their resolution are to be more fully understood, more extensive, long-term and interdisciplinary investigation is required. Obtaining such information and the raising of the standards of health care do not come about easily or by themselves. Their development requires firm and continuous public support. Until this stage is reached, the knowledge about these issues will be partial and it is likely that the problems posed will not be reduced or even contained.

The findings on complications associated with therapeutic abortions indicate that their frequency was lower in the hospitals which did a higher annual number of these procedures. **The implications of these findings are that the performance of therapeutic abortions, like the treatment of other conditions requiring specialized facilities and staffing, could be effectively handled through the principle of regional centres which would bring together the required resources and incorporate into their functions interdisciplinary research efforts. These means might focus on several problems which emerge from the trends on abortion complications. 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 use of the techniques which are available for contraception and early induction, or to finding more acceptable methods for these purposes.**

Chapter 14

# Sexual Behaviour and Contraception

Sexual behaviour has two masks in Canadian society. Alternately, it is private or public, sacred or profane, and wholesome or obscene. Reflecting a gradual change in values, some aspects of sexual behaviour which a short while ago were censored or considered to be criminal are now more widely accepted. There has been much fantasy and ignorance and little fact about the changes in sexual behaviour and contraceptive use which have taken place and what they mean to our way of life. Dual standards are widespread. What an individual might do and accept personally, he might not say in public or accept in individuals who hold high public office. This conflict between private practice and the public morality and the inconsistency of values held about usual sexual behaviour is very much a part of how abortion is seen and dealt with in Canadian society.

There has been a proliferation in the use of sexual images in almost every aspect of daily life. In newspapers, television, and billboards, sexual glamour is used either subtly or directly to sell merchandise, to stimulate ideas about feminine and masculine roles, or on occasion, to promote public programs. These changes have occurred so gradually, but have become so pervasive, that they have minted new customs which are distinctive from those of the previous generation. Despite these trends many Canadians from different walks of life are uneasy when they discuss usual sexual behaviour and the use of contraception. Many persons either withdraw from a discussion of these issues, deal with them in a bantering fashion or adopt in public values which are a masquerade for what is actually done. So prevalent and one-sided is the emphasis on what it takes to be seen to be fully feminine or masculine, that it is often forgotten there is a negative social residue stemming from sexual activity.

While the image of the sexually active person is aroused by various means as a desirable pursuit, the consequences of illegitimate birth or induced abortion invoke a harsh stigma, and in general, are considered to be abhorrent by society. While there may be greater tolerance about illegitimacy now than in the past, few Canadians today enjoy being called by derogatory sexual epithets. A great deal of public attention has dealt with the social cosmetics of making men and women more stimulating and attractive to each other. But little is known, and because there is much stigma involved, little has wanted to

be known, about the socially rejected outcomes of sexual intercourse. Because information about what is the usual experience in these respects is scarce, how to deal with the unusual aspects of sexual behaviour is made more difficult for the law and the healing professions. We know little about the extent of sexual offences and the treatment, or the appropriate services for sexual offenders. There is no accurate documentation of the prevalence of sex-related diseases such as syphilis or gonorrhea, or their social implications for the Canadian population. Many teenagers who are under the age of legal majority have sexual intercourse. The mainstream of public morality in what is a collective ethical fantasy ignores these events. Minors and their partners who have had sexual intercourse are seldom charged under existing legal provisions. While deploring illegitimacy and abortion, Canadian society has had a blind eye when it comes to seeking an understanding of these issues and how they may be resolved.

Tens of thousands of women and their partners in Canada have had to face up to the dilemma of an unwanted or an unexpected pregnancy. Many women in this situation get married, or if they are married, give birth to unwanted children. When this is not done, most single women who have an unwanted pregnancy are faced with two socially condemned choices—the birth of an illegitimate child or an induced abortion. Between 1970 and 1973 there were 1,432,244 deliveries of which 130,543 were illegitimate births. During these years there were 124,129 officially reported therapeutic abortions. Together, illegitimate births and therapeutic abortions constituted 1 out of 6 (17.8 percent) of all deliveries in this four year period.

Because there is still much social ignominy associated with either outcome, these women seek counsel from only a handful of relatives and friends. Particularly for young women who are frightened by their dilemma, there is often a delay in seeking professional advice. Seldom discussed except under unusual circumstances, the fact of an illegitimate birth or an induced abortion is recalled with deep emotion as an intense personal experience. It is often kept as a life-long secret, one which is seldom shared because of an anxiety and a fear that what has been done may become known and jeopardize a marriage or a career at work.

The demographic contours of the Canadian population are well known in terms of the array of measures which are commonly used to gauge its composition. The birth rate has been declining, infant and maternal deaths are substantially lower, the average size of families has been getting smaller, and Canadians as a people now live longer than in the past. The number of births and the size of families vary by the social circumstances of individuals. The general characteristics of women who obtain induced abortions in Canadian hospitals are also known. In comparison with Canadian women giving birth in the reproductive years, these women are younger and more of them are single. But what is unknown in these vital statistics is precisely what it is that is vital to effecting these differences.

The unstated assumptions upon which the analysis of population growth and abortion are based are the facts of what is the usual sexual behaviour of

people and what measures they take to limit their fertility. The indices used in the study of population and abortion trends mean little unless it is known whether they represent fundamental differences in what is the usual sexual behaviour of individuals or in the nature of the birth control measures which they use. It has long been known that fertility and sexual activity vary greatly among individuals. In this context what is the experience of women who obtain abortions? Are they more or less sexually active than the average Canadian woman, or does the fact that they seek abortions mean they have had less experience or knowledge of the means of contraception? The Terms of Reference set for the Committee asked the question: "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?" Information dealing with this question was taken from the national population survey and the national patient survey.

## Definitions of terms used

A number of terms with specific definitions were used in the analysis of the sexual behaviour and the use of contraceptive means of women who have had induced abortions. Sexual behaviour refers in this Report to sexual intercourse, any means used to limit or prevent conception, and subsequent steps which may be taken to alter the outcome such as interrupting a pregnancy. The means of contraception which are commonly used include: oral contraceptives (pills); condoms (safes, rubbers); intra-uterine device (I.U.D., loop, coil); coitus interruptus (withdrawal, pulling out); rhythm (safe period); vaginal spermicides (foam, cream, jelly or suppository); diaphragm (cap); or sterilization (tubal ligation, vasectomy). The effectiveness of contraception refers to the extent to which its use limits conception from occurring, and this result can also be defined in terms of theoretical effectiveness versus their effectiveness in actual use.

Fecundity and fertility are two related aspects of reproduction which refer respectively to a woman's biological capacity to conceive and to having had a conception. An unknown number of women in Canada, sometimes estimated to be between 5 to 10 percent, cannot conceive. General studies of the population usually consider the experience of women in the reproductive years between the ages of 15 and 44 years. The fertility of these women is measured in terms of the range of outcomes of conception. These outcomes of pregnancy calculated in terms of frequency per 1,000 women involved include: (1) live births (premature childbirth and full-term childbirth); (2) the death of the infant (neonatal, perinatal, and infant deaths); (3) the death of mothers; (4) spontaneous abortions which are defined as the termination of a pregnancy from natural causes; and (5) induced abortions. The difference between the potential and the actual fertility rate is the total number of women who have conceived minus the number of conceptions which do not result in the live birth of a child (infant deaths and abortions).

A woman's fertility, or the fact of conception, can be limited by a number of optional means. The moral imperatives of our way of life, while not vigorously adhered to, sanction sexual intercourse between women and men who are married to each other. For those individuals who abide by these values, being single or the loss of a partner through death, separation or divorce, are means of limiting their fertility. Their decision of abstinence effectively limits their fertility. A major change in the reproductive behaviour of Canadians whose repercussions have not been precisely documented in terms of fertility or population policy has been the marked upsurge since the start of the 1960s in the use of various means of contraception. In its work the Committee has sought to document the distribution of contraceptive means, the extent to which they are used, and by whom, and the implications of their use for women who have had induced abortions. There is little accurate information on this issue which is important to an understanding of changes in the nation's birth rate and in terms of population growth in the future. Sterilization, the tying of the tubes, which prevents conception, has become an operation which is now extensively done. So rapid has the change been in this respect that its permanent impact on the size of the average Canadian family and on the total size of the population are just now being recognized. The use of this permanent means of contraception varies substantially from one region to another in the country, the extent to which it is used being inversely correlated with the values which individuals hold about the propriety, the effectiveness, the safety or the convenience of the use of other forms of contraception.

All categories of abortion are the final means by which the potential fertility of women is limited. While spontaneous abortions are defined as resulting from natural biological causes, that this is so is not readily apparent from their uneven provincial distribution throughout Canada, their changing prevalence by the type of ownership of hospitals, or their variable frequency among hospitals which have established or have not established therapeutic abortion committees. In addition to spontaneous abortions and the sizeable number of abortions not specified as induced or spontaneous which are reported each year, the rising number of induced abortions serves to limit directly the potential fertility of women in the reproductive years between 15 and 44 years.

## Sexual behaviour of males

The sexual behaviour of males and their use of contraceptive means are the unknown sides of the issue of induced abortion. The point is often tacitly forgotten that sexual intercourse involving males and females frequently includes the decision of both partners to use or not to use contraception. There is no baseline study which establishes whether the sexual behaviour of men and women in Canada has changed over the years. The rough indicators on this point are contradictory in their implications: a falling birth rate which may suggest less sexual activity contrasted to the recent higher sales of contracep-

tives which would indicate a relatively frequent occurrence of coitus. What can be said is that the sexual activity of many Canadians starts during their early to mid-teens and continues over a period of several decades. Coupled with a rising level of sexual activity, which increases with age and marriage, there is a selective increase in the use of contraception which varies by the different social circumstances of men and women.

For all of the males in the national population survey, 16.0 percent said they never had coitus, 21.1 percent had coitus once monthly or less often, 26.6 percent had coitus once weekly, and 36.3 percent had coitus several times each week. Overall, males in the national population survey had coitus on an average of 1.19 times each week. For males who were 15 years, 30.0 percent had had coitus of whom 25.0 percent had this experience once a month or less often and 5.0 percent once a week. These proportions rose amoung males between 16 and 17 years, with 41.6 percent having had sexual intercourse. The frequency of coitus increased among this age group, with 27.3 percent of males between 16 and 17 years having coitus once a month or less often, 8.4 percent once a week, and 5.9 percent several times each week. Most of the young males between 15 and 17 years were single and still attending high school. Because the sample used in the national population survey was drawn to be representative of the Canadian population, these findings on the level of sexual activity of young males are taken to be representative of the experience of other young males in the population across Canada. Overall, the findings indicated that 2 out of 5 young males between 15 and 17 years in 1976 regularly had coitus.

As the age of young males rose, their level of sexual activity increased. For many males this change coincided with their marriage. Among young adult males between 18 and 23 years, 27.0 percent had not had coitus, 26.6 percent had sexual intercourse monthly or less often, 20.5 percent weekly, and 25.9 percent several times each week. Between the ages of 24 and 49 years, males of these ages had the highest levels of sexual activity among all the males who were surveyed. Few males between 24 and 49 years had never had coitus (4.8 percent between 24 and 29 years, and 1.3 percent between 30 and 49 years) and over 80.0 percent had coitus weekly or several times each week. This trend declined for males 50 years and older, of whom 16.0 percent never had coitus, 34.3 percent had coitus once a month or less often, 32.5 percent once a week, and 17.2 percent several times each week.

Combined with age, a male's marital status was the second major factor accounting for differences in the levels of usual sexual activity. A third of single men (36.2 percent), a majority of whom were teenagers or young adults, never had coitus. A fifth of single males (20.1 percent) had coitus several times each week. In contrast, 4.0 percent of married men never had coitus, while 33.5 percent of married men had coitus once a week, and almost half, or 45.2 percent, had coitus several times each week. The sexual activity experience of the once married men, those males who were widowed, divorced, or separated, closely parallelled the level of frequency of coitus of single men.

Two characteristics of males—their age and marital status—accounted for the major differences in the frequency of sexual intercourse among the

Canadian men in the national population survey. None of the several other social characteristics of males accounted for more than 1.0 percent of these differences, and in some cases had even a more negligible effect. The attributes of males which might be related to the usual frequency of sexual intercourse were a male's level of education, his type of work, the language he spoke or his religious affiliation.[1] If each of these attributes are considered separately, it would appear that substantial differences might occur as for instance by a male's level of education or his religious affiliation. For the most part these trends are spurious. They tend to disappear when they are analyzed by means of the statistical procedure of multiple regression. Overriding most of these apparent differences were a male's age, his marital status and the extent to which a means of contraception was used. Younger and single males less often had sexual intercourse than older married males, and among all males, the frequency of sexual intercourse increased with the use of contraception. These results tend to set aside certain popular myths about the particular virility of one or another group in the population. They indicate that the sexual behaviour of Canadian males is largely a function of maturation and marriage, regardless of what other special attributes males may have.

## Sexual behaviour of females

The overall frequency of coitus reported by women and men in the national population survey was almost identical. Small-scale studies relying on information from a selected group of individuals and some work done in other countries have found on occasion not readily accountable differences in the overall frequency of sexual intercourse between the sexes. The weekly frequency of coitus was 1.18 among females compared to 1.19 among males, or it was essentially identical for both sexes representing an average frequency of coitus five times each month.

Most of the females who were 15 years (91.7 percent) had not had coitus. This proportion declined to 81.4 percent for females between 16 and 17 years. The weekly frequency of coitus was 0.12 for females in this age group (15 to 17 years). This pattern changed sharply for young women between 18 and 23 years, 60.1 percent of whom had coitus and all women of these ages had coitus on an average of once a week (0.98 times each week). Women between 24 and 29 years had the highest coital frequency among all age groups of both sexes of 1.87 times each week. One out of twenty women (5.1 percent) in this age group never had coitus. This level of sexual activity was maintained by females between the ages of 30 and 49 years, but declined sharply among women 50 years and older who had coitus on an average of once every two weeks. A third of these older women (35.2 percent) never had coitus.

The bell-shaped distribution by age of coital experience among females, a distribution which was initially low, then high, and followed by declining rates as age increased, was comparable when the proportions of women who had

[1] Appendix 1, *Statistical Notes and Tables*, Note 4.

coitus once a week and several times each week were considered. The proportion of women in each age group who had coitus once a week or more often was: 2.8 percent for females 15 years; 9.0 percent between 16 and 17 years; 42.9 percent between 18 and 23 years; 87.5 percent between 24 and 29 years; 82.0 percent between 30 and 49 years; and 31.2 percent for females who were 50 years and older.

The age of the sexual partners of young females between 15 and 17 years was unknown. Among these females, 8.3 percent who were 15 years, and 18.6 percent between 16 and 17 years had had sexual intercourse. In these categories for brides and grooms in Canada in 1974, 0.05 percent of the females who were married were under the age of 15 years, 0.31 percent were 15 years old, and 1.78 percent were 16 years old. None of the males married in 1974 were under 15 years, 0.001 percent were 15 years old, and 0.07 percent were 16 years old. On the basis of these rates by age of marriage and the usual discrepancy in the ages of females and males at the time of marriage, it is likely that most of the sexual partners of these young females were their age or older.

The frequency of coitus varied directly with the marital status of females. Almost two-thirds (63.9 percent) of single women never had coitus and the average weekly frequency for these women was 0.44. The coital experience of women who had once been married (widowed, divorced, separated) was similar to single women, with both groups having coitus on an average of once every two weeks (0.44 for single women; 0.49 for widowed, divorced, and separated women). In contrast, almost all married women (97.3 percent) had coitus with an average frequency of 1.57 times each week. The proportion of women who had coitus weekly or more often was: 21.6 percent for single women; 81.2 percent for married women; and 25.4 percent for women who were widowed, divorced, or separated.

The frequency of coitus varied by the ages of women and men, a fact largely accounted for by the social mores relating to the patterns of courtship and marriage in Canada. It is a broadly held practice in courtship and marriage that men are usually slightly older than women. The age at marriage of brides and grooms in Canada is an example of this trend. Of the women who were married in 1974, 27.2 percent were between 15 and 19 years, 45.8 percent between 20 and 24 years, 13.2 percent between 25 and 29 years, 8.6 percent between 30 and 44 years, and the remainder, 5.2 percent, were 45 years and older. In contrast, fewer young males were married but proportionately more men who were older were married. Among the males who were married in 1974, 7.9 percent were between 15 and 19 years, 48.9 percent between 20 and 24 years, 23.0 percent between 25 and 29 years, 13.3 percent between 30 and 44 years, and 6.9 percent were 45 years and older. Overall, almost 3 out of 4 women (73.0 percent) who were married in 1974 were under the age of 25 years, while only slightly over half of the men (56.8 percent) were in this younger age group. Conversely, fewer women (13.8 percent) than men (20.2 percent) were married who were 30 years or older.

With the exception of young females and males between 15 and 17 years, a majority of whom were single and still attending high school, the frequency

of coitus of females and males parallelled the usual age differences at marriage of members of both sexes. Women who were between the ages of 18 and 29 years had an overall 4.6 percent higher frequency of coitus than males of the same age. For both sexes the highest frequency of coitus, averaging between seven and seven and a half times a month, occurred for individuals between 24 and 29 years. The frequency of coitus decreased among older females and males, with the trend among the younger individuals being reversed. Among individuals who were 30 years or older, men had a 17.3 percent higher frequency of coitus than women, a difference which is partly accounted for by the usual difference in the ages of the couples.

As with males, the age and marital status of women were the major factors which accounted for their frequency of sexual intercourse. None of the other general attributes of a woman's circumstances was related to differences in the frequency of sexual intercourse. In a multiple regression a total of 25 variables were considered of which 21, such as education, religion, or language usually spoken, each accounted for less than one percent of the variance.[2] What these results of the regression analysis mean is that for the women from whom information was obtained in a nationally representative sample of the population, and within the context of the types of information which were available, their frequency of sexual intercourse was highly correlated (49.8 percent) with three attributes. These were: (1) maturation (age and marital status); (2) availability of a sex partner; and (3) the reliability of the contraceptive method. More young and single women never had coitus and among those who did their frequency of sexual intercourse was substantially lower than among older and married women. Predictably, the occurrence of coitus and its frequency were the highest among married women in the child-bearing ages. These levels declined with age and the loss of male partners. A third factor which accounted for the occurrence and the frequency of coitus was the use of contraception. These levels were significantly lower among those women who either felt contraceptive means were not needed or who used none. Their lack of use served as a restraint to coitus. Again, as in the case of males, some popularly held myths about the alleged characteristics of sexually active women are not supported on the basis of these findings. It was a woman's age, her marital status, and her use of contraception (or by her partner), which accounted for the occurrence and the frequency of sexual intercourse.

When these findings are considered in the context of the demographic composition of the nation, certain predictable trends emerge. Broadly, these trends are influenced by the ratio of women to men in each region, the relative youthfulness of a region's people, the proportion who are married and the relative use or the non-use of contraception. Across the country in 1971 there was a marked east-to-west difference of 19.1 percent in the ratio of women to men who were between the ages of 15 and 49 years. In the Maritimes for instance, where there were more women than men in these age groups, the ratio was 1:0.85, while the trend was reversed in British Columbia with men outnumbering women by a ratio of 1:1.05. To the extent that these broader

[2] See Appendix 1, *Statistical Notes and Tables*, Note 4.

demographic differences occurred, there was almost a marketplace trend, but only that, involving the proportion of females and males between the ages of 15 and 49 years and their general level of coital frequency. Where men in these ages outnumbered women, there tended to be a higher weekly frequency of coitus. Conversely, where women substantially outnumbered men, as in the case of the Maritimes, the general frequency of coitus was lower. In the terms of the ratio of women to men between 15 and 49 years in each area, or for each woman how many men there were, the regional distribution with the average weekly frequency of coitus among women and men was:

| Region | Ratio of Women to Men 15 to 49 Years | Weekly Frequency of Coitus of Women 15 to 49 Years | Weekly Frequency of Coitus of Men 15 to 49 Years |
|---|---|---|---|
| Maritimes | 1:0.85 | 1.15 | 1.01 |
| Quebec | 1:1.01 | 1.03 | 1.21 |
| Ontario | 1:1.03 | 1.16 | 1.10 |
| Prairies | 1:1.03 | 1.18 | 1.50 |
| British Columbia | 1:1.05 | 1.30 | 1.29 |

The Committee found no evidence to suggest that there were biological differences affecting the prevalence of sterility among women and men in different areas of the country. In the absence of such information, it is concluded that three social factors accounted for the differences between the fertility rates of women and their frequency of coitus. Based on their self-reports, while females and males were more sexually active in the West than in the East, a trend accounted for by different ratios of women to men, there was no direct relation with these trends and the number of children who were born in each region. Combined with different female-male regional distributions which accounted for different levels of sexual activity, two intervening factors masked the general fertility rates of women living in the five regions. These factors were the prevalence of induced abortions which were obtained in each area, a rate which was substantially lower in the East than in the West, and the regional differences in the relative use of contraceptive means including surgical sterilization.

## Social meanings of sex

On the basis of previous work, much of which comes from the United States and the United Kingdom and seldom from basic inquiries done in Canada, it has been found that the accuracy of reporting of the sexual behaviour of females and males varies by their social circumstances and their satisfaction with the sexual partnership. In the case of some studies which have been done in the United States, these trends have been based on "samples"

which usually over-represent the experience of middle-income, married, and college-educated whites. The explanation sometimes given to account for the differences in the reported sexual behaviour of females and males is that there is a broadly held myth that men may have stronger and more constant sexual needs than women. According to this perspective women are expected to defer to the wishes of their male partners, in short, to be more submissive and, if married, to consider having coitus as part of their marital duties. Other studies involving a handful of individuals have suggested that the preferred frequency of coitus may not be constant, but vary for both sexes by their sense of mutual satisfaction and their degree of personal accommodation to each other. The preference for the frequency of coitus may be similar between the sexes, higher for women, or alternately, higher for men. The general conclusion, albeit a tentative one, from much of this work suggests that women report more accurately than men about the nature of their sexual behaviour, and usually more men than women say they prefer to have coitus more often. These time-dated findings do not reflect the broad move toward social parity which is occurring between the sexes in all respects, a trend which has been gaining momentum and can be expected to reshape fundamentally how women and men see sexual behaviour, what they expect from their partners, and the extent to which they honestly discuss these socially sensitive issues.

While the average frequency of coitus of females and males was the same for individuals in the national population survey, there were some marked and consistent differences. The average weekly frequency of coitus was substantially higher for males than females who were: young (0.12 females versus 0.18 males, or by 50.0 percent in the 15 to 17 year age group); single (0.44 females versus 0.71 males, or by 61.3 percent); or widowed, divorced or separated (0.49 females versus 1.88 males, or by 283.6 percent). Overall, these men said they had coitus more frequently than women who had similar social circumstances. Conversely, substantially fewer men than women in each of these categories said they had never had coitus. This difference was particularly marked for young and single males, and males who were widowed, divorced or separated.

With the exception of once-married males, married women and men had the highest levels of coital frequency. Married women reported having coitus slightly more often than married males, but the difference was negligible. Few in each group never had coitus. Both single males and those men who had been widowed, divorced, or separated had substantially higher rates of sexual intercourse than women in these marital categories. Without considerable additional analysis which goes beyond the scope of this inquiry, it is not apparent why this is so, or indeed, if it is actually the case. For both of these types of men, the young single males and the older once-married men, there may be over-reporting of their actual coital experience, a fact which results from their perspective of what it takes to be seen to be masculine.

Two ideas involving an individual's memory—the length of recall and the saliency of the event—may be relevant in accounting for some of the differences in the reported frequency of coitus of young males and older men which was higher than the rates cited by women of comparable ages. The sexual

values of Canadian society put considerable emphasis on the fact that having coitus is integral to being masculine. Men more than women are prone to boast about their sexual "conquests". In the folkways of young males who socially and physiologically are in transition between childhood and manhood, there is much braggadocio about their sexual potency and their alleged sexual liaisons. It is often thought that to be a man is to be sexually intrepid, and to be seen to be so. From the information obtained in the national population survey it is not readily apparent from the higher rate of coitus of once-married men and young males between 15 and 17 years than females, with whom sexual intercourse occurred unless this happened extensively with older women by younger men and between older men and younger women.

TABLE 14.1

COITAL EXPERIENCE OF FEMALES AND MALES

NATIONAL POPULATION SURVEY

| Characteristics of Individuals | Coital Experience | | | |
|---|---|---|---|---|
| | Females | | Males | |
| | No Coitus | Coitus | No Coitus | Coitus |
| | percent | | percent | |
| AGE | | | | |
| 15 years | 91.7 | 8.3 | 70.0 | 30.0 |
| 15-17 years | 81.4 | 18.6 | 58.4 | 41.6 |
| 18-23 years | 39.9 | 60.1 | 27.0 | 73.0 |
| 24-29 years | 5.1 | 94.9 | 4.8 | 95.2 |
| 30-49 years | 5.2 | 94.8 | 1.3 | 98.7 |
| 50 years & over | 35.2 | 64.8 | 16.0 | 84.0 |
| EDUCATION | | | | |
| elementary | 28.9 | 71.1 | 20.8 | 79.2 |
| high school | 25.6 | 74.4 | 19.9 | 80.1 |
| technical | 20.0 | 80.0 | 5.0 | 95.0 |
| college/university | 21.7 | 78.3 | 10.8 | 89.2 |
| MARITAL STATUS | | | | |
| single | 63.9 | 36.1 | 36.2 | 63.8 |
| married | 2.7 | 97.3 | 4.0 | 96.0 |
| widowed, divorced, separated | 56.1 | 43.9 | 31.5 | 68.5 |
| RELIGIOUS AFFILIATION | | | | |
| Catholic | 27.5 | 72.5 | 18.5 | 81.5 |
| Jewish | 25.0 | 75.0 | 4.5 | 95.5 |
| Protestant | 23.9 | 76.1 | 15.8 | 84.2 |
| Other | 23.9 | 76.1 | 11.0 | 89.0 |
| AVERAGE | 24.6 | 75.4 | 16.0 | 84.0 |

TABLE 14.2

WEEKLY FREQUENCY OF COITUS OF FEMALES AND MALES

NATIONAL POPULATION SURVEY

| Characteristics of Individuals | Weekly Frequency of Coitus | |
|---|---|---|
| | Females | Males |
| AGE | | |
| 15-17 years | 0.12 | 0.18 |
| 18-23 years | 0.98 | 0.95 |
| 24-29 years | 1.87 | 1.77 |
| 30-49 years | 1.52 | 1.60 |
| 50 years & over | 0.50 | 0.77 |
| EDUCATION | | |
| elementary | 0.88 | 0.99 |
| high school | 1.14 | 1.12 |
| technical | 1.53 | 1.42 |
| college/university | 1.27 | 1.30 |
| MARITAL STATUS | | |
| single | 0.44 | 0.71 |
| married | 1.57 | 1.48 |
| widowed, divorced, separated | 0.49 | 1.88 |
| RELIGIOUS AFFILIATION | | |
| Catholic | 1.08 | 1.12 |
| Jewish | 1.01 | 1.03 |
| Protestant | 1.19 | 1.15 |
| Other | 1.28 | 1.39 |
| AVERAGE | 1.18 | 1.19 |

While many of the traditional values about the family in Canadian society have disappeared or been reminted, there are still strong vestiges of the patriarchal family which subtly persist, not the least of which involve the usual age of marriage of women and men and their relative values about sexual behaviour. The move toward social parity has resulted for some, but far from all, individuals in profoundly changed ideas about sexual partnership and marital relations. Values now more widely accepted emphasize for women a sense of personal and social security between partners. While sexual compatibility is important to women, it may be less often an end in itself than a vital component of female-male companionship, one which is integral to the meanings of pregnancy and marriage.

As single women get older there is considerable social pressure, which is real or felt, that equates femininity with having a durable female-male companionship, or getting married. In contrast with men, women may tend to see the act of coitus more in terms of what their partners may expect and its long-term implications. Few women boast of their sexual "conquests". To be known as a sexually active single woman in Canadian society is still seen to be

a social liability, one which may restrict a woman's opportunities for marriage. In the speech of every day there is a bundle of sex-related words which are supposed not to be used in circles which consider themselves to be polite, but whose meaning is widely known. These words are less important for themselves than for what they subtly, sometimes insiduously, represent about the images of females and males. For women, these words are often demeaning, one-sided. They represent the male in Canadian society as the aggressor in sexual relations, one who initiates sexual behaviour.

The meaning of sexual promiscuity is seen differently by women and men. The values of our way of life make it more acceptable for males to talk openly about sexual intercourse than is the case for women. Few sanctions apply with any stringency to the sexually active male. This is not the case for women. If an unexpected or unwanted pregnancy occurs, single women are faced with the stigma of illegitimacy or of having an abortion. Even if this does not occur, women more often than men maintain a sense of greater anonymity about the nature of their sexual activity.

On the basis of these broad values about the meaning of coitus, males are more likely than females to recall having had coitus, or what they may feel has been sexual intercourse for a longer period of time. Particularly for young males by whom it is considered a necessary initiation into manhood, this act may have more importance for different reasons than for young females. Because the act of coitus itself may be less important to young and older females for whom it is not associated with marriage or childbirth, more women at these ages may forget or be less accurate in their recall of having had sexual intercourse. In contrast, not only did women and men between 18 and 29 years have more frequent coitus than younger and older individuals, thus contributing to a more accurate recall, but for each sex, this was seen to be an important experience involving parenthood and marriage. As the frequency of coitus rose, occurring once a week or several times each week, there were minimal differences in the frequency reported by females and males.

The general findings on the sexual behaviour of females and males, when combined with information on the relative use of contraceptive means and the volume of abortions, have fundamental implications for the size and the growth of particular regions and provinces. **For the nation as a whole, information about the usual sexual behaviour, the contraceptive use, and volume of induced abortions if coupled with changing external migration trends (immigration, emigration), constitutes 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. This information is the necessary cornerstone to the consideration of national (or regional) population policies.**

## Women who had abortions

In addition to the national population survey, information was obtained about women having abortions in the national patient survey. These two studies

obtained different types of information from different groups of individuals. By including individuals of all age groups, the national population survey provided a vignette of the sexual behaviour and the abortion experience of women over a period of time, and in the case of induced abortions, where and by whom these operations were done. For this reason the characteristics of the women who obtained abortions were different from the attributes of the women from whom information was obtained in the national patient survey. The women in this second study represented a cross-section of patients who obtained abortions in 1976 in Canadian hospitals. By definition, this group was considerably younger than the women in the national population survey who had had abortions. This survey did not include women either who had illegal abortions or who obtained abortions abroad.

Despite the differences in the two sources of information about women who had abortions, several trends emerge. In comparison with all of the women in the *national population survey*, women who have had abortions in general had a higher level of education. In the national population survey, 82.2 percent of all women had an elementary or high school education, while 17.8 percent had technical, college, or university training. In contrast, 68.5 percent of women in the national population survey who had abortions had an elementary and high school education, while 31.5 percent had had technical and college training. While the females in the *national patient survey* were considerably younger than either group of women in the national population survey, their level of education approximated that of women who had had abortions over a longer period of time. A quarter of this group (25.5 percent) had attended college or university. Considering the youthfulness of the women in the national patient survey, and the fact that 21.7 percent were afraid that if they had gone to term they would have had to stop going to school, it is probable that the general level of academic training of these women will increase even further in the future.

Consistently in both groups of women who had had abortions, there were fewer Catholic women and an over-representation of members of other religious affiliations. The smaller proportion of Catholic women who had abortions than their numbers in the population accords with Catholic ethics concerning abortion. The proportion of Jewish women who had had abortions was higher in both surveys than their representation in the national population survey. There were more Protestant women who had had abortions in the national population survey than their overall numbers, but their representation was comparable in the national patient survey to the numbers of women in the national population survey who had not had abortions. Women whose religious affiliation was with smaller denominations or who had no stated faith were substantially over-represented among both groups of females who had had abortions.

In the national patient survey the highest proportion of Catholic patients, 62.8 percent, lived in Quebec. Asian and non-western religions were more often reported in British Columbia, and the proportion of patients who said they had no religious affiliation was also higher in British Columbia than elsewhere. About one-third of the patients in Ontario and the Maritimes were Catholic

and one-half were Protestant. The patient survey was not a representative sample of all women having abortions in 1976 in Canadian hospitals. Despite this fact regional representation was achieved in the survey. It is estimated on the basis of the annual rate of increase of therapeutic abortions done in Canada that the women in this survey represented at least a third of the abortions done in the nation at the time of the survey. With this reservation, the findings of the two surveys may indicate trends in terms of the religious affiliation of women who obtain induced abortions. There may be a decline in the number of Protestant and Jewish women who obtain abortions and an increase in the proportion of women who were Catholics or who belonged to other denominations who had this operation.

TABLE 14.3

CHARACTERISTICS OF WOMEN WHO HAVE NOT HAD AN ABORTION AND WOMEN WHO HAVE HAD AN ABORTION

NATIONAL POPULATION SURVEY & NATIONAL PATIENT SURVEY*

| Characteristics of Individuals | Experience with Abortion | | |
|---|---|---|---|
| | Not Had an Abortion (Population) | Had an Abortion (Population) | Had an Abortion (Patient) |
| | percent | | |
| AGE | | | |
| 15-17 years | 11.0 | 1.9 | 10.2 |
| 18-23 years | 15.6 | 16.6 | 42.6 |
| 24-29 years | 16.9 | 31.5 | 28.3 |
| 30-49 years | 38.3 | 46.3 | 18.8 |
| 50 years & over | 18.2 | 3.7 | 0.1 |
| EDUCATION | | | |
| elementary | 16.0 | 10.6 | 7.9 |
| high school | 66.2 | 57.9 | 66.6 |
| technical | 6.3 | 10.5 | ** |
| college/university | 11.5 | 21.0 | 25.5 |
| MARITAL STATUS | | | |
| single | 27.9 | 28.1 | 64.5 |
| married | 61.6 | 54.4 | 25.0 |
| widowed, divorced, separated | 10.5 | 17.5 | 10.5 |
| RELIGIOUS AFFILIATION | | | |
| Catholic | 50.5 | 31.5 | 35.3 |
| Jewish | 0.5 | 3.7 | 2.3 |
| Protestant | 44.0 | 51.9 | 45.0 |
| Other | 5.0 | 12.9 | 17.4 |

* The age categories used by Statistics Canada and the percent of abortion patients in each category in 1974 were: 31 percent, under 20 years; 48 percent, 20-29 years; 17 percent, 30-39 years; 3 percent, 40-49 years; and less than 1 percent, 49 years and older. The 1974 national distribution by marital status was: 58 percent single; 31 percent married; and 10 percent other and unknown.

** The category of technical education was not used in the hospital patient survey.

Predictably, there was a substantial difference in the age distribution of the women who had abortions in the two surveys. The national population survey, as indicated, represented a cross-section of all ages in Canada while the national patient survey measured a cross-section at one point in time. What these findings indicate, when considered in conjunction with information about the increasing volume of abortions which have been obtained during recent years, is that more females at an earlier age are getting abortions now than in the past. For the population was a whole in the national population survey, 11.0 percent of females were between 15 and 17 years of age and 1.9 percent in this age group had had abortions. In contrast, almost an equal number of young women in the national patient survey (10.2 percent) had had abortions as the proportion of women in the national population survey (11.0 percent). If women between the ages of 15 and 23 years are considered, they represented 26.6 percent of the females who had not had an abortion in the national population survey and 52.8 percent of women in the national patient survey.

The national population survey took a sample of females in the reproductive years, and for this reason the proportion of women who had abortions who were married was considerably higher than would be the case if a total population survey had been taken. Over a quarter (27.9 percent) of females in this survey were single, 61.6 percent married, and 10.5 percent were widowed, divorced, or separated. The marital status of women in the national population survey who had had abortions was somewhat comparable, with slightly fewer being married and more who were once married. In contrast, in the national patient survey which provided a cross-section of females who had abortions in 1976, almost two-thirds of the patients were single (64.5 percent), 25.0 percent were married, and 10.5 percent were widowed, divorced, or separated. This distribution was of the same order as the marital status listed by Statistics Canada for women who had abortions in 1974. These findings are indicative, not conclusive. What they suggest is that many young single women who get abortions subsequently get married.

In the national patient survey, approximately a third of the patients were foreign-born. In the Maritimes and the Prairies, most of the women (an average of about 90.0 percent) had been born in Canada. Elsewhere, the number of Canadian-born patients was between 63.2 and 67.8 percent. The heavier concentration of foreign-born patients were: Asian and United Kingdom patients in British Columbia; women born in the West Indies and Southern Europe in Quebec and Ontario. In British Columbia, Ontario, and Quebec, the 13.3 percent of the patients whose primary language was neither French nor English may have introduced an additional difficulty in their seeking an abortion.

Most of the abortion patients (about three-quarters) assessed their health as being "good". The regional variations in this respect were slight, with 32.8 percent of the patients in the Maritimes saying they were in "average" or "poor" health. In British Columbia, 81.2 percent of the patients had a family doctor with this less often being the case for women living in the Prairies, (71.3 percent) and Ontario (72.0 percent). Among women living in Quebec and the Maritimes, 55.2 percent and 61.9 percent respectively had family doctors. For

these reasons the extent of continuity of care and medical follow-up after an abortion operation was done, might be lower in those areas where a family doctor was not routinely responsible for the health care of these patients. In the patient sample, nearly all of the women saw a doctor at least once a year, 25.1 percent saw a doctor twice a year, and 36.3 percent saw a doctor three or more times annually. The medical consultation rates were lowest among the women living in the Prairies and Quebec.

## Previous contraceptive experience

Each respondent in the *national patient survey* was asked if she had "Ever used any of these contraceptive methods?" This question was followed by a list of the major techniques of conception control. More than 4 out of 5 of these women had at one time used one or more techniques (84.8 percent).[3] The most frequently reported methods which had ever previously been used were the oral contraceptive (63.1 percent) and the condom (44.3 percent). The IUD was less popular, having been used by 13.6 percent of the women. The use in the past of other methods was 31.3 percent, withdrawal; 19.0 percent, foam and other spermicides; 26.5 percent, rhythm; 6.1 percent, diaphragm; and a small proportion of the patients had used other techniques. **A large proportion of the women (84.8 percent) who were seeking an induced abortion were contraceptively experienced. It was factors other than their lack of knowledge or exposure to contraceptives that were involved in accounting for their unwanted pregnancies.**

There was a positive association between the level of education and the proportion of women who at one time had used each of the seven methods. Over half (50.9 percent) of the women with an elementary schooling had used the pill, but the proportion of university trained women who had once used an oral contraceptive was higher (73.5 percent). There was the same range involving the previous use of most of the other methods. The prior use of condoms was 64.0 percent among university graduates, a level which was more than double the rate (28.5 percent) of women who had had a high school education. The overall level, and differences by education, were lower for withdrawal and the previous use of the diaphragm. While overall the diaphragm had not been much used, this method was more often used in the past by women with a university training. The use of withdrawal had been used at a moderately high level by women of all levels of education. In spite of these variations, the differences by education were relatively consistent for all methods.

Whether a woman was working, living at home or was attending school had a more modest effect on her previous contraceptive experience. It was only with the previous use of the pill that clear differences occurred. Seven out of

[3] The previous use of a variety of contraceptive methods was common among these patients with: 27.2 percent, one method; 22.7 percent, two methods; 18.0 percent, three methods; 10.1 percent, four methods; 4.7 percent, five methods; and the remainder, six or more methods.

ten of the women who were working or who lived at home had once used the pill compared to 2 out of 5 (38.3 percent) of those women who were still in school. The use of condoms, withdrawal, rhythm and diaphragm showed no major differences between the primary roles of being at school, work, or housework. The previous use of the IUD and foam was modestly higher among women who were at home or who were working.

The effects of age on the previous use of contraceptives was less marked than that of education. For females who were under 18 years, the use of condoms was the commonest method of birth control; it remained the second most popular method for each of the older age groups. After age 18, the pill was the most popular method, with 49.7 percent of women between 18 and 19 years having previously used oral contraceptives. Among women between 25 and 29 years, the use of oral contraceptives increased to 79.9 percent, but declined in each of the two older age groups so that 58.2 percent of the women who were 35 years and older said they had ever used the pill. Overall, the previous use of contraceptive methods was generally the highest among the women who were between 25 and 29 years. However, the pattern for the prior use of most of the methods was an increasing proportion of use up to that age group and a not unexpected decline among women over age 30. For two methods, rhythm and diaphragm, the increasing proportion of prior use continued throughout the oldest age groups. The effects of age were moderate in the prior use of condoms, withdrawal and rhythm, where the pattern was a relatively high initial use at the earliest age which increased only slightly with succeeding age groups.

The earlier use of the pill, diaphragm, foam and the IUD was the lowest among single women, significantly higher for married women and higher yet for women who were widowed, separated or divorced. Over one-half of the single women had used the pill, but their previous use of other methods was considerably lower. About one-half of the women in each marital category had ever used condoms, one-third had used withdrawal and slightly less had used the rhythm method.

The regional variations in the previous use of contraceptive methods among the women in the national patient survey were:

| Region | Previous Use of Contraceptive Methods |
|---|---|
| | Percent |
| Maritimes | 77.1 |
| Quebec | 85.6 |
| Ontario | 85.1 |
| Prairies | 81.2 |
| British Columbia | 88.5 |

The women in British Columbia in this survey had not only more often used a contraceptive method before but a higher proportion had previously used each method more often than women who lived in nearly all other regions. In Quebec, the previous use of withdrawal and rhythm was higher than in any

other area as was the use of withdrawal in the Maritimes. The prior use of oral contraceptives was low in the Maritimes, where 52.2 percent of the patients had used this method compared to 69.1 percent of the patients in British Columbia. The range was between 61.7 and 63.6 percent among women in the other regions. About half of the patients in British Columbia (51.6 percent) had used condoms as compared to the prior use of this method of between 40.1 to 44.2 percent in other regions.

A similar pattern was found for the previous use of the diaphragm and the IUD , with patients in British Columbia reporting an 18.6 percent previous use of the IUD compared to other areas which ranged between 10.1 to 13.4 percent. The corresponding figures for the prior use of the diaphragm were 9.7 percent versus 4.4 to 7.0 percent. There was less previous use of foam, rhythm and withdrawal, but women in British Columbia also reported higher levels of having used these techniques. Taken together, these findings indicate that the previous use of all types of contraception was the highest among the patients in British Columbia, while patients who lived in other regions had a lower and generally more uniform level of the previous use of birth control techniques.

## Discontinuing the use of contraception

The general dislike of most methods of birth control among the women in the *national patient survey* inhibited their more widespread use. For each method there are known disadvantages which vary from physical and psychological side-effects, a reduction of sexual pleasure and spontaneity, and in some instances, a lack of adequate control over accidental conception. Each patient was asked if she liked, disliked or did not know each of seven methods of family planning. Opinions about methods of conception control are likely to be affected by the personal experiences which each woman had had in use of each method as well as the reports which they may have obtained from other women, physicians, books and magazines or other sources. Accordingly, the opinions of the women who had used any method were separated from those women who had not used a particular contraceptive means.

Half of the patients (49.5 percent) who had used the pill said they liked this method as did 46.1 percent of those who had used the IUD. Between 25.7 and 32.4 percent of women who had previously used the condom, rhythm, diaphragm and foam liked these methods. In contrast, 16.3 percent of women who had used withdrawal said that they liked that method. Among the *women who had never used any method*, 30.6 percent said they liked the pill and 10.5 percent liked the IUD. There was a small group of women who liked other methods which they had never used, but most women in this category were undecided.

The social circumstances of the patients had a limited impact on their opinions about each method of birth control. The effect of age, marital status, primary social role and place of birth showed that for women who used the pill,

the proportion who liked this method was inversely associated with their education and age. Women who were younger and who had less education more often said they liked the pill as a method of birth control. More women born in Southern Europe endorsed the use of condoms, while females born in the United States and United Kingdom generally disliked this method. None of a woman's other social characteristics were related to her preferences about the use of condoms or the IUD.

More women who had been born abroad held favourable opinions about withdrawal and rhythm, while women who had been born in Canada had less favourable views of these methods. Foreign-born women were also more likely to approve the use of the diaphragm as a contraceptive. The proportion of women who preferred the diaphragm increased with the level of education among the patients. Despite these several trends, in general, the social and demographic attributes of the patients who had abortions did not much influence their opinions about these measures. Their age, their level of education and where they lived were only partly related to their opinions about contraceptive methods. These trends were neither strong nor consistent. More important was their actual use of the various methods. When contraceptive methods had been used, this fact sharply influenced their opinions about these measures and transcended the effects of the social and demographic attributes of the patients.

Because of their needs, experience and preferences, women at different stages in their lives may and do change the types of contraceptive methods which they use, or stop using these methods altogether. What is known from fertility surveys which have been done in other nations is that the risks of an accidental conception are increased during the intervals between the non-use of methods and the initial stages of adopting new techniques. These higher risks result from a lack of knowledge and experience with these new contraceptive means and in some cases, they are inherent in the method itself as many physicians, for instance, counsel their patients who use the pill and IUD to use alternate methods during the initial phase of using these two means of contraception.

In examining the reasons why a woman or her partner in the patient survey stopped the use of birth control prior to conception which resulted in an abortion, the Committee obtained information about the use of these methods, the type of medical advice which had been given, and the perceived, changing needs cited by these women for fertility control. The side-effects associated with the use of the pill and the IUD were mentioned by a large number of abortion patients. A second reason often given for stopping the use of these methods was the advice reported to have been given by a physician that a woman should discontinue its use. A further reason involving oral contraceptives was that some women were afraid to continue the use of this method over a considerable period of time. The hormonal effects of the pill have been raised in the media. According to these patients, some physicians had advised them to "take a rest" from the pill after they had used this method for a few years. Stopping the use of condoms among abortion patients prior to conception was associated with objections to its use which had been raised by the partners of

some of these women. The unavailability of condoms was also cited by a few women as a reason for stopping its use. Among some couples a further reason for stopping the use of condoms was the belief that these women thought they could not get pregnant by having sexual intercourse.

Many women who had stopped using the pill and the IUD said they had made this decision because they had been advised to do so by their physicians and because they were afraid of its long-term physical side-effects. The reasons which were given for stopping the use of the condom were more closely tied to the sexual rather than the medical dimensions of contraception. The females who were still in school were more likely to have stopped the use of condoms. Women who were living at home had high rates of discontinuing the use of the IUD. More of the women who were working had previously used the pill. The trend involving the discontinuation of the use of the pill was particularly high in the Prairies, Ontario and the Maritimes. Of the 9.7 percent of the women in the national patient survey who had discontinued the use of condoms, the rate was the highest (17.3 percent) among the patients in the Maritimes. This trend occurred particularly among women who were still in school in the Maritimes. The pill was the method which previously had been the most commonly used birth control measure in each region.

Reflecting the general patterns in the use of contraception, younger and single women were more likely to have stopped the use of the pill, while women over 25 years of age and those women who were married had previously used other contraceptive methods. No strong regional patterns within the age groupings emerged in the previous use of these methods. However, when a woman's age, her marital status, her primary social role and the number of live births which she had had were considered together, several trends emerged. A significant proportion of the women between 16 and 25 years who were living at home or were working had previously been using the pill. Beyond age 25, there were no variations by their primary social role. Among the patients who were under 25 years old, and who were still in school, a sizeable number had relied on the use of the condom for protection against pregnancy. Among the women who were single, a high proportion who were working or who were living at home had been using the pill, while more of those females who were still in school had been using the condom. There was no significant variation in the methods which had been used by type of social role among the other marital groupings. A single woman's other social circumstances, such as her number of live births or her level of education were not related to her prior use of birth control methods. This was also the case among married women who had stopped using contraceptive methods. Women over the age of 25, regardless of their marital status or their primary social roles, had no strong preferences about the use of specific methods.

## Motivation regarding pregnancy

To see if a woman's level of motivation regarding her pregnancy had changed since conception had occurred, each woman in the national patient

survey was asked if she had wanted to become pregnant at the time of conception, whether she did not want a child now but would want a pregnancy later, or if she never wanted to be pregnant. In some fertility studies the extent to which a pregnancy is wanted by a woman has been found to be a strong indicator in limiting the frequency of coitus. If the extent to which a pregnancy was wanted remained the same during the period of contraceptive use and when conception occurred, it might be expected that more women who least wanted to become pregnant might be using birth control measures more often, and in addition, using methods which are recognized for their effectiveness. There was no evidence in the findings of the national patient survey to support this idea. To the contrary, there was a slight tendency for the use of the more ineffective contraceptive methods as often among the abortion patients who never wanted to be pregnant as among those women, a much smaller group, who at the time of conception had wanted to become pregnant. The results did not support the view that differences which may exist in the level of motivation among the women who had abortions determined their use of effective methods of contraception. Among the abortion patients, 7.8 percent of those women who had previously stopped the use of contraception, said they had wanted to become pregnant when conception occurred. These women, though few in number, did not reflect "contraceptive failure". Relatively little is known about this group of women, why they changed their minds or the implications for their medical care. It is equally unknown how many women who had not wanted to become pregnant carried their pregnancies to term.

The time involved in resolving these decisions contributes both to the postponement by some women in seeking out a physician at an early phase of their pregnancies and is also a factor cited by many physicians why they provide an interval between their initial contacts with abortion patients to allow them time to reconsider their decisions. Final and irrevocable decisions about an abortion may not be fully made until an operation has in fact been done. This fact was tacitly recognized by the medical staff of some of the large hospitals visited by the Committee. At some of these hospitals which did a high volume of day surgery abortion operations, there was an unstated and internal policy of the "extra-booking" of patients which was based on the premise that some patients who had been approved for the operation would not turn up on the day which had been scheduled for the operation. Some of these patients may "double-book" applications at hospitals but the extent to which this may happen is discounted by the time involved for appointments with physicians. From the information received from women who went to the United States, there was no indication that any of these women had had an abortion approved at a Canadian hospital, and then gone to the United States for this purpose.

At 19 large hospitals in 1974, which did 35.8 percent of all abortions in the country that year, there was a difference of 7.8 percent between the number of approved abortion applications and the number of the abortion operations which had been done at these hospitals. Once their application had been approved to be done in a Canadian hospital, these "no-show" patients represented the proportion of women who had changed their minds about obtaining an induced abortion. **When the number of women who withdrew from having an abortion after obtaining approval from a hospital committee (7.8**

**percent) are considered with the number of women who initially had wanted to become pregnant and then decided to seek an abortion (7.8 percent), then 1 out of 6 women changed their decisions one way or another about having an induced abortion.**

## Use of contraceptive means

One out of four females (24.6 percent) in the *national population survey* did not have coitus. This finding does not mean that these females may not have had coitus in the past or might not do so in the future. What this finding means is that at the time of the 1976 survey these women in their present circumstances never had sexual intercourse. Over half of these women used contraceptive means (13.2 percent), a fact which indicates the possibility or anticipation of coitus. The remainder (11.4 percent) never had coitus and did not use contraceptive means.

In comparison with sexually active females, women who did not have coitus were predominantly young and single. More of these women had an elementary and a high school level of education and there were slightly more Catholics than members of other religious denominations in this group. Because they were sexually inactive, the women who never had coitus and did not use contraceptive means are not considered in the review of the use of contraceptive means. In epidemiological terms, these women were not "at risk" of becoming pregnant. It is unknown whether the size of this group has remained constant or has fluctuated over a period of time. Depending upon its proportions and the direction of its incidence, the number of sexually inactive females has implications for the rate of population growth and programs involving family planning.

Three out of four females (75.4 percent) had sexual intercourse with a frequency which ranged from a few times each year to more than four times each week. The highest coital frequency was among women between 24 and 29 years and those who were married. **Among sexually active women in the national population survey slightly less than a fifth (17.8 percent) did not use any form of contraception when they had coitus.** The characteristics of females in the national population survey who had coitus regularly but who did not use contraceptive means varied by their social circumstances. In particular, **more females in the reproductive years who were young, single, and had an elementary and high school education never used contraceptive means.** By age, the proportions of sexually active women not using contraceptive means were: 33.3 percent, 15 years ; 17.2 percent, 16 to 17 years; 14.6 percent, 18 to 23 years; 11.4 percent, 24 to 29 years; and 16.6 percent, 30 to 49 years. **Contraceptive means were not used by 28.2 percent of the sexually active single women.**

Males used contraceptive means slightly less often than females. The experience of females and males was similar for those individuals who were over 30 years. Young males and those with less formal education far less often than females in these categories used contraceptive means. The general trend

of this information indicates that women having coitus took more precautions involving the use of contraceptive means, but the contraceptive practices of young and single females and males made them a high-risk group in terms of becoming pregnant.

TABLE 14.4

CHARACTERISTICS OF NON-USERS OF CONTRACEPTIVE MEANS WHO HAVE COITUS

NATIONAL POPULATION SURVEY

| Characteristics of Individuals | Percent of Individuals Having Coitus Who Do Not Use Contraceptive Means | |
|---|---|---|
| | Females | Males |
| AGE | percent | |
| 15 years | 33.3 | 66.7 |
| 16-17 years | 17.2 | 28.1 |
| 18-23 years | 14.6 | 21.7 |
| 24-29 years | 11.4 | 15.1 |
| 30-49 years | 16.6 | 16.9 |
| 50 years & older | 32.2 | 31.8 |
| EDUCATION | | |
| elementary | 25.1 | 33.0 |
| high school | 16.8 | 22.6 |
| technical | 10.2 | 15.1 |
| college/university | 14.5 | 13.8 |
| MARITAL STATUS | | |
| single | 28.2 | 27.1 |
| married | 23.0 | 26.4 |
| widowed, divorced, separated | 14.5 | 4.0 |
| RELIGIOUS AFFILIATION | | |
| Catholic | 18.8 | 24.1 |
| Jewish | 0.0 | 19.1 |
| Protestant | 16.8 | 18.2 |
| Other | 16.4 | 14.2 |
| AVERAGE | 17.8 | 21.1 |

In the general research on coitus, contraception and pregnancy, several different approaches have been used to estimate the frequency of pregnancy relative to the frequency of unprotected coitus. In-depth and exact information has on occasion been obtained from small groups of fecund women which in general suggests that pregnancy results from approximately 2.0 percent of the times when coitus occurs. Such detailed information was not obtained by the Committee, but on the basis of the general information on the sexual behaviour of females, somewhat lower rates were derived. Two general methods were used. The first approach considered the average weekly frequency of coitus

prorated to an annual rate by the proportion of females not using contraception. On this basis, for each 1,000 females, there were 61,360 times of coitus of which 10,922 had not involved the use of contraception. On an age-specific basis, the number of pregnancies for each 1,000 Canadian women between 15 and 49 years was calculated by taking into account the number of live births, stillbirths, the total of all officially reported abortions (therapeutic, spontaneous, and other categories) and unreported abortions (illegal in Canada and out-of-country). The rates per 1,000 women between 15 and 49 years in 1974 were: 60.6 live births, 0.63 stillbirths; 11.9 reported abortions, and 1.7 unreported abortions for an accumulative total of 74.8 pregnancies per 1,000 women in these ages. On this basis, 0.12 percent of the frequency of coitus resulted in pregnancy and when contraceptive means were not used, pregnancy occurred 0.68 percent of the time. Put another way, there was one pregnancy for every 820 times of coitus, and one pregnancy for every 146 times of coitus when contraceptive means were not used.

The second approach took into account only the coital experience of sexually active females. The frequency of pregnancy was lower among these women, with the overall rate being 0.10, and for females not using contraceptive means, 0.59. In terms of becoming pregnant, for all sexually active women, one pregnancy would be expected for every 1,028 times of coitus and among those women who did not use contraceptive means, one pregnancy for every 169 times of coitus. These findings outline general trends. It is recognized that the biological capability to become pregnant varies particularly among younger and older women in the reproductive years, and with the extent of the fertility of males.

TABLE 14.5

FREQUENCY OF COITUS
BY THE TYPE OF CONTRACEPTIVE MEANS USED

NATIONAL POPULATION SURVEY

| Type of Contraceptive Means | Frequency of Coitus | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Females | | | | Males | | | |
| | None | Once a month or less often | Weekly | Several times each week | None | Once a month or less often | Weekly | Several times each week |
| Pill | 4.8 | 13.0 | 26.1 | 56.1 | 0.9 | 14.9 | 27.7 | 56.5 |
| Condom* | 1.8 | 19.6 | 28.6 | 50.0 | 0.7 | 36.8 | 27.9 | 34.6 |
| I.U.D. | 1.9 | 9.4 | 26.4 | 62.3 | 2.2 | 4.4 | 32.6 | 60.8 |
| Withdrawal* | 5.9 | 29.4 | 20.6 | 44.1 | 5.0 | 20.0 | 37.5 | 37.5 |
| Rhythm | 2.1 | 14.9 | 31.9 | 51.1 | 3.2 | 3.2 | 16.1 | 77.5 |
| Foam | 12.5 | 8.3 | 37.5 | 41.7 | 5.6 | 11.1 | 22.2 | 61.1 |
| Diaphragm | 0.0 | 25.0 | 20.0 | 55.0 | 0.0 | 16.7 | 58.3 | 25.0 |
| Sterilization* | 2.3 | 6.8 | 32.1 | 58.8 | 0.6 | 7.2 | 30.5 | 61.7 |
| Other | 13.2 | 15.8 | 36.8 | 34.2 | 10.0 | 20.0 | 40.0 | 30.0 |

* The use of these contraceptive methods refers to their use either by women or men at the time of coitus.

TABLE 14.6

## CONTRACEPTIVE USE OF FEMALES HAVING COITUS

NATIONAL POPULATION SURVEY

| Characteristics of Individuals | Type of Contraceptive Means | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Pill | Condom* | I.U.D. | Withdrawal* | Rhythm | Foam | Diaphragm | Sterilization* | Other | Total |
| | percent | | | | | | | | | |
| AGE | | | | | | | | | | |
| 15-17 years | 55.2 | 10.4 | 3.4 | 13.8 | 0.0 | 3.4 | 7.0 | 3.4 | 3.4 | 100.0 |
| 18-23 years | 76.2 | 9.8 | 4.1 | 4.9 | 2.5 | 1.6 | 0.9 | 0.0 | 0.0 | 100.0 |
| 24-29 years | 63.0 | 4.8 | 7.9 | 2.2 | 3.5 | 2.2 | 0.9 | 14.1 | 1.4 | 100.0 |
| 30-49 years | 25.9 | 5.5 | 6.2 | 3.0 | 7.2 | 3.0 | 2.5 | 40.8 | 5.9 | 100.0 |
| 50 years and over | 16.0 | 20.0 | 4.0 | 16.0 | 8.0 | 0.0 | 16.0 | 12.0 | 8.0 | 100.0 |
| EDUCATION | | | | | | | | | | |
| elementary | 37.9 | 6.9 | 2.3 | 4.6 | 6.9 | 6.9 | 2.3 | 21.9 | 10.3 | 100.0 |
| high school | 45.1 | 5.8 | 6.1 | 4.3 | 5.2 | 1.3 | 2.5 | 26.3 | 3.4 | 100.0 |
| technical | 50.7 | 11.5 | 5.8 | 1.5 | 2.8 | 1.5 | 1.5 | 23.2 | 1.5 | 100.0 |
| college/university | 41.9 | 6.8 | 8.5 | 1.7 | 6.8 | 4.3 | 2.6 | 24.8 | 2.6 | 100.0 |
| MARITAL STATUS | | | | | | | | | | |
| single | 67.3 | 10.2 | 5.5 | 6.1 | 3.4 | 2.0 | 2.7 | 1.4 | 1.4 | 100.0 |
| married | 39.2 | 6.0 | 6.0 | 3.4 | 6.1 | 2.5 | 2.2 | 30.5 | 4.1 | 100.0 |
| widowed, divorced, separated | 38.8 | 2.0 | 10.2 | 2.0 | 2.0 | 4.1 | 4.1 | 28.6 | 8.2 | 100.0 |
| RELIGIOUS AFFILIATION | | | | | | | | | | |
| Catholic | 49.7 | 5.1 | 4.8 | 3.7 | 8.0 | 1.3 | 0.3 | 23.4 | 3.7 | 100.0 |
| Jewish | 66.7 | 0.0 | 33.3 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 100.0 |
| Protestant | 37.5 | 7.5 | 6.2 | 3.5 | 3.5 | 3.0 | 4.0 | 30.0 | 4.8 | 100.0 |
| Other | 51.0 | 10.6 | 8.5 | 6.4 | 4.3 | 4.3 | 4.3 | 10.6 | 0.0 | 100.0 |
| AVERAGE | 44.0 | 6.5 | 6.2 | 3.8 | 5.3 | 2.5 | 2.4 | 25.5 | 3.8 | 100.0 |

* The use of these methods refers to their use either by women or men at time of coitus

TABLE 14.7

## CONTRACEPTIVE USE OF MALES HAVING COITUS

NATIONAL POPULATION SURVEY

| Characteristics of Individuals | Type of Contraceptive Means | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Pill | Condom* | I.U.D. | Withdrawal* | Rhythm | Foam | Diaphragm | Sterilization* | Other | Total |
| | percent | | | | | | | | | |
| AGE | | | | | | | | | | |
| 15-17 years | 30.2 | 44.2 | 4.7 | 9.3 | 4.7 | 2.3 | 2.3 | 0.0 | 2.3 | 100.0 |
| 18-23 years | 54.4 | 30.6 | 0.8 | 6.0 | 3.7 | 1.5 | 2.2 | 0.0 | 0.8 | 100.0 |
| 24-29 years | 64.5 | 12.5 | 8.0 | 1.7 | 1.4 | 4.0 | 0.5 | 7.4 | 0.0 | 100.0 |
| 30-49 years | 33.1 | 10.9 | 6.6 | 4.8 | 5.3 | 1.3 | 1.3 | 35.2 | 1.5 | 100.0 |
| 50 years and over | 25.8 | 15.5 | 3.5 | 12.1 | 1.7 | 3.5 | 3.5 | 32.7 | 1.7 | 100.0 |
| EDUCATION | | | | | | | | | | |
| elementary | 38.8 | 5.6 | 5.6 | 11.1 | 5.6 | 0.0 | 1.4 | 30.5 | 1.4 | 100.0 |
| high school | 40.0 | 20.9 | 4.4 | 5.4 | 3.2 | 2.9 | 1.0 | 21.0 | 1.2 | 100.0 |
| technical | 49.0 | 10.8 | 5.9 | 2.0 | 2.0 | 2.9 | 2.0 | 24.5 | 0.9 | 100.0 |
| college/university | 48.2 | 15.6 | 8.5 | 2.5 | 4.5 | 1.0 | 2.5 | 16.2 | 1.0 | 100.0 |
| MARITAL STATUS | | | | | | | | | | |
| single | 52.7 | 28.8 | 4.6 | 5.9 | 2.9 | 1.3 | 1.7 | 1.3 | 0.8 | 100.0 |
| married | 38.9 | 12.0 | 6.4 | 4.6 | 4.2 | 2.6 | 1.3 | 28.7 | 1.3 | 100.0 |
| widowed, divorced, separated | 47.3 | 5.3 | 0.0 | 5.3 | 0.0 | 0.0 | 5.3 | 36.8 | 0.0 | 100.0 |
| RELIGIOUS AFFILIATION | | | | | | | | | | |
| Catholic | 53.2 | 13.1 | 0.0 | 8.2 | 0.0 | 2.0 | 1.0 | 22.2 | 0.3 | 100.0 |
| Jewish | 6.8 | 13.6 | 27.3 | 0.0 | 47.7 | 2.3 | 0.0 | 0.0 | 2.3 | 100.0 |
| Protestant | 36.1 | 20.9 | 7.3 | 3.3 | 2.1 | 3.0 | 1.8 | 25.2 | 0.3 | 100.0 |
| Other | 54.9 | 18.2 | 11.0 | 2.5 | 2.4 | 0.0 | 0.0 | 11.0 | 0.0 | 100.0 |
| AVERAGE | 43.0 | 16.8 | 5.6 | 5.1 | 3.8 | 2.2 | 1.5 | 20.9 | 1.1 | 100.0 |

* The use of these methods refers to their use either by women or men at the time of coitus.

**Two major types of contraception were used by women having coitus. The pill, or oral contraceptive, was used by 44.0 percent of these sexually active women; 25.5 percent of these women or their partners had been surgically sterilized. These two methods accounted for 69.5 percent of the contraceptive means used by sexually active women in the national population survey.** Six other methods, each of which was less often used, were: 6.5 percent, condom; 6.2 percent, IUD (intra-uterine device); 5.3 percent, rhythm; 3.8 percent, withdrawal; 2.5 percent, foam; and 2.4 percent, diaphragm. Other unspecified means were used by 3.8 percent of women having coitus

There was a direct association between the type of contraceptive means which were used and the frequency of coitus. Among individuals who used withdrawal, 35.3 percent seldom had sexual intercourse or did so only a few times each year. This was also the case among females who used other, unspecified contraceptive methods (29.0 percent). Conversely, the frequency of coitus was highest among women who relied on sterilization, 90.9 percent of whom had sexual intercourse once a week or more often. This higher frequency of coitus (once a week or more often) was also the case for users of the IUD (88.7 percent), the pill (82.2 percent), and the rhythm method (83.0 percent).

Several contraceptive methods such as the condom, withdrawal, and the diaphragm were more extensively used by older rather than younger women or their partners. Few young women used the rhythm method. While this means was used by 5.3 percent of all women using contraceptive means, it was more often used by older women (8.0 percent who were 50 years and older) and by Catholics (8.0 percent). Withdrawal was least used by the partners of married women, those individuals with a higher education, and females between 18 and 49 years. In contrast the partners of 13.8 percent of females 15 years and younger and 16.0 percent of women who were 50 years and older used the withdrawal method.

From information which was available on the sales of pills and other pharmaceutical and mechanical means and the volume of female sterilizations done in Canadian hospitals, the two major methods were the use of pills and surgical sterilization. These were also the methods most frequently used by the women and their partners in the national population survey.

The women who had abortions from whom information was obtained in the *national patient survey* can be divided into three broad groups on the basis of their contraceptive usage. The first group of women (47.3 percent) reported they were using birth control at the time of conception of the present pregnancy. The second group of women (25.5 percent) discontinued use of contraception some time before the present pregnancy. The third group of women (27.2 percent) had not used contraception at any time.

The largest group of women, reporting use of contraception at the time of conception, can be considered to be seeking an abortion as a result of a contraceptive failure. The contraceptive methods used by these women at the time of conception included: pill, 18.0 percent; condom, 26.2 percent; IUD, 9.9 percent; diaphragm, 4.3 percent; foam and rhythm, 15.3 and 14.9 percent respectively, and the remainder, other methods. A proportion of these women were using ineffective methods.

The use of contraceptive methods among the patients obtaining induced abortions was associated to a moderate extent with ethnic and religious factors. The use of oral contraceptives was higher among Catholics (21.6 percent) than all other religions (16.1 percent) and was particularly high among women born in the West Indies (35.1 percent). The use of condoms was somewhat higher at 29.0 percent by the partners of Protestant women compared with 23.8 percent among other religious groups, but it was much higher by the partners of women born in India and Asia than for those females who were born elsewhere. Both the IUD and diaphragm were popular methods among Jewish women and for women born in the United States or United Kingdom. The use of rhythm and withdrawal tended to be higher in Catholic women and among women who were born in Southern Europe.

The pill was more likely to be used by women in the national patient survey: with eleven years or less of education; those between 18 and 24 years; women who were working or at home; and those who were separated. The use of condoms by the male partners of these women was more frequent among females who were: 19 years and under; single women; and females who were still in school. Both the IUD and diaphragm were used more frequently by older women, those with more education and among women who had been widowed, separated or divorced. The reliance upon withdrawal was the highest among women under 17 years, females who were still in school, and women who had eight years or less of schooling.

**An unresolved question is why among women reporting the use of a contraceptive method at the time of conception there should have been such a high level of unwanted pregnancies associated with the use of the pill and IUD.** Almost 1 out of 5 (18.0 percent) of the women said they were using the pill and another 9.9 percent the IUD at the time of conception. While there is not an appropriate denominator for calculating failure rates for these methods, the high levels of protection generally attributed to their use would suggest lower failure rates. It is unknown whether the method failed, or whether it was used incorrectly. In each instance even the most effective methods did not confer protection from conception for these women.

There were some provincial variations in the use of contraceptive methods among women in the national patient survey. Women who had had an abortion in Quebec and the Maritimes used the rhythm method 21.3 and 24.0 percent respectively in comparison with the use of this method at the time of conception by 13.0 percent of all other patients. The use of the pill and the condom was higher among patients or their partners in the Prairies and Ontario than in the other regions. When use of rhythm, withdrawal and other unspecified methods were combined, 36.6 and 35.0 percent of the patients in Quebec and the Maritimes respectively used these methods compared with 15.2 percent in the Prairies, 27.1 percent in Ontario and 22.5 percent in British Columbia. When the levels of the use of the pill and IUD were combined, there was no significant variation between the provinces. The moderately effective methods, condom, vaginal spermicides, foam and diaphragm, were used by about one-half of the women or their partners in British Columbia, the Prairies and Ontario compared to 37.5 percent in the Maritimes and 37.0 percent in Quebec.

The use of specific contraceptive techniques among the patients by their age, education, primary social roles and place of birth did not differ greatly for any geographic region from the patterns which have been outlined. Within each region married women or their partners were less likely to have used the pill or condom and had higher rates of the use of the IUD and diaphragm than single women. Women who were in school in each region were more likely to be using condoms than those who were working or living at home. A high proportion of patients who were young, single, and had an elementary and a high school education had not used contraceptive means at the time of coitus. Over half of the women (55.1 percent) felt they became pregnant easily, although immediately after conception had occurred over a quarter (26.1 percent) did not think they were pregnant.

## Previous abortions

The concern over the occurrence of repeat abortions stems from a number of factors including: the effect of an abortion on a woman's fertility; an increased exposure of the patient to immediate and long-term psychological and physical health risks; the increasing costs of health care assigned to abortion services; and the possibility that some couples may use abortion as a method of contraception. The experience of other nations suggest that in general as abortion services have become more available, there has been a reported increase in the number of second or repeat abortions. Reports for instance from some centres in New York, California and elsewhere in the United States indicate that a small group of women may be involved who have second or more abortions. Based on the experience of these studies the total number of women who have repeat abortions tends to increase as the pool of women who have had a first abortion grows. In reviewing the experience at these centres in the United States, the level of second abortions initially rose, then reached a plateau within each group of patients. The point at which the plateau was reached differed between areas and varied in part with the types of abortion services which were then available.

For 17.9 percent of the patients in the 1976 *national patient survey*, the abortion which they then obtained was their second (or more) induced termination of pregnancy. Exact information on the number of women who have had more than one abortion is difficult to obtain. Unless there is specific medical evidence of a prior induced abortion, the accuracy of reporting a second induced abortion depends upon the willingness of women to provide this information to physicians. In comparison to women either who have not had abortions or for whom the abortion was their first termination of a pregnancy, women who have had repeat abortions may have: an earlier onset of or a higher frequency of sexual activity; a less effective use of contraception; and a higher level of fecundity. Information from the national patient survey did not document the changes through time in the levels of repeat abortions, but it provided a measure of the extent of second or more abortions among a large group of women who were interviewed in 1976. This source was relevant to

distinguish the variations which may occur in the prevalence of repeat abortions and it provides some insights into different abortion practices between the regions of Canada.

Regional variations in the prevalence of previous abortions reported by women in the national patient survey rose from 11.9 percent in the Prairies to 15.6 percent in the Maritimes and to 15.7 percent in Ontario. The highest prevalences of 20.7 and 24.4 percent were among the patients in Quebec and British Columbia respectively. These regional trends were similar, but at a higher level than the prevalence of second abortions reported by Statistics Canada in 1974. At that time the proportion of women who had repeat abortions of all women then having induced abortions was: 3.1 percent, Maritimes; 9.8 percent, Quebec; 7.3 percent, Ontario; 5.0 percent, Prairies; and 11.2 percent, British Columbia. Assuming that the 1976 national patient survey was generally comparable in its scope to the coverage given by Statistics Canada in 1974, it would appear that **the proportion of women having repeat abortions may have more than doubled across the nation (from 7.9 percent in 1974 to 17.9 percent in 1976)** and risen substantially in each region. This change may be wholly spurious. It could result from how the patients in the 1976 survey were selected and in this respect their experience may not represent the actual situation for the country. But the trend would appear to indicate that what may be happening in Canada is following broader trends elsewhere involving an increase in the numbers of women seeking repeat abortions.

In the Committee's judgment there is also another factor which may account for this apparent increase in the proportion of women having repeat abortions. How information is obtained from women who are in this situation may significantly affect the accuracy with which this experience is documented in official statistics. It may well be the case that official statistics substantially under-represent the actual extent of repeat abortions.

In the case of the 1976 national patient survey, the information was obtained directly from women about to have induced abortions. The information was recorded on a confidential basis which assured the anonymity of these patients. It was given freely without any suggestion that it might affect a women's chances of getting an induced abortion. These procedures contrast with how this information is sometimes obtained as part of a medical consultation when such patients may assume, on occasion accurately, that volunteering such information either may jeopardize their chances of getting a second (or more) induced abortion, or invoke a professional prerequisite of giving consent to sterilization as a precondition to getting this operation. Many physicians were reluctant to discuss this aspect of medical practice.

On its site visits to hospitals the Committee was told of a number of instances where approval for abortion was contingent on receiving consent for sterilization. These instances were not confined to any one province, but occurred in nearly all of the provinces. The Committee was told of individual physicians who would only perform abortions on women who agreed to be sterilized. One hospital stated that when a woman had a second abortion approved, she was told that if she wanted to have a third induced abortion she

would be required to be sterilized. The Committee was told at another hospital that women who were to be sterilized when the abortion was performed were not considered to be urgent cases because a hysterotomy was frequently the procedure which was used in these instances. There may be longer delays for these women. Information provided by Statistics Canada for 1974 indicates that of the 3.0 percent of the women for whom the abortion procedure was a hysterotomy, 83.2 percent of these women had concurrent sterilizations. On its visits to some hospitals and community agencies, the Committee was told that these pressures to have concurrent sterilizations usually came from referring physicians and gynaecologists who performed abortions; this policy was never stated explicitly as a requirement by therapeutic abortion committees.

The prevalence of repeat abortions did not differ much by the social circumstances of the patients in the 1976 national patient survey. One out of six (16.7 percent) of the women who did not have a college or university education had had a prior abortion compared with 21.5 percent of the women who had some university training. Predictably, fewer females (11.4 percent) who attended high school had had a prior abortion compared to 19.5 percent of the women who lived at home or who were working. Catholic and Protestant patients had levels of 17.8 and 15.1 percent respectively, levels which were lower than the prevalence of 22.8 to 27.1 percent among women who were Jewish, of other faiths or who reported no religious affiliation.

The majority of patients in the survey were born in Canada and 16.7 percent of these women, as well as those who were born in India and Pakistan had had previous abortions. Among the women who had been born in other countries, such as in Europe, other parts of Asia, or elsewhere, the prevalence varied between 19.6 and 23.3 percent.

The influence of marital status and number of live births on repeat abortions was not marked. Married and single women were somewhat less likely to have had prior abortions (between 17.8 and 16.8 percent respectively) than those who were widowed, divorced or separated (24.3 percent). Women who had had one or two previous live births were slightly more likely to have been previously aborted, but the differences were not great compared to those women who had had no live births. Not unexpectedly, the rate of repeat abortions increased with age. For the youngest group of patients, females under 18 years, 5.9 percent had had an earlier abortion. The proportion of the women who had had an earlier abortion rose to 11.3 percent among women between 18 to 19 years, and it was 19.7 and 25.8 percent respectively for women between 20 to 24 and 25 to 29 years. For those women who were 30 years and older, the proportion of repeat abortions declined to 18.7 percent.

This information refers to the entire patient survey population and as such, it provides a guide for understanding repeat abortions in the broader population. A more detailed study of the factors which may affect the rates of repeat abortions would require the use of a more restricted population. Specifically, this step would involve an examination of those forces which influence the prevalence of repeat abortions by eliminating from consideration the experience of women who had not previously been pregnant. Such a study

group, or population at risk, could be defined as those women who had had one or more previous pregnancies who were obtaining a first or a subsequent abortion.

About 1 out of 5 women in the national patient survey had had a prior abortion. This group of women was fairly evenly divided between those women who had had an earlier pregnancy (46.0 percent) and the slightly over half of the women for whom this conception was the first recognized pregnancy. Among those women who had been pregnant before, 33.6 percent had had a previous abortion. Regional variations followed the patterns for all abortion patients. In British Columbia 46.2 percent of the women who had previously been pregnant and were having an abortion had had an earlier abortion. The level was lower in Quebec at 37.1 percent, and declined further to between 25.8 and 28.7 percent among the abortion patients who lived in the remaining three regions.

The level of earlier pregnancies and previous abortions was not uniform across the sub-groups of the population in each of the major geographic regions. Although the number of young, previously pregnant women was small, those women under age 20 in this group had a higher rate of prior abortions. In British Columbia (59.3 percent) and Quebec (56.0 percent), this rate included 3 out of 5 of the women in this age group. While the rate was still high in other regions, it was lower involving about 2 out of 5 women. The rate among women who were 20 years or younger for instance was 43.1 percent in Ontario. The declines in previous abortion with age were regular and about one-third of the women in British Columbia and Quebec between 30 and 24 years and one-quarter or less of those who were 35 years and older had had a previous abortion. In the other three regions the proportions were much lower at older ages. The effect of marital status was similar as the highest previous abortion level was among single women. There was some variability within each region, but in general women who were married or had been married had similar levels of previous abortion which was about a half of the rate for women who were single. In each region about half of the single patients had had previous abortions. Correspondingly, 83.4 percent of those women with no prior live births had had a previous abortion compared with between 12.2 and 27.3 percent of women who had had one or more live births.

Among the women who had been pregnant before and who had had an earlier abortion, the lowest number was among females who lived "at home". Among all of the women across the country who were living at home, 24.0 percent had had previous abortions. The prevalence of prior abortion among previously pregnant women was higher among those females who were working. The level varied from a high of 50.0 percent in British Columbia, 42.7 percent in Quebec to between 31.7 and 39.3 percent in other areas. The prevalence of prior abortion among previously pregnant women who attended school was between 55.1 and 63.6 percent for all regions, except in the Prairies where it was 31.8 percent.

With relatively few exceptions the influence of where these women had been born was unimportant. The proportion of women who had had prior abortions was relatively higher among women who had been born in the United

States or United Kingdom and who at the time of the survey lived in British Columbia. This pattern did not occur in other regions. In a similar manner the prevalence was relatively higher among the women from the West Indies who lived in Quebec, but this was not the case elsewhere.

**There was a more direct and significant association between the years of education and the prevalence of repeat abortions among the previously pregnant abortion patients.** In each region the proportion rose with the level of a patient's education. The effect of schooling was strong in British Columbia where 28.6 percent of females with an elementary school level of education having had a prior abortion compared to 56.8 percent among women with a university degree. As would be expected, the overall level varied between regions, but the difference between women who had different levels of education was unmistakable. **The proportion was double in the highest education category in contrast to women who had less formal education.** There was no association between having had a previous abortion and a woman's length of gestation.

Overall, the experience of the women who had been previously pregnant and had had prior abortions differed from the majority of the women in the national patient survey. **More of these women were single,** they had on an average a higher level of education, **more were working outside the home and fewer had had previous live births.** What these findings suggest is that there is a discernible group of women who have somewhat similar backgrounds who may be at a higher risk of having repeat abortions in the future. It is this group of women as well as women having their first abortion whose patterns of sexual behaviour and contraceptive practices need to be understood if birth control programs are to be effective in reducing unwanted conceptions.

From the upward trend in induced abortions in Canada in recent years, it is likely that the number of women obtaining repeat abortions will also increase in the future until it reaches a plateau. A higher proportion of women who had had second abortions (57.3 percent) than other abortion patients (46.7 percent) had used a contraceptive means at the time of coitus when conception occurred.[4] Like other patients their use of contraception was substantially lower than among sexually active women in the general population (82.2 percent). Their use of contraceptive means rose by their age and level of education. Among females between 16 and 17 years who had had second abortions, 39.1 percent had used contraception. The rate with which these measures were used was 58.1 percent for females between 18 and 23 years, 58.9 percent for females between 24 and 29 years, and 55.9 percent for females who were 30 years and older. A third of women with an elementary school education (32.2 percent) who had had second abortions used contraception in contrast to 55.9 percent who had a high school education, and 68.1 percent who had college or university training. The level of use of contraceptive means varied little by the religious affiliation of Catholic, Jewish, and Protestant

[4] The proportion of *all* women in the national patient survey who used contraception at the time of conception was 47.3 percent.

females, but it was appreciably higher (65.8 percent) among women affiliated with other denominations or who had no stated religious affiliation.

In contrast with all other groups of women, both females who had not had abortions and those individuals who had had first abortions, a substantially higher proportion of females who had had second abortions used oral contraceptives. Overall, among these females 80.5 percent had used the pill at the time of conception; 4.4 percent, condom; 4.4 percent, intra-uterine device (IUD); and 10.7 percent, other methods or a combination of contraceptive means. More women (90.1 percent) between 18 and 23 years than females of other ages had used the pill, while the use of the condom was the highest among females between 16 and 17 years (20.0 percent) and women 30 years and older (10.3 percent). There was a decrease in the use of the pill as the level of education increased, a shift which was complemented by a higher use of the condom and the IUD among women with more educational training.

The reasons why 42.7 percent of females who had had second abortions did not use, or had discontinued, the use of contraception were basically similar to the reasons cited by other abortion patients. A slightly higher proportion (53.7 percent) were afraid of the hormonal side-effects of oral contraception. Comparable proportions to other abortion patients had not used contraception because they had left their partner, they were sexually inactive, or they had not been prepared for coitus (27.6 percent). A quarter (25.3 percent) had discontinued the use of contraception because they had been using a particular method for a long time; and 21.1 percent of these women had stopped on the basis of following their physicians' recommendations. Almost 1 out of 5 (19.1 percent) had felt that they could not become pregnant at the time of coitus. None of the younger females had discontinued the use of contraception because they were afraid their parents would find out.

While fewer younger patients who were having their first abortions were concerned with the side-effects of contraception, there was a uniform concern among all age groups with this issue among patients who had had second abortions. Among these younger patients, a substantially higher proportion had not used contraception because, based on the assumption they were not sexually active, they had been unprepared for coitus. Three out of ten women (29.6 percent) between 30 and 49 years of age who had had second abortions felt they could not become pregnant at the time of coitus.

More of the married women who had had second abortions than either single or once-married females were concerned with the side-effects of the use of contraceptive means. While fewer of these married women than other females had stopped using contraception because they felt they had been sexually inactive, almost a third of them had discontinued this measure on their physician's recommendation. There was a marked difference by the marital status of patients who had second abortions in terms of the proportion who had felt they could not become pregnant at the time of coitus. While few single women (11.1 percent) said this was why they had not used contraception, 23.4 percent of married women gave this reply and 39.1 percent of once-married women had made this assumption.

## Sterilization

The birth of a child, the experience of a therapeutic abortion and other gynaecologic events can involve considerable emotional and physical stress for a woman. This fact is also true of surgical sterilization. It marks the end of reproduction for a woman. Sterilization may involve even more stress if it is performed in conjunction with another critical event such as an abortion or a delivery. To minimize these problems, it is the practice of some hospitals and physicians to discourage the simultaneous undertaking of sterilization with a delivery or an abortion. But from the opinions of some of the physicians in the national physician survey and of some patients in the national patient survey, it is apparent that an agreement to be sterilized has been used on occasion as a prerequisite to obtaining an abortion. The emotional vulnerability and the feeling of being under duress of a woman either at the time of a delivery or an abortion makes it somewhat easier for her to agree or to be persuaded to have the sterilization done at the time of these other procedures.

Information from Statistics Canada for 1974 indicated that 5,065 cases or 12.3 percent of the total terminations of pregnancy had been concurrently sterilized. Tubal ligation was the leading surgical procedure used to sterilize 59.0 percent of the sterilized cases. This procedure was followed by tubal coagulation (19.7 percent); bilateral salpingectomy (16.7 percent); hysterectomy (3.9 percent); and other procedures (0.7 percent) of the sterilized cases. For the women who obtained abortions in 1974 for whom information was available, 57.3 percent of the women who were subsequently sterilized were under 35 years of age. The frequency with which this procedure was performed rose directly with the number of previous deliveries which these women had had. It was more often performed for patients who had their abortions done earlier in their length of gestation.

The sterilization experience of the women in the 1976 *national patient survey* parallelled many of the trends for 1974 documented by Statistics Canada. The proportion of women who had a concurrent sterilization operation at the time of their abortion rose directly with their age and the number of their previous live births. Few women under age 25 had this operation. While only 1.0 percent of the patients under age 20 were to be sterilized, this rate rose to 9.4 percent of women between 25 and 29 years, 26.8 percent between 30 and 34 years, and 47.0 percent of women who were 35 years and older. This rate closely approximated the 52.2 percent of the women over 35 years who had concurrent sterilizations with their abortions in 1974 across Canada. Similarly, it was only at the level of two or three or more previous live births that the proportion of women who were to be sterilized rose to 24.5 and 47.1 percent respectively.

Married, widowed, and divorced women were more likely to be sterilized. A majority of the women having this operation said they lived at home and were neither at school nor had a job. However, 38.8 percent of the women who were to be sterilized were working. Protestant and Catholic women were both moderately likely to be sterilized and those women who reported either no religious faith or who were Jewish were slightly more likely to be sterilized. Where a woman had been born made little difference. Among the women who

had been born in Canada, 7.8 percent were to be sterilized. Women who had been born in other countries did not differ greatly in this respect, except for those who came from Southern Europe of whom 18.1 percent were to be sterilized after the abortion operation. Women who had had a previous abortion were no more likely to be sterilized than the women who were having a first therapeutic abortion.

**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 had attended high school and 6.2 percent who had been to college or university.** The prevalence of sterilization was significantly higher for those women who were less well educated. Only 1.0 percent of the sterilizations were performed on women under 20 years of age. The education of the women who were to be sterilized was in most cases completed. Women who were to be sterilized in British Columbia had the smallest range between the levels of education with 12.8 percent of women who had an elementary school education and 6.6 percent with a university education who had the operation. This gap by the level of education of abortion patients and their concurrent sterilization was greater in other regions with the Prairies and the Maritimes having the largest discrepancies. In each region those women with fewer years of schooling were more likely to be sterilized. Excluding British Columbia, the proportion of women with an elementary school level of education who were to be sterilized varied between 16.7 and 21.7 percent, while the proportion of women with a university education who were to be sterilized was between 2.9 and 8.3 percent. Women with a high school education were between these levels, but they were closer to the experience of university-trained women.

One-quarter of the women in the national patient survey were still attending school. This fact might affect the relationship among the women between their level of education and who was to be sterilized. A separate analysis was done which reviewed the experience of the women who were to be sterilized in each educational level by how old they were. Predictably, there were significantly few sterilizations among women under age 20. For women between 20 and 35 years there was a pronounced association between the extent of sterilization and the level of education. Women who had a university education were less likely to be sterilized than were those women who had an elementary school education. The general proportion of women who were to be sterilized increased with each age group, but within each age category the trend was evident that less well educated women were consistently more likely to be sterilized. For women between 20 and 24 years, the proportions rose from 1.1 percent of the women with university training to 10.4 percent of women who had an elementary school education. The proportions of women who were to be sterilized among the older age groups were 2.8 percent among university graduates who were between 25 and 29 years and 13.2 percent for women of these ages who had an elementary school education. Among women between 30 and 34 years, 19.3 percent who had university training and 46.3 percent who had an elementary school education were to be sterilized. This trend by education did not occur among women who were 35 years or older. For these women, the proportion who were to be sterilized was relatively high at each

educational level with no indication for any educational group to have a higher prevalence.

Several factors may account for the finding that the education of a woman seeking an abortion had such a clear role in determining the probability of her sterilization. The women who were less well educated may have had other characteristics which acted in concert to increase the chances of their sterilization. It is also possible that their relative lack of education protected them less from the advice which was given by physicians, who in deciding that these women were less effective in controlling their fertility, may have more strongly counselled their sterilization.

While there were minor variations in the national patient survey in the regional occurrence of the concurrent sterilization of women obtaining abortions, there were substantial differences by the age and parity of these women. There were also significant differences when the regional analysis was set aside and the experience in this respect of the individual provinces was considered. These several differences were influenced partly by the attributes of the women who were involved, but a more important consideration was the nature of the various guidelines set by the medical staff and the hospital boards in different parts of Canada involving their sterilization policies of abortion patients.

Based on information provided by Statistics Canada about abortion patients who were concurrently sterilized in 1974, the regional occurrence was: 8.3 percent, the Maritimes; 9.5 percent, Quebec; 13.4 percent, Ontario; 15.6 percent, the Prairies; and 9.7 percent, British Columbia, the Yukon and the Northwest Territories. These broad regional groupings mask significant provincial differences, such as the one-third (32.6 percent) of the women who obtained abortions in Newfoundland in 1974 who were concurrently sterilized, or the 1 out of 5 such women (20.5 percent) in Manitoba who had both of these operations done together. The proportion of the women who had abortions and were concurrently sterilized for each province in 1974 was: 32.6 percent, Newfoundland; 6.0 percent, Prince Edward Island; 5.4 percent, Nova Scotia; 5.5 percent, New Brunswick; 9.5 percent, Quebec; 13.4 percent, Ontario; 20.5 percent, Manitoba; 12.8 percent, Saskatchewan; 14.8 percent, Alberta; 9.8 percent, British Columbia; and 6.5 percent, the Yukon and the Northwest Territories.

While there is a difference of two years between the 1974 information provided by Statistics Canada and the 1976 national patient survey, it would appear that among women who had a concurrent sterilization at the time of their induced abortion, this experience was matched for the Maritimes and British Columbia. There may have been either an under-representation in the 1976 survey in other regions or an actual shift in the occurrence of this procedure may have taken place.

| | Statistics Canada, 1974 | National Patient Survey, 1976 |
|---|---|---|
| | percent | percent |
| Maritimes | 8.3 | 9.2 |
| Quebec | 9.5 | 5.8 |
| Ontario | 13.4 | 9.2 |
| Prairies | 15.6 | 9.8 |
| British Columbia | 9.7 | 9.7 |

There was greater regional variation among the married women having induced abortions of whom 45.9 percent were to be sterilized in the Maritimes and in the Prairies where the corresponding level was 39.7 percent. The level in other areas was lower with 12.6 percent of married women who were obtaining abortions in Quebec concurrently having the sterilization operation. Among the women who were widowed or divorced, 27.6 percent were to be sterilized in British Columbia and 28.6 percent in Ontario. These levels were twice the rates for each of the remaining three regions. Fewer separated women were sterilized at the time of their abortions. The influence of religion on the sterilization of abortion patients in the survey was pronounced for Catholics in some regions. In Quebec and the Maritimes, 5.0 and 4.7 percent respectively of the Catholic women were to be sterilized compared to between 9.6 to 11.2 percent of the Catholic women living in other areas. There was little variation in the proportion of women who were scheduled to be sterilized by their religious affiliation among women who lived in other regions. About 1 out of 10 Protestants, Jews and those women who reported no religious affiliation were to be sterilized in each of the regions outside Quebec. However, 1 out of 20 of the Protestant women in Quebec had this operation. These findings indicate that there may be factors other than the religious affiliation of the women who lived in Quebec which affected the extent to which they were sterilized.

Within each geographic region, sterilization was rare among younger and low parity women. Beginning with the 25 and 29 age group and those women who had two children, the proportion who were to be sterilized rose in the regions outside Quebec. The proportion who were to be sterilized in the other four regions was between 9.7 percent and 14.0 percent for women who were between 25 and 29 years; it rose to between 47.2 percent and 67.6 percent among women who were 35 years and older. The proportion of women who were to be sterilized rose from a low of between 2.6 to 6.6 percent among women who had had none or one birth to about 1 out of 3 of the women who had had two live births who lived in Ontario, the Prairies and British Columbia. About a half of the women who had had three or more live births were to be sterilized in all regions except Quebec which performed fewer sterilizations on any women who had had less than three live births and the Maritimes where few women were to be sterilized, except those who had had three or more live births (57.1 percent).

The need for a further analysis of the effects of age, the number of live births and marital status of women on the likelihood of sterilization is indicated by these findings. On its site visits to hospitals, the Committee found that these factors were given considerable weight in the decision which was made to sterilize a patient. Among the hospitals visited by the Committee, 44.9 percent based the decision for sterilization on the agreement of a woman and her physician, 23.1 percent used the "rule of 100" or the age of a woman multiplied by the number of children to whom she had given birth, 20.5 percent reviewed such requests before a hospital committee, and the remainder either used other formulae or approved sterilization only for medical reasons. There was a definite east-to-west trend in these review procedures. The age-parity mathematical formula (e.g., age of woman—35 years $\times$ 3 children = 105; or age 25 $\times$ 4 children = 100) was most extensively used in Quebec, where 55.6

percent of the hospitals visited by the Committee followed this procedure[5]. The decision that sterilization was solely a matter between a woman and her physician at the hospitals visited by the Committee was followed by: 40.0 percent, Maritimes; 25.9 percent, Quebec; 41.7 percent, Ontario; 59.1 percent, Prairies; and 66.7 percent, British Columbia, the Yukon and the Northwest Territories.

With the exception of Quebec, most hospitals in other provinces required the consent of a married woman's husband prior to her sterilization (65.4 percent), her former partner, if she was separated or divorced (3.8 percent) or if she was single of her male partner (7.7 percent). In Quebec, about half of the hospitals which were visited (44.4 percent) required only the consent of a woman, while the extent of this requirement in other regions was: 12.5 percent, Maritimes; 13.3 percent, Ontario; 20.0 percent, Prairies; and 15.8 percent, British Columbia, the Yukon and the Northwest Territories.

Among the women in the national patient survey the proportion to be sterilized according to the number of their previous pregnancies was analyzed by their ages. For women under 20 years there had been 10 sterilizations, but there were no trends in their distribution. Among the women who were over 20 years, there was a strong and consistent pattern of sterilization associated with their number of prior live births. The prevalence of sterilization increased with age and increased with the number of live births in each age category. For women between 20 and 24 years, the proportion of sterilizations for those females with none or one live birth was 1.1 percent. This rate rose sharply from 15.6 to 16.7 percent among women who had two or three and more children. The same pattern occurred among women who were between 25 and 29 years. The increase was from 2.8 percent of all women with none or one live birth to approximately one-quarter of those women who had two or more live births. The trends in the sterilization of the women who were over 30 years of age did not display the same sharp increase among those who had two or more live births. For these women the proportion who were to be sterilized was relatively high, even if they had had no live births and rose to over half of those women who had had three or more previous live births. Twenty percent (20.0) of the women with no live births and who were 35 years and older were to be sterilized; the proportion of these women to be sterilized who had three or more live births was 58.7 percent.

The effects of marital status were also examined. This factor had a less pronounced effect. To explore the interaction of these factors a further statistical analysis was undertaken.[6] The findings of this further analysis support the results described above. In examining the relative impact of age and the number of live births on the extent of sterilization, the findings from the hospital patient survey indicate that a woman's age was the most important factor. Regardless of their number of live births, relatively few women were to be sterilized at the time of their abortions who were under age 25. However,

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[5] This type of formula was used by relatively few of the hospitals visited by the Committee in other regions with its overall occurrence being: 75.0 percent, Quebec; 4.2 percent, New Brunswick; 12.5 percent, Ontario; 8.3 percent, Saskatchewan.

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

for women over age 35, a high proportion of the women who had had no previous live births were scheduled to have the operation at the time of their abortions. Married, widowed or divorced women were more likely to be sterilized with those women who were separated being less likely to have the operation. Between 1.1 and 2.0 percent of single women receiving an abortion were to be sterilized compared with 22.6 to 45.9 percent of the married women living outside Quebec. For married women in Quebec, the level was 12.6 percent.

Predictably, few women who were attending school were to be sterilized. Less certain was the level of sterilization among women who were working or who lived at home. A comparison of the regional findings found that working women were unlikely to have the operation. Most of those women who were to be sterilized said that their main responsibility was "at home" and their regional distribution was: 12.1 percent, Quebec; 15.1 percent, British Columbia; 20.8 percent, Ontario; 26.8 percent, Maritimes; and 27.8 percent, the Prairies.

The findings on the sterilization of abortion patients showed consistent patterns for a variety of social and demographic factors across the five regions in Canada. **The typical woman having an abortion who was to be sterilized had an elementary school level of education, spent most her time at home, was over 30 years of age and had two or more children.** With the exception of Quebec, a woman's religion played a less important role in determining who would be sterilized. In general, the pattern in Quebec was consistently lower than the rates in other areas in Canada for each of the groups which were considered.

## Sexual behaviour and abortion

Among females in the *national population survey*, those **women who had had abortions were on an average more sexually active than the other women** in the survey. While 24.6 percent of women in their reproductive years did not have coitus, 4.2 percent of women who had had abortions said that at the time of the survey that they then never had sexual intercourse. In almost equal proportions, 16.0 percent and 16.7 percent respectively, both groups of women had coitus once a month or less often. Among women who had not had abortions, 59.4 percent had coitus once a week or more often while 78.1 percent of women who had had abortions had sexual intercourse with this weekly frequency. **The overall weekly frequency of coitus for the two groups was 1.18 for all women and 1.62 among women who had had abortions.** The difference in the usual frequency of coitus was 27.2 percent.

The difference in the frequency of coitus between women who had had abortions and women who had not had abortions was consistent by their marital status. In particular, single women (1.63 times per week) and once-married women (1.35 times per week) who had had abortions were between 3 to 4 times more sexually active than all women in these categories (0.44 and 0.49 respectively) in the national population survey, while there was less of a

difference between married women in each group (1.78, abortion; 1.57, no abortion). Young women between 15 and 17 years who had had abortions were the most sexually active (2.00 times per week) of all females whether they had had or not had this operation. In comparison, the weekly coital frequency of young females who had not had abortions was 0.12. A higher level of coital frequency also characterized women between 18 and 23 years who had had abortions. Beyond the age of 24 years the usual weekly frequency of coitus was similar for both groups of women, a change which was related to a larger number of women who had had abortions in these older age groups who were married. This pattern remained about the same for all women over 23 years of age including those individuals who were 50 years and older.

TABLE 14.8

CONTRACEPTIVE MEANS USED BY ABORTION EXPERIENCE OF WOMEN WHO HAVE COITUS

NATIONAL POPULATION SURVEY & NATIONAL PATIENT SURVEY

| Type of Contraceptive Means | Experience with Abortion | | |
|---|---|---|---|
| | Not Had an Abortion (Population) | Had an Abortion (Population) | Had an Abortion (Patient) |
| | percent | | |
| Pill | 44.0 | 47.0 | 18.0 |
| Condom* | 6.5 | 2.0 | 26.2 |
| I.U.D. | 6.2 | 9.8 | 9.9 |
| Withdrawal* | 3.8 | 3.9 | 9.4 |
| Rhythm | 5.3 | 5.9 | 15.3 |
| Foam | 2.5 | 3.9 | 15.3 |
| Diaphragm | 2.4 | 2.0 | 4.3 |
| Sterilization* | 25.5 | 25.5 | 0.4 |
| Other | 3.8 | 0.0 | 1.2 |
| TOTAL | 100.0 | 100.0 | 100.0 |

*The use of these contraceptive methods refers to their use either by women or men at the time of coitus.

Four out of five women (82.2 percent) in the national population survey who were sexually active used contraceptive means. Excluded from this group of women were those females who at the time of the survey never had coitus. If these women in the reproductive years are included, then 47.0 percent of all women in the national population survey used contraceptives. In comparison with *all* of the women in the national population survey, 86.0 percent of women who had had abortions and who were sexually active at the time of the national population survey were using contraceptive means. While the characteristics of

both groups were generally comparable, a higher percentage of younger and single females who had had abortions were using contraceptive means than was the case for women of similar ages who had not had this operation. It is unknown whether the women in the national population survey who had had abortions had been using contraceptive means at the time of conception. What is apparent from these findings is that their current use of contraceptive means was higher than for all women in the national population survey.

**The type of contraceptive means used by the 47.3 percent of the patients who had abortions in Canadian hospitals in 1976 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 these patients used oral contraceptives, or the pill, a proportion which contrasted with the 44.0 percent of women in the national population survey who had not had abortions who used the pill and the 47.0 percent of women who had previously had abortions. In contrast with the two other groups of women in the national population survey, the patients who had had abortions in 1976 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.**

When the findings from the two national surveys are considered together, what emerges are distinctive differences in the usual sexual behaviour of women who have not had abortions and women who have had abortions. These differences are in terms of: (1) their usual level of coital frequency; and (2) the types of contraceptive means which were used, in particular by young and single females. What is needed in considering the patterns of sexual behaviour involving women who have had abortions are in-depth studies done over a period of time which compare what they do relative to the experience of other women in terms of: their sexual experience; the attributes of their male partners or marital cohabitational circumstances; and their use of contraception. The findings obtained by the Committee are only a first step in a comparison of the sexual behaviour of these two groups of women.

## Sources of information about contraception

In the *national population survey* women and men were asked from whom they had obtained information about contraception. What the findings indicate is that: **a sizeable number of Canadians have had no formal instruction on the use of contraceptive means; the physician is seen as the chief source of such information for women and men; and learning about these methods from all other sources is very much a hit-or-miss affair in Canada.** The findings on the sources of information about contraception confirm from the perspective of women and men whom these programs were intended to serve that there was little coordination between these programs. Their impact has been diffuse and minimal. From the receiving end—the people who were to be informed and counselled—the work of voluntary associations, churches, schools, and public

health units had reached about 1 out of 10 individuals. Overall, 4 out of 10 women and men looked to physicians for this type of information. An almost equal number either did not know about the use of contraception or had been informed, or misinformed, by casual and informal sources.

The major sources of information about contraception cited by the women and men in the national population survey were:

| Source | Females | Males | Total |
|---|---|---|---|
| | | percent | |
| physician | 45.9 | 33.5 | 39.7 |
| none | 35.5 | 43.2 | 39.4 |
| school | 6.5 | 9.3 | 7.9 |
| other | 5.5 | 6.7 | 6.0 |
| multiple | 3.2 | 3.3 | 3.3 |
| church | 2.2 | 1.8 | 2.0 |
| community agency | 0.6 | 1.2 | 0.9 |
| public health | 0.6 | 1.0 | 0.8 |

Almost half of the women (45.9 percent) and a third of the men (33.5 percent) said their main source of information about contraception was from physicians. In recent years some Canadian medical schools have initiated instruction on the usual sexual behaviour of women and men. Most of these programs were started since 1970. In general, little curriculum time was assigned to instruction on contraception, and there was no uniform syllabus used by the 16 medical schools dealing with the full range of sex-related medical issues. In some medical schools there was only minimal coordination between the various academic departments in the development of a curriculum on these issues. Because the formal academic instruction of medical students on the sexual behaviour of women and men has only been recently started, a majority of physicians now in medical practice in Canada have had no formal preparation on these issues. This point was made by many physicians to the Committee on its site visits to hospitals across Canada. For these reasons the basis of the counsel on sexual behaviour and contraception use given by many physicians to their patients may be a blend of professional experience and personal views. These factors affect what type of advice is given, how it is given, and when it is given.

In the national survey of family physicians and obstetrician-gynaecologists, physicians were asked at what age they usually began to provide contraceptive counselling to their patients. A small number of these physicians said they would provide contraceptive counselling to patients regardless of their age whenever in their professional judgment they felt such advice was required (12.2 percent gynaecologists; 7.9 percent family physicians).[7] The ages of

[7] This group of physicians is included in the listing of physicians who would provide contraceptive counselling to females 13 years and under.

patients at which these two groups of physicians would start providing contraceptive counselling were:

| | Gynaecologists | Family Physicians |
|---|---|---|
| | percent | |
| 13 years and under | 13.8 | 12.8 |
| 14 years | 16.5 | 19.6 |
| 15 years | 12.0 | 13.3 |
| 16 years | 22.4 | 24.8 |
| 17 years and over | 34.7 | 27.6 |
| never, non-applicable to type of medical practice | 0.6 | 1.9 |
| TOTAL | 100.0 | 100.0 |

Although there is considerable individual variation among females and males by their ages when puberty starts, this change usually occurs for females between 12 and 13 years and for males at about 14 years of age. About a third of both groups of physicians (30.3 percent of gynaecologists and 32.4 percent of family physicians) in the survey of physicians were prepared to provide contraceptive counselling to teenagers who were 14 years and older. About 2 out of 5 physicians in each specialty (42.3 percent gynaecologists, 45.7 percent, family physicians) would be prepared to start this type of counselling for females who were 15 years and older. Two-thirds of the physicians (64.7 percent of gynaecologists and 70.5 percent of family physicians) were prepared to give such information to teenagers who were 16 years and older. About a third of the physicians were reluctant to provide contraceptive counselling to young teenagers who were under 17 years because they were uncertain whether such information could legally be given to minors, they did not want to do so without parental knowledge or consent, or in some instances, they did not want to contribute to what they felt was the promiscuous sexual behaviour of teenagers.

Between the ages of 15 and 17 years, females in the national population survey had coitus on an average of once every two months and males in this age group once every five weeks. Among females between 15 and 17 years who had had abortions, their average frequency of coitus was twice a week. A substantial number of the females in this age group who had had abortions (national patient survey) had not used contraceptive means. Many of these young females, while having made one or more visits annually to physicians, had not sought or received contraceptive counselling.

There were sharp differences in the sources of contraceptive information which females had involving the use of contraception resulting from medical consultation and their use of other methods. Approximately three-quarters of women who used the pill (77.3 percent), the intra-uterine device (82.1 percent), the diaphragm (68.2 percent), or who had been sterilized (71.1 percent) said that physicians were their main source of contraceptive counselling.

Other sources of information about these four methods had had little impact and were not extensively cited by women in the national population survey. A small number of women said they had had no advice from any source about these methods.

In contrast with women who used the four methods requiring medical consultation, about half of the females who used other means had not had medical consultation on the use of these techniques. Despite the reports given by public health and community agencies, few individuals in the national population survey had obtained contraceptive information from these sources. Less than half of the women (47.5 percent) whose partners used condoms during coitus had obtained information from any formal public or community program. A substantial number of females (44.0 percent) and males (55.0 percent) who used the withdrawal method had had no formal instruction about this means of contraception.

What these findings about the sources of information and the use of contraception indicate is that **a substantial number of women and men across Canada have had no formal instruction about any method of contraception.** Among the individuals who used a particular method, a large proportion had had no instruction on its effective use. **The physician was seen by the women and men in the national population survey as the major source of contraceptive advice. All other programs 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.** These sources of information were seldom, if ever, mentioned. Overall, **schools were cited by 7.9 percent of women and men, the churches by 2.0 percent, community agencies by 0.9 percent, and public health programs by 0.8 percent.** While some community agencies have developed active family planning programs which include contraceptive counselling, in terms of the broad cross-section of the population which was represented in the national population survey, these programs had had a minimal impact on the individuals whom they were intended to serve.

In recent years federal and provincial programs of family planning have become more extensive and have received increased financial support. Eight provinces operated family planning programs in 1976; four of the provinces had appointed full-time staff as family planning consultants or coordinators. These provincial programs were intended to encourage the development of family planning measures, increase the involvement of public health personnel in this field, and on occasion, to provide contraceptive information and counselling for the public.

The Committee received information from 137 provincial public units about the different phases of their family planning activities which variously involved: family planning counselling; pregnancy counselling; or the operation of family planning clinics. The provincial distribution of these programs was:

| | Family Planning Counselling | Pregnancy Counselling | Family Planning Clinic | Responses from Provincial Health Units/Programs |
|---|---|---|---|---|
| Newfoundland | — | — | — | — |
| Prince Edward Island | 1 | 1 | — | 1 |
| Nova Scotia | 5 | 4 | 2 | 5 |
| New Brunswick | 3 | 2 | — | 3 |
| Quebec | 13 | 14 | 8 | 25 |
| Ontario | 31 | 27 | 23 | 34 |
| Manitoba | 11 | 10 | 4 | 11 |
| Saskatchewan | 9 | 9 | 2 | 9 |
| Alberta | 26 | 20 | 2 | 27 |
| British Columbia | 15 | 15 | 5 | 18 |
| Northwest Territories | 3 | 3 | 2 | 4 |
| TOTAL | 117 | 105 | 48 | 137 |

Based on the replies which were received from the 137 public health units, their administrators felt that sex education programs were inadequate in 93 regions served by these units. Many of these programs involved the distribution of pamphlets, instruction given at pre-natal classes by public health nurses, visiting on maternity wards by public health nurses, or programs combining health promotion with other health services. Taken together, these public health programs were not associated directly as a source of contraceptive counselling for the women and men in the national population survey. Not only were these public health programs not reaching a sizable number of individuals, but among senior hospital staff including physicians, nurses and administrators whom the Committee met with across the country, these programs were often seen to be expensive and ineffective. Many of these provincial and municipal programs were located in difficult-to-reach sites, scheduled their family planning clinics at times which were convenient for staff but not for individuals to be served, or combined these efforts with other programs such as venereal disease clinics. There was seldom any coordination between these public health programs and the family planning work done in hospitals. Little effort was evident to effect such an integration. Likewise, there was often little coordination between the churches, the schools, or the community agencies which were involved in family planning. In some instances there was an open hostility between public health programs and community agencies, a conflict based on establishing or maintaining a territorial imperative of an institution rather than achieving an accommodation to use effectively scarce resources to assist individuals whom it was intended to serve.

Relatively few of the hospitals visited by the Committee had established family planning clinics or programs. While there was a much broader interest expressed by hospital administrators and senior medical staff about the need for such programs, the reason usually given why they had not been started were the constraints of existing health budgets. The few hospitals which had started family planning programs have had some difficulty in their operation

and the medical and nursing staff have not been satisfied with their effectiveness. The work of two hospital clinics illustrates how the programs are organized and some of their difficulties.

*Hospital One*

Our clinic has operated weekly throughout the year except for the month of August and is held each Wednesday evening from 7:00 p.m. in the Outpatient Gynaecology Clinic. The medical and nursing staff were initially volunteers from the Department of Obstetrics and Gynaecology including fellows and residents from the Department assisted by a small group of volunteer registered nurses. Through the active assistance of the Medical Officer of Health representations were made to the Board of Health for financial support as it was soon realized that an ongoing and growing facility could not indefinitely survive as a volunteer operation.

It was our early impression that we would attract several types of patients, namely the hospital-clinic-oriented patient, the patient who either lacked a family physician or, having one, was not finding her needs in this area met by him; the young woman who would not approach the family physician, newcomers already accustomed to clinic programs in their own homeland. All applicants without regard to race, colour or creed, with or without insurance and regardless of ability to pay are welcomed.

From the outset we have tried to draw a clear distinction between "Family Planning" and "Therapeutic Abortion". Patients attending our clinic under the impression that they could obtain an abortion have been referred to morning gynaecology clinic. Patients have come from a number of sources. No actual advertising program has ever been used. Our major source has been patient referrals from the gynaecology clinic, the postnatal clinic and, latterly, referrals from the therapeutic abortion program. A number of patients used to be referred from the Planned Parenthood Association and from the university. Both of these sources have ceased. A number of cases have come from outside physicians; a surprising number came from outside. A fairly large number are now simply self referred.

The number of patients who have been seen are:

VISITS TO CLINIC

| | New Patients | Totals |
|---|---|---|
| 1968 | 591 | 1,592 |
| 1969 | 679 | 1,749 |
| 1970 | 628 | 1,546 |
| 1971 | 713 | 1,589 |
| 1972 | 798 | 1,874 |
| 1973 | 671 | 1,790 |
| 1974 | 589 | 1,615 |

On arrival, a patient is registered and interviewed by the public health nurses. We use a film about family planning as an educational aid. Brochures and other reading material are provided as part of the educational program. Interviewing and counselling are provided by the public health nurses. The

patient is then called by name in order of arrival for an interview by the physician. The medical history is reviewed along with the hospital record, if any.

Initial examination consists of a brief general physical and a detailed gynaecological examination. Pap smears are done routinely on an annual basis. Vaginal cultures for G.C. etc., are carried out as indicated. Any general medical or surgical condition encountered is referred to the appropriate specialty clinic, family practice, general surgery, urology, etc. Simple gynaecological problems are treated in the clinic but major gynaecological problems are referred to morning gynaecology clinics or admitted as an in-patient to our service.

From discussion with and examination of the patient, the physician selects the appropriate contraceptive method desired and/or indicated along with explanation, advice and a return appointment. If further explanations are desired the patient is referred back to the public health nurse.

Follow-up of cases needing further supervision and who fail to keep appointments has been and remains difficult, frustrating and disappointing. Cases most in need of this service are the ones least likely to make use of it.

Operating under the above constraints of time and space, our clinic appears to have reached a plateau in attendance figures. Family planning services though needed in the community continue to be hampered by apathy, inertia, fear and suspicion on the part of potential users of these services. Nor are we being helped by the negative nature of publicity we have been receiving.

Efforts to provide post-operative follow-up and supervision of the patients coming through the therapeutic abortion program have so far been ineffectual. Although these patients are most in need of contraceptive counselling, between 70 and 80 percent of the appointments made for these women are not kept. This occurs in spite of an in-hospital educational program being provided by our department of these as well as post-natal patients. The substantial numbers of "repeat offenders" now seeking another abortion is evidence of the magnitude of this unsolved problem requiring more attention and effort on our part.

*Hospital Two*

The system was designed to produce what we hoped was a maximum impact on continuing contraception for the individual seeking termination and also to allow a realistic amount of pre and post-abortion counselling to go on. We found that this activity along with post-partum contraceptive counselling could in fact keep one individual busy full-time. Consequently, for the past three years we have utilized the services of a full-time family planning nurse in this role. The majority of our therapeutic abortions are undertaken through our clinic representing probably the lower socio-economic class in the community.

The therapeutic abortion and family planning clinic is held in a relatively new facility. The personnel consists of a nurse in charge, a family planning nurse who does all the counselling, a secretary and part-time nursing aide. Other things go on in this clinic in that we have special diagnostic services such as colposcopy and endocrinology, infertility, and so on, but at different hours. The family planning nurse has a small office for private counselling. There is a generous waiting room, a secretarial post, and four consulting and examining

rooms. Immediately adjacent is our ultrasound facility which is primarily designed for research and the clinical management of high risk pregnancy.

The hospital renovated this area in 1972, the personnel are paid by the hospital and also by the active obstetrical staff. The active obstetrical staff through its staff association also provides monies for equipping this and the high risk pregnancy unit.

Our current financial commitment to this is in the order of $30,000 per year. My own feeling is that this method of financing is the best of both worlds. It is apparent in the private sector that provincial health insurance will not support by itself an extensive counselling or follow-up mechanism. Also, the hospital budgets will not support the extra personnel which are required to produce this kind of service. Hence, the cooperative agreement between staff and hospital to produce funds from both professional services and hospital budget produced this capability.

We accept patients on referral and on direct application by patients themselves. The patient who comes to our clinic is registered by our secretary and is seen first by our family planning nurse. She discusses with them the reasons for seeking termination and the attitude of the patient and her husband if he also attends. She notes a short social history on the chart, and at the same time begins to introduce some family planning education in the form of a contraceptive choice.

The patient is then seen by the professional staff. This professional staff in our clinic consists of a professional staff member, a resident, and a junior or clerk who is there for educational purposes occasionally. The social history is noted and clarified by discussing this with the professional staff. A physical examination is undertaken with the usual smears, cultures, and so on and the dating of the gestation. If the circumstances are such that the professional staff is going to recommend termination, such a recommendation is made at the time, and the patient is made aware of such a recommendation. In view of the fact that house staff do change, we felt it important to have a consistent attitude towards this and have a local house rule that no patient is sent from the clinic without a recommendation for termination unless this is confirmed by the attending staff member. In other words, it is the attending staff who produce a consistency of attitude. No house staff is required to undertake an abortion which they are not willing to recommend. If the rare occasion arises that house staff members aren't willing to make a recommendation and a staff member is willing to make a recommendation, then the procedure is done by the staff member.

Following this portion, the patient is once again seen by the family planning nurse who informs her of the therapeutic abortion committee procedure, the time of its meeting and gets all the details (on how to contact the patient quickly). Our clinics are held Mondays and Wednesdays, and the therapeutic abortion committee meets on Thursdays. Also, the particular procedure recommended is explained to the patient and her hospital stay is also explained.

The therapeutic abortion committee then meets and the family planning nurse attends this meeting to bring to the committee the full range of information available on the patient. If a recommendation is made for termination by the committee, the family planning nurse then contacts the patient and through the resident staff, arranges for her admission and her procedure.

When the patient is admitted to the hospital, the family planning nurse visits her before or after the operation. The morning following the procedure she holds her class on contraception where the particular method prescribed for the patient is discussed and explained. This will at times occur on a private basis at the bedside of the patient if she is reticent to join a group. The contraception, usually the pill or IUD, is initiated immediately. The follow-up visit is then given.

The patient is requested to return to our family planning clinic for our follow-up in six weeks time. Once again, when she comes she is seen by the family planning nurse who reviews her first six weeks experience with the method of contraception and she is then seen by the professional staff who do her post-operative check, and appropriate continuance or changing of her contraception method is undertaken.

Following this visit, the patient is then followed on an annual basis, either by her family physician or at our clinic, whatever is her choice.

The system is designed, of course, to put one knowledgeable person with some rapport as the prime and continuing contact with the patient. We felt that this would assure a more reasonable follow-up and acceptance. We have been somewhat disappointed since our follow-up rate does not yet equal 50 percent. We sometimes make ourselves feel better that the patients are being followed up by their family physicians, but I think this is a phenomenon common to many units, that once the procedure is done, the patient is loath to return for follow-up.

In addition to the clinic patients about ten therapeutic abortions are done weekly, generated by 11 staff physicians. These patients are almost always on referral from general practitioners and the physician does his own assessment, makes the recommendation and undertakes the procedure. The family planning nurse visits these patients while they are in hospital, discusses their contraception and gives them their class on family planning. They are, however, followed by the private physician. It is my feeling that the follow-up in this group, which is largely middle-class, is greater than in our clinic.

It is obvious to us all, I think, that the family planning nurse is the key person in the operation of this facility. The technology is largely at hand in any well organized gynaecology department, but in this particular therapeutic situation, an extensive amount of patient contact, time and counselling is required. This is best done by a person who is skilled and interested in this, and particularly well done by a woman. The family planning nurse's activity is also extended to our post-partum patients to undergo family planning education during their post-partum stay. It has been our feeling that probably one of the most sensitive times to introduce responsible contraception to patients is at the time of a recently completed pregnancy either by childbirth or abortion. In addition, our family planning nurse also is responsible for organizing the childbirth education program in the hospital. All in all, we feel that she makes about 3,000 interventions in a year in the field of contraceptive counselling information and family planning in general.

It is my feeling that if municipalities are going to get into the business of spending money on family planning, they had best forget about renting or building shining edifices full of examining tables and doctors. The technology and the facility to provide this is already at hand for the most part. The

funding is also readily at hand for this activity through provincial health insurance. What is not available through this means or hospital sources is the provision of key counselling personnel of this type who can be spotted in key places.

The number of accidental pregnancies reported in fertility surveys and the volume of requests for induced abortion have prompted some experimental programs which are aimed at reducing unwanted conception by the promotion of contraceptive education. The assumption on which these programs were based is that the level of motivation for use of methods of fertility control and the knowledge of human sexual behaviour and contraception were low among many individuals in the population. The general intent of these programs is to increase these levels of motivation and knowledge so that the likelihood of unwanted pregnancies could be reduced. **There are significant implications in terms of costs in time and the allocation of personnel and money if such measures were to be implemented more broadly on a regional or national basis. Before embarking on such ambitious programs, it would be necessary to review the effectiveness of the programs which are underway.** The findings of the national patient survey may have a bearing on the effectiveness of current programs. Questions were included about whether a women had had sex education in school, and if that curriculum had included contraceptive education.

| Method Used at Time of Conception | Had School Sex Education Program | Not Had School Sex Education Program |
|---|---|---|
| | percent | percent |
| pill | 19.5 | 17.0 |
| condom | 27.5 | 25.3 |
| IUD | 8.8 | 10.6 |
| withdrawal | 3.7 | 4.7 |
| rhythm | 15.0 | 15.0 |
| diaphragm | 11.3 | 8.2 |
| foam | 13.1 | 16.6 |
| other | 1.0 | 2.6 |

Overall, there was a slight trend, but just that, which indicated that sex education which had been received in school by women in the national patient survey led to their greater use of more effective methods of contraception such as the pill, the condom and the diaphragm when conception occurred. But in looking at the experience of the women who had abortions and who had no sex education in school, their use was marginally higher of the IUD, withdrawal, foam and other contraceptive means. The findings indicate a slight trend toward the use of more effective contraceptive means, but the major conclusion is that for the women who had such programs in school, they had made little real difference to their subsequent use of contraception. **In almost equal numbers, women who were having induced abortions who had no instruction used the same types of contraception as the women who had such instruction in schools. The findings for these women do not lend support for the usefulness**

**of current contraceptive and family life education programs undertaken at schools across Canada.**

Among individuals in the national population survey, most sexually active women and men used a contraceptive method during coitus. The number of women who had abortions was considerably higher, particularly for younger females, among those women who never used contraception. This was a predictable outcome. But a substantial number of women in the national patient survey had used a contraceptive means at the time of coitus when conception occurred. Why the use of this preventive measure had failed was accounted for by the fact that these women and their male partners had not known enough how to use effectively these contraceptive means. A sizeable number of other women who had abortions either were afraid of the side-effects of the use of contraception, or they had been counselled by their physicians not to use such methods.

**Many women and men had no formal instruction on the use of contraceptive methods. By having coitus under these circumstances, the chances of an unexpected, and for many women, an unwanted pregnancy were sharply raised. This fact stands out starkly as a major factor contributing to the number of induced abortions across Canada. Like Russian roulette, 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.**

**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 this situation. 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 it 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 programs of public education and health promotion. There is no surety that such steps will be fully effective, but without taking them, there is virtually no likelihood that the volume of induced abortion will be reduced, or even contained, at its present level.**

# Chapter 15

# Cost of Health Services

More than in the past a growing number of voluntary community associations and programs paid for by all levels of government are dealing with issues affecting population growth. There is usually a sharp distinction made in most public programs in Canada between services and programs involving abortion, contraceptive counselling and services, and general family planning programs. These services and programs relate to the knowledge and practices which enable couples either to avoid or to terminate unwanted pregnancies or to bring about wanted births.

The health costs associated with induced abortions may include: (1) the personal expenses for a woman who may travel some distance to a hospital or who may lose income while being away from work; (2) additional medical expenses, if extra-billing is involved; (3) the medical and hospital costs which are paid for under national health insurance; and (4) for women who go abroad, the total direct costs of travel and the surgical operation. Health costs are one factor which influence the decisions made by women about where they obtain abortions in Canada or abroad. In considering the health costs associated with induced abortions, it is relevant to compare these expenditures with the costs of related programs, and where additional charges are involved, whether these are apportioned equitably by the social circumstances of the women.

In its work the Committee found that many patients, physicians, and hospital administrators were reluctant to discuss the issue of health costs associated with induced abortion. The reluctance of some abortion centres in the United States to provide information on their monetary charges and the number of Canadian patients whom they treated may have stemmed in part from a concern that such information might be used for the purposes of income tax calculation. There was an initial concern among some of the hospitals involved in the national patient survey that the doctor-patient relationship might be affected if private patients were to be included (for most hospitals, they were) and if information about the medical costs to these patients was obtained.

The Terms of Reference set for the Committee included the stipulation to determine "What types of women are successful and what types unsuccessful

in obtaining legal abortions in Canada?" Information is given here about the economic circumstances involved in obtaining an induced abortion in Canada and abroad, and a comparison is made between the relative costs of induced abortion, childbirth, and family planning programs.

## Non-profit voluntary associations

National non-profit voluntary associations concerned with various aspects of family planning have been active over a period of several decades. Their growth has increased in recent years to include a broad spectrum of interests. The primary concerns of most of these non-profit associations were with the dissemination of information about family planning and the counselling of women and men about critical family choices. Their involvement in abortion may be part of these general activities, but it was seldom their central purpose. From its survey of these agencies the Committee found that most reported there were no direct cost charges involved in providing these services. When costs were involved (10.7 percent), these were intended to cover the expenses of clinical testing services and, on occasion, were considered a donation or involved a membership fee. Depending upon the type of services provided, the fees charged by the community referral agencies were:

| | No Charge | Ability to Pay | Fixed Fee | Average Fee |
|---|---|---|---|---|
| | percent | percent | percent | dollars |
| Pregnancy Counselling | 96.1 | — | 3.9 | 2.25 |
| Contraceptive Counselling | 96.2 | 1.9 | 1.9 | 2.50 |
| Abortion Referral | 98.0 | 2.0 | — | — |
| Clinical Services | 10.0 | — | 90.0 | 3.11 |

Approximately 1 out of 5 women in the national patient survey had contacted one or more community referral agencies prior to obtaining their abortions. These women were asked if they had paid any charges for these services, and if so, how much had been paid. There was a discrepancy between the reports of these patients and the information provided by the community referral agencies which suggests that while these services may have been based on a non-profit principle, there were still attendant costs for some women who turned to them for assistance. Among the women in the national patient survey who used each resource, the proportion who said they had paid for the services was: 3.1 percent, school nurse; 10.5 percent, social service agency; 8.2 percent, Planned Parenthood; 9.4 percent, Birthright; and 37.4 percent, abortion referral agencies.

**The charges paid by the women obtaining abortions who had used non-profit community referral resources varied by their social circumstances and where they lived in Canada.** About 1 out of 5 of the women in the national patient survey who lived in Ontario (21.0 percent) and British Columbia (18.1

percent) had paid when they had contacted these agencies. Making such payments was unusual elsewhere (0.0 percent, Maritimes; 1.2 percent, Quebec; and 1.6 percent, Prairies). **Younger patients, women who were born abroad, and women who had more formal education more often made such payments.** One out of ten women (12.4 percent) who were 19 years or younger had paid for this assistance while the experience among women who were older was: 12.5 percent, 20-24 years; 8.6 percent, 25-29 years; and 6.3 percent, 30 years and older. Almost 1 out of 5 (19.8 percent) of the women who had been born in other countries had paid for these services, a proportion double that of women who had been born in Canada (9.2 percent). There was a direct association between the level of education of these women and the payment of charges. One out of twenty women (5.9 percent) who had an elementary school education said they had made such payments, while this was the case for 10.3 percent of the women who had been to high school and 13.2 percent of the patients with college and university training.

TABLE 15.1

FEES AND/OR CHARGES PAID BY WOMEN USING NON-PROFIT COMMUNITY AGENCIES

NATIONAL PATIENT SURVEY

| | $1-$15 | $16-$30 | $31-$45 | $46-$80 | $80+ |
|---|---|---|---|---|---|
| | | | percent | | |
| School Nurse | 3.1 | 0.0 | 0.0 | 0.0 | 0.0 |
| Social Service Agency | 10.5 | 0.0 | 0.0 | 0.0 | 0.0 |
| Planned Parenthood | 7.8 | 0.4 | 0.0 | 0.0 | 0.0 |
| Birthright | 6.3 | 3.1 | 0.0 | 0.0 | 0.0 |
| Abortion Referral Agency | 8.4 | 1.1 | 25.3 | 2.1 | 0.5 |

The non-profit voluntary associations dealing with family planning have an important responsibility in serving the needs of individuals who seek their assistance. Most of these agencies relied upon the dedication and the substantial effort of volunteers, and their services were provided free without regard to a woman's circumstances. In the case of the women obtaining abortions in the national patient survey, where some form of payment was involved, these charges were not evenly distributed.

## Commercial abortion referral agencies

The Committee obtained information on commercial abortion referral agencies from several sources, but when these are put together, only an incomplete summary of their work is possible. They were cautious to divulge information which might be of use to competitors, professional regulatory agencies, or government inquiries. Since they were in this work as profit-making enterprises, most of these commercial abortion referral agencies neither kept full records of what they did, nor were they prepared to release detailed information about the scope of their work. Much of the Committee's informa-

tion about these commercial enterprises came from secondary sources which included: provincial government health departments; the registrars of provincial medical licensing authorities (colleges of physicians and surgeons); direct reports from women who had used these agencies; the results of the survey done by the Committee of abortion clinics in the United States and the national patient survey; and site visits to hospitals across Canada made by the Committee. From these sources of information as well as a review of advertisements in newspapers of all major cities across Canada and a search of telephone directory listings of all cities with a population of 10,000 or above, a total of 13 commercial abortion referral agencies were identified. The use of the word *abortion* only occurred in the white pages of the telephone directories of larger cities, and in particular, was used by American agencies which advertised their abortion services in Canadian telephone directories. In some instances these agencies provided a toll-free long-distance telephone number which could be used. Newspaper advertisements were usually listed in two or three lines in the personal columns; in a few instances these announcements were commercially drafted larger advertisements.

One provincial health department had obtained extensive statistical information with the cooperation of the director of one commercial agency. None of the other provincial health authorities had any direct information about the work of these agencies or the types of services which were provided. Like provincial health departments, the professional medical licensing authorities had little first-hand information about the work of commercial abortion referral agencies. From the information obtained from the registrars of the provincial colleges of physicians and surgeons, a brief social history of these enterprises emerged. Most of these commercial agencies had started in the mid-1960s or later and their work had become more visible with the change in the abortion legislation in the United States. Their number and the scope of their work was directly related to the existence of alternative sources of public information about family planning. Where other sources of information were more extensive and better known to the public, there were few, if any, commercial agencies. While a number of commercial abortion referral agencies had been started, most of these had been closed. The enterprises which remained were located in a few major cities. The continued existence of these agencies was a relative measure of the existence or the non-existence of other active and known sources of information about family planning, and in particular about abortion.

The commercial agencies which were known to be in operation in 1975-76 were requested by the Committee to provide information about their work on the same basis as non-profit volunteer associations. It was indicated that the information to be obtained would be used for the purpose of assembling a statistical summary and there would be no identification of any agency. With one exception, an agency which had a trained professional staff, strong ties with a local university, and whose director had been a consultant to government,[1] none of these agencies provided detailed statistics about their

[1] In its principles of counselling, the training of its staff and its carefully assembled records, this commercial agency was the exception. The general findings about commercial agencies do not apply in this instance.

operations, their services, or the costs which were charged. Some of the information about these agencies, while incomplete, was assembled from the various secondary sources contacted by the Committee. No information was obtained about the operations of three commercial agencies, two of which used telephone answering services. One agency which had been established by an abortion clinic in upstate New York had subsequently closed.

**At several of the commercial agencies clients were routinely told that obtaining an abortion was illegal in Canada, misinformation was given about the actual costs involved, and alleged trained counsellors were paid on a commission basis.** Nine of these agencies routinely referred women who were seeking an abortion to clinics across the border in the United States. The staff members of one semi-commercial agency were privately employed by a group of physicians who performed abortions in two Canadian hospitals. This agency did not directly charge fees, but received most of its referrals through the agency from physicians. How these arrangements were sometimes made with these commercial agencies is illustrated by the experience of one woman who obtained an abortion in the United States.

> I contacted Mrs. _____ by phone. She insisted that there was no charge to the women who called her number asking for assistance and it very much depended upon what they asked, what information they were given in return. She repeatedly insisted, "goodness of her heart". She said that she was not receiving a salary from anyone and that her service was not supported by agency funds. There was one other woman present who also did counselling. She at one point said she received a salary from the doctors.
>
> I was told that it was understandable that I didn't want to have the abortion in _____ where I lived because there were "too many people". She was referring to the abortion committee which I would have to go through.
>
> I was asked if I planned to drive or to fly to _____. I said that I would fly and was told that I should use a flight connecting with _____ airport. The fee for the abortion was $150 and I must stay in the office for two to three hours.
>
> The woman then said that our connection was poor and she would have to hang up and call me back. In about 30 minutes, a different woman, whose name was _____ and who was a receptionist at the office, returned the call. She gave me the address of the office and told me that I must bring $150 in American currency (cash or money order).
>
> Since my pregnancy was about 12 weeks, it was necessary that I come the next day at 9:00 a.m. for the abortion. She had told me before that they could only do the abortion up to 12 weeks. I was told that if I was between 12 and 13 weeks I could still have the abortion done but it would cost $225. Since my pregnancy was on the "borderline" of 12/13 weeks, she advised that I bring an extra $75.

Nine of the commercial abortion referral agencies had made special arrangements with American clinics and operated on a cost-sharing basis. At each of these agencies the full fee was paid prior to a woman leaving a Canadian centre to obtain an abortion. The average fee for a first-trimester abortion was $250 and for abortions done between 13 and 16 weeks of

gestation the amount varied between $325 and $350. In some instances travel costs were included while for other agencies the charge for a chartered bus or limousine service was an option amounting to $50. The costs of one referral agency which had been established in conjunction with an American clinic operated on an "at cost" basis were $130, which included transportation to New York City and the charges for a first-trimester abortion.

The owner of one busy American clinic located near the Canadian border provided the Committee with a breakdown of that centre's operating costs. This clinic which performed between 75 and 100 abortions each week had several gynaecologists on its staff. The attending physicians were paid $35 for each abortion operation; the costs for administration, personnel, and maintenance amounted to $35, and a profit was made of $80. The fee for each patient was subsequently raised from $150 in 1975 to $160 in 1976.

In its survey of abortion centres used by Canadian women in the United States, the average cost of a first-trimester abortion was $163.75 and for second-trimester abortions, $438.88. Among the American abortion clinics to which most patients were referred by commercial agencies in Canada, the costs for patients—had they gone directly without using a commercial agency—were between $140 and $190. The most common charge was $160. Based on the location of these agencies, the average return bus fare to reach the American clinics to which Canadian women were referred by commercial agencies was from $11.20, $12.20, to $20.55. Depending upon the nature of the financial arrangements which were made between Canadian commercial agencies and abortion clinics in the United States to which they referred women, the average profit made directly by the commercial agencies was at least $75 per client.

From the review of all referral and counselling agencies across Canada, it was estimated that non-profit associations referred some 3,500 Canadian women each year to abortion clinics in the United States. The number which it is estimated were referred by commercial abortion agencies was approximately 3,200. The Committee calculated that approximately 9,627 Canadian women obtained abortions each year in the United States. The difference between the number of patients referred by the two groups of agencies and the estimated total of all Canadian women who went to the United States for this purpose is accounted for by referrals made by physicians or direct contacts made with the clinics by women themselves. In terms of the average annual costs involved for the women routed to American clinics by commercial agencies, these women spent approximately $780,000, while patients who contacted these clinics through other sources paid $1,028,320 for a combined total of $1,808,320.

From information received by the Committee, few complaints had been made to provincial colleges of physicians and surgeons about the commercial abortion referral agencies. For the most part it was felt by these provincial medical licensing bodies that they had no direct authority to obtain such information or to monitor the activities of these agencies. Established to supervise the licensing of physicians and to monitor the operation of statutory professional medical codes, a central concern of these professional colleges was to enforce the requirement that no person should engage in the practice of

medicine who had not been licensed by a provincial college. Under the statutory authority of these colleges, only licensed physicians are entitled to make a diagnosis of pregnancy. Once such a confirmed medical dianosis has been made by a licensed physician, the counselling of individuals was not a field restricted to the medical profession. These professional statutory regulations were breached only when a diagnosis of pregnancy was made by individuals other than physicians prior to a medical consultation and when based on this non-medical diagnosis a fee was charged for this service and a referral was made to a physician.

In the context of the regulatory powers of provincial colleges of physicians and surgeons, there is reasonable doubt about the propriety of the work of most commercial abortion referral agencies. In one respect these agencies, like many voluntary family planning programs which are staffed by non-professionals, and like drugstores, provide pregnancy testing services whose main purpose is diagnostic. There is a fine distinction between indicating that the results of such tests are positive or negative and telling a woman that she is or is not pregnant, a step which constitutes making a diagnosis. In practice no such distinction is made. Acting upon the results of this simple laboratory test, women seeking an abortion are accordingly referred to clinics or hospitals. While the full extent of this practice is unknown, it is so widespread that it has become an accepted custom, one which may contravene the statutory responsibilities of provincial medical licensing bodies.

In a second respect there is reasonable doubt about the propriety of the work of commercial abortion referral agencies. This concern is with the practice of referring clients for abortion without consultation with a physician and charging a fee for this service. The major service provided by commercial abortion referral agencies was a link-up function between women seeking an abortion and abortion clinics, most of which were located in the United States. With the exception of one professionally staffed agency, the clients of these agencies got little or no counselling. The advice which was given was provided by individuals who neither had long experience nor professional qualifications. For an average profit of at least $75 obtained from each client, a sum which the Committee estimates to be the minimum amount gained, some of these agencies did not seek a confirmation of pregnancy by medical consultation but made a lay diagnosis for which a fee was charged. The essential services provided for by this payment were the arrangements for transportation and an appointment which was booked with an American abortion clinic with which these agencies had a continuous affiliation.

Several allegations have been made in the mass media that commercial abortion referral agencies may be storefronts for abortion clinics in the United States. Based on information received by the Committee, these assertions neither can be confirmed nor refuted. But what is known is that the client referral patterns were so consistent that they were not a matter of chance. Most of these agencies (with the two exceptions which were cited) had special cost-sharing arrangements with American abortion clinics.

Some of these agencies fostered an illicit atmosphere about abortion, a stance which contributed to their continued operation on a profitable basis.

**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.** Because of the stigma associated with abortion, there have been few direct complaints made by the clients of these agencies either about the charges which were levied or the quality of the services which were provided.

## Physician income and induced abortion

Under the financial arrangements for national health insurance in Canada, there is a central statistical accounting for each medical or surgical service provided to patients by physicians. The physician reimbursement formulae vary between the provinces according to the amount of the fees listed in medical fee schedules which are paid for by the provincial governments. A majority of physicians in the country have "opted in", that is, they have accepted the payments made for their services by government health insurance programs as the full payment for the services which they provide to patients. It is on the basis of this information, not the total earnings of physicians, that the proportion of income derived by physicians from performing induced abortions has been calculated here. This information does not list the earnings of physicians who treated patients who had spontaneous abortions or the number of patients who had abortions not indicated as being induced or spontaneous. This information provides a summary for nine provinces for 1974-75, the last

TABLE 15.2

PAYMENTS FOR THERAPEUTIC ABORTIONS AS A PERCENTAGE OF TOTAL PROVINCIAL PLAN PAYMENTS TO PHYSICIANS PERFORMING ABORTIONS

Fiscal Year 1974-75

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

| Province | Percentage |
|---|---|
| 1 | 2.99 |
| 2* | 3.81 |
| 3** | 2.90 |
| 4*** | 2.21 |
| 5 | 2.05 |
| 6 | 2.37 |
| 7 | 4.47 |
| 8 | 2.39 |
| 9 | 0.86 |
| AVERAGE | 3.82 |

* First half on Fiscal Year 1974-75
** Fiscal Year 1973-74
*** First half of Fiscal Year 1975-76

TABLE 15.3

## DIFFERENCES IN AVERAGE PLAN-PAYMENTS BETWEEN OBSTETRICIAN-GYNAECOLOGISTS* WHO PERFORM AND DO NOT PERFORM ABORTIONS: BY PROVINCE AND NUMBER OF THERAPEUTIC ABORTIONS PERFORMED

Fiscal Year 1974-75**

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

| Number of Therapeutic Abortions Performed | Provinces | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3*** | 4 | 5 | 6 | 7 | 8 | 8 Provinces Combined |
| 1-5 | −8,711 | −7,048 | +14,719 | +38,541 | +48,056 | −3,315 | −2,219 | +37,184 | −191 |
| 6-10 | −2,481 | −6,807 | +31,822 | – | +30,168 | +6,255 | – | – | +3,383 |
| 11-15 | −3,904 | +9,834 | +17,195 | −32,927 | – | +7,241 | +12,679 | – | −840 |
| 16-20 | +1,853 | +30,534 | +11,268 | – | +736 | +1,706 | – | – | −793 |
| 21-25 | +11,371 | +18,682 | −4,435 | – | – | +12,789 | +39,166 | – | +7,448 |
| 26-50 | +19,244 | +27,435 | +16,064 | – | +20,266 | +6,229 | +76,822 | +70,282 | +8,351 |
| 51-75 | +35,432 | +57,705 | +10,004 | – | – | +14,116 | – | – | +15,947 |
| 76-100 | +40,424 | +35,065 | +41,700 | – | +22,038 | +20,375 | – | – | +21,252 |
| 100+ | +38,251 | +60,234 | +30,649 | +32,624 | +24,051 | +33,455 | +67,277 | – | +31,066 |

*Includes physicians who received from the provincial plan at least one payment for their services during the year.

** One province is deleted because its data are available only for the first half of Fiscal Year 1975-76.

*** Fiscal Year 1973-74.

financial year for which a complete tabulation was available. The special tabulation was commissioned by the Committee from the Health Insurance and Resources Directorate of the Department of National Health and Welfare.

**On an average, physicians who performed therapeutic abortions during 1974-75 earned 3.8 percent of their total incomes from doing this surgical procedure.** For the nine provinces for which information was available, the proportion of incomes of physicians who performed induced abortions ranged between 0.86 to 4.47 percent. The Committee was provided with information on the average health insurance payments to obstetrician-gynaecologists who performed and who did not perform therapeutic abortions in eight provinces. The average annual income derived from national health insurance payments of physicians in eight provinces who performed therapeutic abortions was substantially higher than the reported average annual income of physicians who did not do this surgical operation. Overall, **obstetrician-gynaecologists who did 20 or fewer therapeutic abortions during 1974-75 earned slightly less money from medical care insurance sources than the 48.9 percent of the members of this medical specialty who did not do this operation. The 323 gynaecologists, or 30.0 percent of the active specialists in this field in eight provinces who did 20 or more abortions, earned on an average $18,099 more that year than their medical colleagues who did no therapeutic abortion operations. Gynaecologists who did between 21 and 25 of these operations annually had incomes which were $7,448 higher than for members of this speciality who did none, an amount which rose to $31,066 above the specialty's average income for 95 gynaecologists who did over 100 abortions each year.**

The decision to perform or not to perform therapeutic abortions is based on the specialization within obstetrics-gynaecology and on the professional and ethical decisions made by physicians about the issue of therapeutic abortion. While overall the *average* contribution to the annual incomes of gynaecologists involved in this operation was 3.8 percent, because many gynaecologists did none or a limited number, the reported incomes from medical care insurance sources of the specialists who did this procedure more often were considerably higher. As the difference in these incomes is not accounted for by income earned directly from fees paid for this operation, it is concluded that these physicians were in general more active than their colleagues in doing general surgical procedures as gynaecologists than in providing medical services as obstetricians.

## Extra-billing of medical fees

Consisting of three major parts which were introduced over a period of two decades, coverage under national health insurance became virtually universal when the Northwest Territories entered this federal-provincial cost-sharing program on April 1, 1971. The National Health Grants Program was started in 1948, the Hospital Insurance and Diagnostic Services Act was introduced in 1958, and the Medical Care Act went into effect in 1968. Under the four terms

of the Medical Care Act, coverage for insured individuals was to be comprehensive, universally available, portable, and the programs were to be operated on a non-profit basis. By comprehensive care was meant the inclusion of all medically required services provided by physicians for individuals who were insured. The program was intended to be widely available, or to be universal to the extent that 95 percent of the population in a province were to be insured. The third requirement, that insurance benefits be portable, allowed for the continued coverage of individuals who might move between provinces. The programs were to be administered on a non-profit basis and be accountable for their financial operations to provincial governments.

Extra-billing is a sensitive and divisive matter for the public and the medical profession. When it is coupled with the issue of therapeutic abortion, it assumes emotive proportions. This fact was made clear to the Committee on its visits to hospitals across the nation and from some of the written replies from doctors who responded to the national physician survey. The extra-billing of medical fees poses a dilemma for a number of groups which may be concerned with this practice. In 2 out of 10 provinces the extra-billing for insured medical services was allowed, while elsewhere if physicians participated in provincial medical care insurance programs, with minor exceptions, extra-billing was not permitted. How extra-billing was seen by the medical profession varied between regions, by medical specialties, and by the type of work or hospital privileges which physicians had. In some instances this practice was well accepted and was widespread. Traditionally, a high quality of medical service has been associated with high medical charges, as for example the costs of treatment at several distinguished medical centres with international reputations. From another perspective the extra-billing of patients was seen as unnecessary, unethical, and in some instances, illegal. At a number of prestigious medical centres visited by the Committee, concern was expressed that extra-billing, if it occurred, would tarnish the public reputation of the medical specialty involved and of the hospital where it occurred.

When this practice involved patients who were treated at a hospital, and if a decision in principle had been made to curb or eliminate this practice, the administration and the senior medical staff had little or no direct authority to do so. This was the case at a number of hospitals visited by the Committee as extra-billing related to patients seeking or obtaining therapeutic abortions. The position of a majority of physicians who held hospital appointments in Canada, with the exception of physicians who were paid on a full-time basis, is analogous to that of being working guests. The hospital is the workplace where much of their medical practice is done. The quality of medical practice which is done in hospitals may be subject to professional review, a principle which underlies the accreditation of hospitals by the Canadian Council on Hospital Accreditation. But the hospital has no authority to audit directly the billing practices of its medical staff. Such a review, were it to be attempted, would be regarded as an unwarranted intrusion of individual and professional rights.

Some regional and provincial medical associations have considered the issue of medical fee extra-billing, and in some instances, resolutions have been passed about the practice. But as with the administration of hospitals, these

associations have little direct authority to monitor the effects of their decisions. In a similar fashion, while provincial medical care insurance authorities variously audited reported charges for insured medical services, they were seldom provided with full information about extra-billing by physicians. Such information was not considered to be in the public domain. In some cases extra-billing could have implications for income tax, or such practices could be illegal when done by physicians participating in some provincial medical care insurance programs which do not make provisions for this practice by participating physicians. Few of the senior administrators of provincial health departments whom the Committee met across Canada were aware of the extent of extra-billing of abortion patients. In some cases it was concluded that it did not occur, or if it did, it involved a handful of cases.

For their part, patients, unless they are directly asked and even then except under unusual circumstances, are unlikely to volunteer easily such information. This is particularly the case when the treatment for which they seek medical counsel is one about which there is much apprehension, or as in the case of induced abortion, involves much social stigma. Little is known for these reasons about the extent of extra-billing, how it affects the accessibility of patients to medical treatment or whether the extra charges which are made were equitably apportioned by the social circumstances of the patients involved. The personal account given by one woman who had an abortion illustrates the patient's dilemma.

> In 1974, shortly after being fitted with a Lippes Loop, I found myself pregnant . . . A doctor referred me to the women's clinic at the hospital. He assured me that my insurance would cover all costs . . . The actual abortion was horrifying. My husband, who was suffering through this decision also, was literally shoved aside by a cold hospital staff who paused with us just long enough to insist on a $52 fee (which [provincial medical insurance] refused to reimburse).

At 24 hospitals visited by the Committee, administrators, senior medical staff, or directors of nursing services reported that the extra-billing of abortion patients occurred. How this medical billing practice was seen varied from one region to another. A number of senior gynaecologists, including specialists who followed and did not follow this custom, felt that the usual fee for a therapeutic abortion was too low for the amount of work which was involved. One gynaecologist noted that in his practice the fee which was charged included services for: (1) between half an hour to an hour spent with each patient on an initial visit; (2) the time involved in the surgical operation; and (3) the follow-up visit. Another physician told the Committee that most gynaecologists who did therapeutic abortions did this procedure out of a sense of professional obligation to their patients. There were other services, this physician noted, upon which members of this specialty could spend their time more profitably. In his words, "Financially, these operations are a loser."

Indirect income benefits accruing from performing therapeutic abortions were cited by a number of gynaecologists. The augmented income of these physicians, it was suggested, did not result from direct or additional charges from doing this operation, but came about because some abortion patients

continued to consult these physicians for other gynaecological services. The collection of additional fee charges was often done prior to the operation, sometimes by a mailed invoice, while on occasion the assistance of the nursing staff was involved. Several examples were reported to the Committee by directors of nursing services of family physicians, gynaecologists, or anaesthetists who asked the nurses in the operating rooms or the day-care surgical units to collect fees from patients. In one instance this custom was discontinued after the director of nursing requested a review be made by the hospital's chief of medical staff. At another hospital the nursing director of the operating room reported it was customary for abortion patients to pay physicians in cash immediately prior to the operation.

At half a dozen large university-affiliated teaching hospitals, the chairmen of departments of obstetrics and gynaecology considered the extra-billing of abortions to be unethical professional behaviour. The major dilemma raised by these senior gynaecologists was the difficulty of obtaining exact information on the extent to which this practice occurred among their medical colleagues, particularly those physicians who had part-time staff appointments. At one major university hospital, the chairman had reviewed this issue at several staff meetings. It had been decided at this hospital that if this practice became too extensive, the hospital privileges would be revoked for the physicians who were involved. But it was recognized at this hospital that it was inappropriate for the hospital administration to seek to review directly the medical fee charges which were made by medical staff colleagues. At another major hospital which was affiliated with a faculty of medicine, the medical advisory committee had endorsed a resolution that there would be no extra-billing of abortion patients. The chairman of the medical staff subsequently wrote to each physician about this decision adding the proviso that if the extra-billing of abortion patients continued, the hospital staff appointments and privileges of the physicians involved would be cancelled.

In their written replies returned to the Committee in the national physician survey, a number of obstetrician-gynaecologists and family physicians commented on the practice of extra-billing and the costs involved in induced abortions.

> As far as fee is concerned, it should be as is done in plastic surgery, for example, with the physician obtaining fees set out by fee schedule only.
>
> • • •
>
> Reduce the fee and the number of abortions would be reduced . . . (provincial health insurance) should not pay this fee, nor should it pay for voluntary sterilization—this has become a rape of the provincial taxpayers' money.
>
> • • •
>
> I do abortions, but I find them an unpleasant part of my practice. Every abortion is a failure of birth control. Even when I do them I don't like doing them, as they are dangerous, difficult, messy, and not satisfying. Since the Government pays so little for doctors' services, one of the benefits we do get that the government can't tax is the pleasure of doing something for a patient—a healthy baby is much more pleasant to give a patient than an abortion.

Colleagues are unscrupulous in recommending and performing for financial gain . . .

• • •

It should not necessarily be paid for by medical plans and hospital insurance. But payment should not be an issue. I don't believe any blanket statements can apply in medicine or abortion. Some patients' cases are valid, others, particularly the very young, often regard abortion as an extension of birth control. Last year in _____ we had an abortion bill of over $1,000,000. The hospital beds and physicians' time involved are often wasted by too liberal interpretation.

• • •

Far too costly to the taxpayer; where affordable it should not be covered by (provincial health insurance). It has no place in publicly supported hospitals. Far, far too liberal.

• • •

The fee for this service should be small—or the same as for a D & C. Many patients are ripped off by unscrupulous practitioners.

• • •

I know of no physician doing abortions who does not extra bill 100 percent to 200 percent of the fee schedule in advance. Surely, this is taking advantage of a person in distress . . .

• • •

The Committee would do well to investigate the structure, and financial support of anti-abortion groups. Several physicians participate and add their names to such organizations, subjecting their colleagues to tasteless, sensationalistic anti-abortion propaganda (photos of aborted foetuses, etc.).

• • •

Abortion makes up for a large portion of income of gynaecologists who extra-bill for this procedure.

• • •

Therapeutic abortion blackmail is abhorrent. Patients have encountered large surcharges payable in advance. One doctor asks the patient to bring $100 on the first visit as his charge over and above _____ . In the past, patients referred to England were charged $400 for the minor operation of abortion. Other patients I have referred for abortion have encountered delays for many weeks until a simple suction procedure will no longer suffice. They have then been subjected to hysterotomy, which is 100 times as hazardous, but of course is more lucrative for the doctor. The restrictive abortion law in Canada has not brought out the best in the medical profession. It has resulted at times in undignified scrambling for control of public facilities where abortions are permitted.

• • •

> When Canada's 50,000 abortions annually must be done by law in hospital, an unnecessary expense is incurred by the taxpayer. A few years ago the average hospital stay in abortion cases was four days. At present, with more procedures being done in ambulatory care facilities at the hospital, the average stay is likely two days. Hospital care costs about $300 per patient, therefore, or $15 million annually of the taxpayers' money in unnecessary expense. Is this prudent?

The provinces made payments to physicians under the terms of the *Medical Care Act* which were variously set at between 85 percent or above the designated provincial schedule of medical fees. The assumption on which these reimbursement arrangements were made was that participating or "opted-in" physicians would have a reduced cost overhead in the collection of their fees, and losses incurred through the non-payment of bills would be reduced or eliminated. Regulations governing the payment of physicians who work under national health insurance vary across Canada. In all provinces there is a statute in the medical care legislation specifying that physicians who practice outside these plans retain their full billing prerogatives. These private practitioners with the consent of their patients may bill for their medical services on the basis of the schedule of fees drawn up by regional or provincial medical societies, or they may charge above these recommended fee levels. The majority of the members of the medical profession have "opted in", that is, they work within the provincial regulations under which provincial medical care insurance programs operate. Like other facets of Canadian society, and in particular provincial legislation, there is a broad diversity in these regulations which establish slightly different conditions for medical practice and the payment of physicians in each province.

In eight of the ten provinces, physicians who participate in provincial medical care insurance programs with minor exceptions accept as payment in full the fees for their medical services which are set out in the designated schedule of fees.[2] In these eight provinces (excluding Nova Scotia and Alberta), the extra-billing of patients by physicians is allowed only under special circumstances which usually involve patients who are not referred to specialists by family physicians, the provision of treatment which is deemed not to be medically necessary, or work which is particularly unusual or time-consuming.

In Newfoundland specialists may extra-bill patients who have not been referred to them by other physicians. The two conditions under which extra-billing is allowed in Prince Edward Island are for services which are not deemed to be medically necessary, or where an insured patient does not supply

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[2] *The Newfoundland Medical Care Insurance Act*, R.S.N. 1970, c. 265 as amended.

Prince Edward Island, *Health Services Payment Act*, R.S.P.E.I. 1974, c.H-2.

New Brunswick, *Regulation 70-124 under the Medical Services Payment Act*, consolidated to April 30, 1975.

Quebec, *Health Insurance Act*, S.Q. 1970, c.37 as amended.

Ontario, *An Act Respecting Health Insurance*, S.O. 1972, c.91 as amended.

Manitoba, *The Health Services Insurance Act*, R.S.M. 1970, c.H-35 as amended.

*The Saskatchewan Medical Care Insurance Act*, R.S.S. 1965, c.255 as amended.

British Columbia, *Regulations* 5.04, 5.10 and 5.11, Division 5 under *An Act Respecting Medical Services* as amended.

a physician with his medical care insurance identification number within 30 days of having received treatment. In New Brunswick when a participating specialist in obstetrics provides obstetrical delivery service including pre-natal and post-natal care, he may charge a patient up to $43.50 in addition to the amount paid for under provincial health insurance. No allowance is made for the extra-billing by physicians participating in provincial medical care insurance programs in Quebec, Ontario, Manitoba, or British Columbia. In Manitoba the provincial agency may reimburse at its discretion the higher charges which have been made to patients by physicians working outside the public health insurance program. In most of these provinces if insured patients are served by physicians who work outside the programs, either they or the physicians are reimbursed for these charges according to the designated schedule of fees.

The situation in Saskatchewan is somewhat different in terms of the options for the modes of medical practice but comparable in their consequences for the payment of physicians. This province, the first to start a universal and comprehensive public program of medical care insurance in 1962, allows for four methods of payment for medical practice.[3] These means of payment of physicians are: (1) private agreement—where a practitioner advises a beneficiary that he wishes to treat him on a private basis and the patient agrees, an itemized statement submitted to the Commission is not required and extra-billing may occur; (2) direct payment to physicians—accounts are submitted directly to the Commission and except for certain authorized charges, physicians working under this method accept the Commission payment as reimbursement in full for their medical services; (3) payment through an approved health agency—if the patient and the physician are members of the same approved health agency which involved an enrolment charge for patients, accounts submitted to the Commission by the agency which are reimbursed to physicians are taken as payment in full; and (4) payment to patients—insured patients who submit physicians' bills to the Commission are reimbursed at designated rates, and pay their medical bills which may involve extra-billing. In 1975, of $49,316,809 paid for medical services in Saskatchewan, 77.6 percent were direct payments to physicians (method 2), 19.4 percent were through approved health agencies or community health associations (method 3), and 3.0 percent were payments to patients (method 4). Under these different payment arrangements, 3.0 percent of physicians who received indirect reimbursement from the Commission (method 4) were eligible to extra-bill their patients.

Allowance is made in provincial medical care insurance statutes in Nova Scotia and Alberta for the medical fee extra-billing of patients by physicians participating in these public programs. In Nova Scotia[4] a participating physician who provides an insured medical service to a patient may extra-bill if: (1) prior to giving the service, he gave reasonable notice to the patient of his intention to do so; (2) the patient, or someone acting on the patient's behalf,

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[3] Saskatchewan Medical Care Commission, *Annual Report 1975* (Regina: Government of Saskatchewan, February 1976).

[4] *Nova Scotia Health Services and Insurance Act*, S.N.S. 1973, as amended by S.N.S. 1974, c.31.

consents in writing to the extra charge; and (3) the amount of the extra charge is made known to the Commission. Participating physicians in Alberta who provide a basic insured health service may charge in excess of the amount of the benefits payable by the provincial Commission, if the receipt provided to patients clearly shows the amount of the benefits payable by the Commission for that service.[5]

TABLE 15.4

PARTICIPATION OF PHYSICIANS IN NATIONAL HEALTH INSURANCE AND THE EXTRA-BILLING OF MEDICAL FEES

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

| Province | Participation and Extra-Billing | |
|---|---|---|
| | 1974* | 1975** |
| Newfoundland | 4 opted out. | 3 opted out. |
| Prince Edward Island | None opted out.<br>Extra-billing:<br>0.5 percent | None opted out.<br>Extra-billing: less than<br>0.5 percent |
| Nova Scotia | Extra-billing:<br>3.1 percent of<br>payments (1971-72). | 2 opted out:<br>2.9 percent extra-<br>billing (1972-73). |
| New Brunswick | 4 opted out. | 4 opted out.<br>1.7 percent claims by patients. |
| Quebec | 7 specialists and 3 family doctors opted out. | 53 specialists and 17 family doctors opted out. |
| Ontario | 9 percent opted out. | 9.8 percent opted out. |
| Manitoba | 5 percent opted out. | 3 percent opted out. |
| Saskatchewan | 3 to 4 percent opted out. | 2.4 percent of claims submitted by patients. |
| Alberta | None opted out.<br>Extra-billing allowed under certain circumstances. | None opted out.<br>Extra-billing allowed. |
| British Columbia | None opted out. | None opted out. |
| Yukon | — | None opted out. |
| Northwest Territories | — | None opted out. |

* Maurice LeClair, "The Canadian Health Care System", in S. Andreopoulous, ed., *National Health Insurance: Can We Learn From Canada?* (New York: John Wiley & Sons, 1975), pp. 54-56. At the time of this report, Dr. LeClair was Deputy Minister of Health, Department of National Health and Welfare, Canada.

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

The Health Insurance and Resources Directorate of the Department of National Health and Welfare estimated that in 1975 over 90 percent of physicians across the nation were participating in provincial medical care insurance programs, or had "opted in". In most instances these participating physicians agreed to accept as reimbursement in full the prorated fee schedule

[5] *The Alberta Health Care Insurance Act*, R.S.A. 1970, c.166 as amended.

payments established by provincial health authorities for each category of medical service provided to insured patients. The extent to which the opting-out of physicians and the practice of extra-billing of patients occurred varied across the country in 1975. In general, few physicians in eastern Canada followed either practice. Almost all of the physicians in Newfoundland, Prince Edward Island, Nova Scotia, New Brunswick, and Quebec participated in provincial medical care insurance programs. It was estimated that less than 0.5 percent of physicians in Prince Edward Island and 2.9 percent of physicians in Nova Scotia (1972-73) extra-billed their patients under the provisions allowed for in provincial medical care insurance statutes. The Health Insurance and Resources Directorate made no estimate of the extent of extra-billing in eight provinces. The trend toward an increased proportion of physicians who had opted out rose in Ontario and two of the Prairie provinces. The proportion of physicians who practiced outside these provincial medical care insurance programs in 1975 was: 9.8 percent in Ontario; 3 percent in Manitoba; and about 2.4 percent in Saskatchewan. All of the physicians in active medical practice in Alberta and British Columbia participated in the public insurance programs, and in Alberta, physicians could extra-bill patients under certain circumstances.

The issue of extra-billing was reviewed by the Committee on its visits to provincial health departments and hospitals across the nation. There were no reports of this practice in five provinces. In Nova Scotia, Ontario, Manitoba, Alberta, and British Columbia, while it was known that extra-billing occurred, its proportions were seldom known to the senior staff of provincial health departments. The Saskatchewan Medical Care Insurance Commission provided the Committee with information about extra-billing for therapeutic abortions for that province.

On the basis of the provincial medical care insurance statutes, information about the extent of physicians participating in these programs and the reported prevalence of extra-billing, few extra charges would be expected to be made to patients seeking induced abortions in Newfoundland, Prince Edward Island, New Brunswick, Quebec, or British Columbia. In provinces where more physicians did not participate directly in these public programs such as Ontario, Manitoba, or Saskatchewan, or where as in the case of Nova Scotia and Alberta, additional charges were allowed, the extent of extra-billing of abortion patients might be expected to be more extensive. The ratio for each province of the number of physicians who did not participate in provincial medical care insurance plans or who were eligible to extra-bill patients was calculated on the basis of the number of physicians in active medical practice listed by the *Canada Health Manpower Inventory 1975*. On this basis the extra-billing for medical services, if this practice was uniformly distributed among physicians and patients, would be: 0.6 percent in Quebec; 9.8 percent in Ontario; 3.0 percent in Manitoba; about 2.4 percent in Saskatchewan; and none in British Columbia. In the case of Ontario, this proportion rose to about 15 percent as between April 1974 and April 1975, the number of obstetrician-gynaecologists who had opted out of the provincial health insurance plan varied between 10 and 21 percent. In Manitoba in 1975, 5.17 percent of obstetrician-

gynaecologists and 3.85 percent of family physicians and general surgeons practiced outside the provincial plan.

Where precise information was not available, these ratios were based on the number of physicians known to be working outside the provincial medical care insurance programs relative to the total number of physicians in active medical practice in that province (e.g., 70 "opted-out" physicians in Quebec out of a 1974 total of 11,051 active physicians). In two provinces, Nova Scotia and Alberta, where extra-billing was allowed by participating physicians, the rates were calculated in the case of Nova Scotia on the known rate of 44.8 percent extra-billing of induced abortion services (1975-76)[6] and for Alberta, this rate was set at its potential maximum of 100 percent. The rate for New Brunswick was based on the proportion of claims submitted by patients for incurred services to all claims including those submitted for payment directly by physicians. The rates for two provinces, Newfoundland and Prince Edward Island, were not derived as these provinces were not included in the national patient survey.

Patients from whom information was obtained in the national patient survey were asked if they had health insurance, if the costs of the abortion were completely paid for by health insurance, and, if this was not the case, if they had to pay extra and how much they had to pay. When these findings are compared for the eight provinces included in this survey with the extent to which additional charges might have been expected on the basis of the number of physicians who had "opted-out" or who were eligible to extra-bill patients, on an average a higher than expected number of patients who obtained therapeutic abortions had been extra-billed for this surgical procedure. The provincial rates for the extra-billing of patients were calculated on the basis of the number of patients in this category compared to the total number of patients in that province who had abortions and who were included in the 1976 national patient survey.

**When the expected and the actual rates of the medical fee extra-billing 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.** This practice was most frequent in Alberta which allows extra-billing and where 91.6 percent of abortion patients reported paying extra charges. In Nova Scotia where on an average 2.9 percent of medical services involved extra-billing in 1972-73, the reported extra-billing of women having induced abortions in 1975-76 involved 44.8 percent of these patients. This level then is considerably higher than would be expected for all patients consulting physicians for other services. In the national patient survey, 20.1 percent of abortion patients were extra-billed. The extent of extra-billing of abortion patients in New Brunswick was over twice the expected rate of extra-billing. Participating physicians in New Brunswick have the right to choose not to participate or to participate for

[6] Of a total of 958 therapeutic abortions for 1975-76, there were additional charges for 429 of these operations. Of 768 abortions done by obstetrician-gynaecologists, 423 had extra charges; of 130 abortions performed by family physicians, 6 had extra charges; and none of the remainder (60) done by other specialists involved extra charges.

a particular service. When participating obstetricians in this province provide obstetrical delivery service including pre-natal and post-natal care, an additional charge of $43.50 can be charged the patient which is in addition to the amount paid for under provincial medical care insurance.

TABLE 15.5

EXTRA-BILLING OF ABORTION PATIENTS IN EIGHT PROVINCES, 1975

NATIONAL PATIENT SURVEY

| Province | Expected Extra-Billing Rate* | Proportion of Abortion Patients who were Extra-Billed |
|---|---|---|
| | percent | |
| Nova Scotia | 44.8 (2.9) | 17.0 |
| New Brunswick | 1.7 | 3.9 |
| Quebec | 0.6 | 1.4 |
| Ontario | 15.0 | 18.3 |
| Manitoba | 5.2 | 1.0 |
| Saskatchewan | 2.4 | 32.9 |
| Alberta | 100.0 | 91.6 |
| British Columbia | 0.0 | 12.9 |

* This rate is based for six provinces on the number of physicians not participating in provincial medical care insurance programs compared to the total number of physicians in active medical practice in a province. For Nova Scotia a rate of 44.8 percent was reported for 1975-76, while the number of "opted-out" physicians was estimated to be considerably lower (2.9 parcent). The rate for Alberta was the potential maximum of extra-billing.

The extent of extra-billing of abortion patients in Quebec and Ontario were respectively 2.3 and 0.2 times above the expected rates. Extra-billing was reported by obstetrician-gynaecologists at 12 of the hospitals visited by the Committee in Ontario; it was alleged to be extensive at one hospital in Quebec. In Quebec, as none of the "opted-in" physicians were eligible to extra-bill patients and as most physicians participated in the provincial health insurance program, it would appear that many of these extra charges may not be in accord with provincial policies. In Ontario the 1975 fee schedule for specialists performing abortion services for patients was: $60, abortion incomplete and including dilatation and curettage; $75, therapeutic abortion/intra-ammiotic injection of saline; $10, ammiocentesis; $35, genetic ammiocentesis (within 16 weeks of pregnancy); and $150, hysterotomy. Based on information received by the Committee, the fees were listed of 25 identified obstetrician-gynaecologists affiliated with hospitals which performed 22.9 percent of the province's therapeutic abortions in 1974. The charges of these 25 physicians indicated that in most instances abortion patients were extra-billed over the provincial schedule of fees for which payments were prorated at 90 percent. Eighteen of these physicians requested payment in cash or a certified cheque at the time of a patient's first visit or prior to the operation.

TABLE 15.6

FEE BILLING PRACTICES OF 25 PHYSICIANS IN ONTARIO

| Physician | Abortion Services and Fee Charges | | | |
|---|---|---|---|---|
| | Up to 12 Weeks | Saline | Tubal Ligation | Without Ontario Health Insurance Plan (OHIP) |
| 1 | $125.00 | $125.00 | $100.00 | $125. + $169./day + anaesthetic |
| 2 | $110.00 | $110.00 | $135.00 | $110. + $169./day + anaesthetic |
| 3 | $100.00 | $100.00 | $100.00 | $100. + $169./day + anaesthetic |
| 4 | $ 67.50 | — | — | — |
| 5 | $150.00 | $150.00 | $150.00 | $150. + $187./day + anaesthetic |
| 6 | $125.00 | — | — | — |
| 7 | $150.00 | — | $150.00 | $150. + $187./day + anaesthetic |
| 8 | OHIP | OHIP | OHIP | + $187./day + anaesthetic |
| 9 | $125.00 | — | $150.00 | $125. + $169./day + anaesthetic |
| 10 | $100.00 | — | $125.00 | $100. + $169./day + anaesthetic |
| 11 | $125.00 | — | — | — |
| 12 | $100.00 | $100.00 | $100.00 | $100 + $169./day + anaesthetic |
| 13 | $150.00 | — | $150.0 | $150. + $187./day + anaesthetic |
| 14 | $200.00 | 200.00 | $175.00 | $200. + $187./day + anaesthetic |
| 15 | $125.00 | — | — | — |
| 16 | $200.00 | $200.00 | $175.00 | $200. + $187./day + anaesthetic |
| 17 | $100.00 | $100.00 | $100.00 | $100. + $169./day + anaesthetic |
| 18 | $150.00 | $150.00 | $150.00 | $150. + $169./day + anaesthetic |
| 19 | $125.00 | — | — | — |
| 20 | $190.00 | $250.00 | $250.00 | $190. + $169./day + anaesthetic |
| 21 | $200.00 | $200.00 | $175.00 | $200. + $187./day + anaesthetic |
| 22 | $125.00 | — | — | — |
| 23 | $220.00 | — | $150.00 | $220. + $187./day + anaesthetic |
| 24 | $350.00 | — | $350.00 | $350. + $187./day + anaesthetic |
| 25 | $ 67.50 | — | — | — |

Source: Community service agency survey and hospital site visits by Committee

With the exception of Alberta where extra-billing occurred extensively, Manitoba was the only province where the extent of extra-billing of abortion patients was subsantially lower than might have been anticipated on the basis of the number of physicians who did not participate in the provincial medical care insurance program.

The extent of extra-billing of abortion patients in Saskatchewan was 13.7 times the expected rate. The payment schedule used by the Saskatchewan Medical Care Insurance Commission for therapeutic abortions and related procedures in 1975 was:

| | Specialists | Family Physicians |
|---|---|---|
| Therapeutic Abortion | $ 64.00 | $ 51.00 |
| Dilatation and curettage | 38.30 | 38.30 |
| Hysterotomy—abdominal | 128.00 | 102.00 |
| Hysterotomy—vaginal | 115.00 | 92.00 |
| Amniocentesis | 25.50 | 25.50 |

Information provided to the Committee by the Commission listed 253 services to therapeutic abortion patients in 1975 where extra-billing had occurred. The average amount billed for therapeutic abortion services was $86.09 and the average amount paid by the Commission was $61.04. The average amount involved in the extra-billing was 41.0 percent above the customary charges paid for by the Commission. In some instances these amounts were considerably higher as in the case of one bill for $150 which was reimbursed by the Commission at the fee schedule amount of $64.

The practice of extra-billing which was allowed under provincial legislation in Alberta extended to most patients in that province who had induced abortions and who were included in the hospital abortion survey. Nine out of ten (91.6 percent) of these patients paid extra charges for this operation.

In British Columbia the *Medical Services Act* stipulates that extra-billing is allowed where a practitioner has treated a patient "who requires unusual time-consuming service over and beyond ordinary required care", if the practitioner complies with the regulations. The 1975 Approved Schedule of Fees in British Columbia listed the gross fees paid for the methods used for therapeutic abortion as: $56.65, operation only—therapeutic abortion (vaginal) by whatever means, less than 12 weeks of gestation; and $113.30, therapeutic abortion over 12 weeks of gestation. In the autumn of 1975 the Executive of the British Columbia Medical Association reviewed the question of medical fees for patients obtaining abortions with members of the Section of Obstetrics and Gynaecology. It was then indicated that the extra-billing of patients by physicians participating in the public program was contrary to the regulations of the *Medical Services Act*. At that time none of the physicians in active medical practice had opted out of the provincial health insurance program.

According to information received from the British Columbia Department of Health, this review was effective as since that time only a small number of claims made by abortion patients indicated extra-billing. In the national patient survey undertaken in 1976, 12.9 percent of abortion patients from whom information was obtained in British Columbia were extra-billed on an average of $85.39 for medical services. Among the patients who were extra-billed, on an accumulative basis, 8.6 percent were charged over $200; 11.5 percent over $150; and 35.6 percent, over $100.

Members of several medical specialties are involved in the performance of therapeutic abortions. These specialties include: obstetrics-gynaecology, family medicine, general surgery, and anaesthesiology. In addition, other physicians such as psychiatrists who are required as consultants may be involved prior to the review of an application by a hospital's therapeutic abortion committee. Based on information received from provincial health authorities, 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. It is estimated that this pattern was similar for the remaining provinces where the majority of therapeutic abortion services were done by specialists in obstetrics-

gynaecology. At its June 1971 meeting, the Society of Obstetricians and Gynaecologists of Canada passed the following resolution:

> That for the time being the fees for the performance of termination of pregnancy should not exceed that set in the local and provincial fee schedules.

On the basis of the findings of the national patient survey, this resolution does not seem to have been fully adhered to in 1976 by some members of this medical specialty.

In the 1976 national patient survey undertaken in 24 hospitals in eight provinces (Newfoundland and Prince Edward Island were not involved), patients were asked whether they had health insurance coverage and if they had to pay extra fee charges for the abortion operation. At some of these hospitals there was a concern among medical staff members that information about physician's fee charges would be obtained. At several of the hospitals included in the survey a distinction was made between public and private patients, with some of the latter being excluded from the group of patients from whom information was obtained. Despite this fact, information was obtained from a substantial number of public and private in-patients at each of these medical centres. *The information obtained on the extent of extra-billing in the national patient survey is a minimal estimate.* The actual proportion of extra-billing, if the total experience of hospitals where extra charges were involved had been documented, would lead to a projection on an average basis of at least 10 percent higher than the reported rate.

At 6 of the 24 hospitals included in the national patient survey, there was no extra-billing of abortion patients. The provincial distribution of these hospitals was: 1, New Brunswick; 2, Quebec; 2, Ontario; and 1, Manitoba. There was medical fee extra-billing of abortion patients at the 18 other hospitals which were located in each of the eight provinces included in the survey (Nova Scotia, New Brunswick, Quebec, Ontario, Manitoba, Saskatchewan, Alberta, and British Columbia).

While it is known from provincial medical care insurance annual reports that over 95 percent of the Canadian population is enrolled in these public programs, there has been no national review of the extent to which this coverage may extend to all Canadians or how participation may vary among groups in the population. In the *national patient survey*, 96.3 percent of abortion patients said they had health insurance. At this high level of public participation not much variation could be expected, but this in fact did occur on the basis of self-reported coverage among these patients. Almost all of the abortion patients (99.2 percent) in the Maritimes were enrolled in provincial medical care insurance programs, while only 92.8 percent of abortion patients in British Columbia said they had health insurance coverage. Representing their inclusion as family members, all abortion patients who were 15 years or younger had health insurance. There was a predictable dip in the extent of health insurance coverage followed by an increase as the ages of the patients rose. Among women who were between 18 and 19 years, 94.9 percent were enrolled in these public programs, a trend which may represent an uncertainty about their health insurance status, or a time of transition in their coverage

between the enrolment provided for them by their parents and when they started to work or got married.

Participation in medical care insurance programs was associated with where abortion patients had been born, again an expected trend which was partly contingent upon the length of residence in Canada and an individual's familiarity with the nature of social security and health insurance measures. Among abortion patients who had been born in Canada, 97.4 percent had health insurance, while the proportions were lower for all groups of women who were born abroad. The distribution of health insurance coverage by place of birth was: 96.6 percent, Europe; 94.3 percent, India; 93.3 percent, United Kingdom and United States; 90.7 percent, West Indies; and 92.0 percent for all other individuals.

At one hospital which was visited by the Committee, the chief of obstetrics and gynaecology observed that medical fee extra-billing by his colleagues varied by the social circumstances of the patient. Most physicians, this senior specialist noted, considered the issue of abortion with distaste, if not repugnance. The physicians who performed this operation did so out of a deeply held sense of professional obligation. But the personal outlook and background of physicians affected how they reached their decisions on this matter, decisions which were not made solely on the basis of impartial professional judgment. "If a woman is physically attractive, well educated, and can otherwise relate," this physician observed, "then the fee is sometimes reduced." In the context of the 1 out of 5 abortion patients (20.1 percent) who were extra-billed, this observation was partially valid.

Patients in the national patient survey were asked if they had to pay extra money which involved a sum over the usual and customary charges for the abortion operation. There was substantial variation among the patients who were extra-billed by: their age, level of education, religion, and where they lived. One-third (33.3 percent) of teenage females who were 15 years or younger paid extra medical charges in contrast to 13.3 percent of women who were 35 years or older. When abortion patients of all ages are considered, there is a direct decrease by the age of patients and the proportions who were extra-billed by physicians. Consistent with this finding, but representing a difference of smaller proportions, fewer married women were extra-billed than either single women or women who were widowed, divorced, or separated. The proportion of women with college or university training who were extra-billed (22.0 percent) was double that of women who had an elementary school level of education (10.9 percent). Fewer Jewish and Catholic patients and more Protestants and women affiliated with other faiths were extra-billed.

The average amount which abortion patients in the eight provinces were extra-billed was $73.71. Among the fifth of all patients who had extra medical fee charges, 16.2 percent paid up to $30; 29.4 percent, $31 to $63; 32.5 percent, $66 to $90; 15.7 percent, $91 to $150; 3.1 percent, $151 to $200; and 3.1 percent, $200 to $300. The distribution of these charges among abortion patients was different from the distribution of attributes of all of the women who were extra-billed. While considerably more younger abortion patients had

TABLE 15.7

## HEALTH INSURANCE COVERAGE AND MEDICAL FEE EXTRA-BILLING OF ABORTION PATIENTS

NATIONAL PATIENT SURVEY

| Characteristics of Patients | Health Insurance Coverage and Extra-Billing | | |
|---|---|---|---|
| | Have Health Insurance Coverage | Proportion of Patients Who Were Extra-Billed | Average Sum Paid for Extra-Billing |
| | percent | percent | dollars |
| AGE | | | |
| 15 years and under | 100.0 | 33.3 | 76.09 |
| 16-17 years | 96.8 | 24.4 | 74.69 |
| 18-19 years | 94.9 | 26.3 | 78.32 |
| 20-24 years | 95.3 | 19.9 | 75.83 |
| 25-29 years | 96.6 | 17.3 | 75.60 |
| 30-34 years | 98.1 | 14.5 | 71.63 |
| 35 years and above | 97.4 | 13.3 | 73.16 |
| COUNTRY OF BIRTH | | | |
| Canada | 97.4 | 21.1 | 72.12 |
| Europe | 96.6 | 15.6 | 86.25 |
| India | 94.3 | 14.4 | 78.33 |
| U.K. and U.S.A. | 93.3 | 20.5 | 75.23 |
| West Indies | 90.7 | 17.7 | 102.52 |
| Other | 92.0 | 19.4 | 78.76 |
| EDUCATION | | | |
| elementary school | 96.5 | 10.9 | 79.06 |
| high school | 96.3 | 20.5 | 74.12 |
| college/university | 96.2 | 22.0 | 71.96 |
| MARITAL STATUS | | | |
| single | 95.7 | 21.0 | 74.18 |
| married | 97.8 | 16.2 | 67.88 |
| widowed, divorced, separated | 96.2 | 22.0 | 78.47 |
| REGION | | | |
| Maritimes | 99.2 | 13.7 | 25.97 |
| Quebec | 96.8 | 1.8 | 78.50 |
| Ontario | 96.9 | 18.4 | 75.49 |
| Prairies | 97.3 | 58.8 | 74.95 |
| British Columbia | 92.8 | 11.3 | 85.39 |
| RELIGION | | | |
| Catholic | 96.1 | 14.1 | 79.09 |
| Jewish | 95.5 | 11.7 | 101.72 |
| Protestant | 97.0 | 29.0 | 70.45 |
| Other | 95.0 | 18.0 | 76.92 |
| AVERAGE | 96.3 | 20.1 | 73.71 |

been extra-billed, there was little difference by the ages of the patients in the actual sums involved. The reverse trends were the case by the level of education and religious affiliation of abortion patients. While fewer women with an elementary school education were extra-billed, the women with less education

who actually paid extra charges had an average bill of $79.06, while women with college and university training paid on an average $71.96, or a difference of 11.0 percent. While fewer Jewish and Catholic women than Protestant women were extra-billed, among the patients who paid extra medical charges, there were sizeable differences by their religious affiliations. Protestant women on an average paid $70.45, Catholic women $79.09, and Jewish women $101.72, or an amount which was 30.7 percent more than for Protestant women. The usual charge for married women was less than for single women or women who were widowed, separated, or divorced.

There was a difference of 29.7 percent in the average extra-billing charges between abortion patients who had been born in Canada, who paid $72.12, and women from the West Indies, who on an average were extra-billed by $102.52. The extra-billing charges for women born in other countries were: $86.25, Europe; $78.33, India; $75.23, United Kingdom and United States; and $78.76, individuals from other countries.

In its *Review of Health Services in Canada, 1975* the Department of National Health and Welfare indicated that:

> Utilization charges at the time of service are not precluded by the federal legislation if they do not impede, either by their amount or by the manner of their application, reasonable access to necessary medical care, particularly for low-income groups.[7]
>
> Seven of the 12 provincial (or territorial) medical plans finance their share of the cost from general revenues only and in those plans there is virtually no direct cost to families, apart from additional billing that doctors may impose in some instances . . . It should be noted that all provinces permit specialists to extra-bill for non-referred care if the specialist rate is higher than the rate the plan will pay for such services.[8]

In reviewing the establishment and the operation of the Canadian health care system, Maurice LeClair, then Deputy Minister of Health of the Department of National Health and Welfare, concluded in 1975 that:

> The greatest benefit has been the provision of financial accessibility to health care . . . : no longer do people wait to seek care because they cannot afford it and a sudden illness or accident is not a financial catastrophe for an individual or a family. It is a fact though that the very poor are still not utilizing the system as much as they could for a variety of reasons: lack of a baby-sitter, taxi, or bus fares, etc.[9]
>
> In a health insurance system with no direct financial burden on the patient, the only deterrents to seeking care are the time and trouble involved, and there is a large untapped reserve of "beneficial" services which can be offered.[10]

There has been no comprehensive national review of the extent to which the extra-billing of medical fees may occur across Canada, the specialties of

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[7] *Review of Health Services in Canada, 1975* (Ottawa: Health Economics and Statistics Division, Health Programs, Department of National Health and Welfare, 1975), p. 4.

[8] Ibid., p. 24.

[9] Maurice LeClair, "The Canadian Health Care System" in S. Andreopolous, ed., *National Health Insurance: Can We Learn From Canada?* (New York: John Wiley & Sons, 1975), p. 42.

[10] Ibid., p. 79.

the physicians who adopt this practice, what types of health conditions or diseases may be involved, or the social attributes of patients who pay extra medical fee charges. **The conclusion that there are no financial deterrents to obtaining health services was not valid for the 20.1 percent of 4,754 women who had therapeutic abortions in eight provinces in 1976.** Between a quarter to a third of young abortion patients were extra-billed. There were sharp regional differences in this practice and in the actual amounts of money which many women were charged. In general, women who had less education and who had not been born in Canada had to pay more. The direct impact of these charges influenced the relative accessibility by the social circumstances of women to these medical services. **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.**

## Medical and hospital costs of induced abortion

The calculation of the financial costs attributable to therapeutic abortion which are paid for directly by national health insurance involves various provincial accounting procedures and rests upon a number of assumptions. There is some variation between provincial programs in how medical fee schedule items are coded and paid for, in the timing of the financial year which is used for accounting purposes, and the extent to which all medical and hospital services associated with the therapeutic abortion procedure are completely documented and indicated as relating to this operation in terms of their costs to the public purse. In the context of the different provincial health systems and their cost-accounting procedures, there is much variation in the average *per diem* costs of hospital care for patients, differences in the provincial fee schedules for medical procedures which are involved in the surgical operation of therapeutic abortion, and different styles of medical practice for the procedure of first-trimester induced abortions which may be done on a day-care (out-patient) basis or involve one or more days of in-patient hospital treatment.

While the Committee received information from provincial departments of health on the medical care insurance costs and medical fee payments made for therapeutic abortion procedures, this information involved different and non-comparable periods of time in the listing of abortion procedures and due to different accounting procedures these sources were not complete for 1974-75. In January of 1975, the Health Economics and Statistics Division, Policy Development and Coordination Directorate of the Department of National Health and Welfare completed a review of the known direct costs associated with the total number of therapeutic abortions done in Canada in 1973. This review was subsequently updated to 1974 at the request of the Committee. This analysis indicated the general nature of public expenditures for this surgical operation. In terms of subsequent increases in the cost of living, the information for 1973 and 1974 provided a comparison which is still valid in the

analysis of the relative costs of therapeutic abortion and the health costs which would have been incurred if these pregnancies had not been terminated. These cost estimates dealt only with monies paid from the public purse. Excluded from these estimates were the personal costs incurred by women who obtained induced abortions, the payment of medical fee charges which were made by patients in addition to the various medical care insurance fee reimbursement schedules, or the costs involved for women who obtained abortions in the United States.

Several assumptions were made in calculating the cost estimates for therapeutic abortions in 1973 and 1974. Included in these expenditures were the direct costs of medical and hospital care including related anaesthetic services. Medical care cost estimates were based on the quarterly medical care utilization information provided by the provinces to the Department of National Health and Welfare. No estimates were developed to determine the costs of medical complications which might develop following induced abortion. Allowance was made in deriving medical care costs for different rates established in provincial medical care payment schedules. These charges varied between the provinces by 33.2 percent, being on an average $50.68 for 1973 in British Columbia and $67.50 in Newfoundland.

The calculation of hospital costs was based upon the valid assumption that a majority of therapeutic abortions were done in larger rather than smaller hospitals and *per diem* patient costs were derived on this basis. Like medical care costs, average *per diem* hospital costs in 1973 varied across the country: by 77.9 percent from $60.95 in New Brunswick to $108.45 in Nova Scotia.

With the exception of Ontario, Manitoba, and British Columbia, there was an inverse relation among the seven other provinces between the average medical care costs and the average *per diem* hospital costs. For those provinces whose medical care costs were higher in 1973, average *per diem* hospital costs were considerably lower. The reverse situation obtained as where there were higher hospital costs, the average medical care costs were lower. The broad regional cost differences resulted from different health priorities set by the provinces, coupled with different patterns of medical care which were followed throughout the nation. There were differences between the provinces in the average number of annual visits made by patients to physicians and in the average length of hospitalization for specific hospital treatment procedures. These differences in how provincial health services were organized affected the health costs involved in the payment for therapeutic abortions under national health insurance.

More complete information on the experience of women who had therapeutic abortions was available for eight provinces in 1973 and information was available for all provinces in 1974. In 1973 the average length of hospital stay of patients having induced abortions was 2.5 days, a level which dropped slightly to 2.4 days by 1974. This level was then uniform for all provinces but where major differences occurred was in the proportion of patients who were treated on a day-care basis or as in-patients in hospitals. Almost all of the induced abortion patients in two provinces were treated in hospital and these two provinces predictably accounted for the highest average health costs per

abortion patient. In general, the experience of the other provinces showed that there was an association with average health costs involved with the abortion procedure by the extent to which these patients were hospitalized. The estimated health costs arising from the combined medical and hospital services provided for each therapeutic abortion patient in Canada was $284.17 in 1973. In terms of national expenditures for all reported therapeutic abortions, the estimated total costs of therapeutic abortions for that year were $12,242,000 of which $3,296,700 were medical care costs and $8,945,300 resulted from hospital services. Total average health costs for each therapeutic abortion patient varied between the provinces from $199.12 to $418.13. **By 1974, the average hospital and medical care costs for the treatment of each woman having a therapeutic abortion dropped to $270.76, or by 4.7 percent. The range between the 10 provinces was between $195.45 and $320.00, or a variation in health costs of 61.1 percent.**

Differences in health care costs may be associated with the types of procedures which are performed, whether services are provided by family physicians or medical specialists, whether treatment is given on an in-patient or out-patient basis, and by a difficult-to-measure factor, the quality of medical care which is given to patients. Many different standards have been used to measure the quality of medical care. These measures have included: optimal standards of care; the assessment of the health needs of patients or a population; the average pattern of medical services; and the use of outcome indices which may involve the number of deaths associated with a disease, related morbidity, physical and social functioning measures, or subsequent complications related to a specific medical or surgical procedure. Information on two of these indices related to therapeutic abortion was available. Only one death associated with abortion occurred in Canada in 1973. The assessment of medical complications associated with therapeutic abortions depends upon how such complications are defined, whether they are recorded in connection with this procedure, and whether they are measured as short-term or long-term sequelae. There is no information available to determine if there are different means used across the country in the listing of complications associated with therapeutic abortions. This may be the case, for there are substantial variations in the complication rates per 100 therapeutic abortions between provinces which are geographically adjacent. Until much more is known about the definition and the codification of abortion complications, their analysis must be seen with some reservation. It is within this context that they are considered here in conjunction with health costs.

In 1973 there were on an average 4.2 complications per 100 therapeutic abortions which were done in the eight provinces for which health cost information was available relating to therapeutic abortion. This rate of reported complications declined to 3.1 per 100 therapeutic abortions in 1974, but this rate was based on the experience of more provinces for that year and for Ontario from May to December of 1974.

In 1974 the complication rate per 100 therapeutic abortions among the provinces ranged from 2.0 to 8.0. Allowing for the difficulties involved in interpreting what medical complications may mean, on the basis of officially

reported morbidity information, **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.**

TABLE 15.8

MEDICAL AND HOSPITAL COSTS, PROPORTION OF PATIENTS HOSPITALIZED, AND COMPLICATIONS ASSOCIATED WITH THERAPEUTIC ABORTION: BY PROVINCE, 1974*

| Province | Services Associated with Therapeutic Abortion | | | |
|---|---|---|---|---|
| | Average Health Costs per Patient | | Proportion of Abortion Patients Who Were Hospitalized, | Complication Rate per 100 Therapeutic Abortions, |
| | 1973 | 1974 | 1974 | 1974** |
| | dollars | | percent | percent |
| 1 | 343.90 | 320.00 | 98.0 | 2.0 |
| 2 | 418.13 | 315.22 | 97.3 | 3.8 |
| 3 | 349.36 | 289.07 | 55.6 | 8.0 |
| 4 | 392.93 | 279.14 | 66.8 | 5.5 |
| 5 | 293.68 | 275.30 | 70.0 | 2.2 |
| 6 | 233.91 | 268.56 | 73.4 | 2.1 |
| 7 | 314.52 | 264.46 | 76.7 | 4.2 |
| 8 | 266.40 | 253.25 | 79.3 | 4.7 |
| 9 | 258.70 | 235.30 | 47.5 | 5.9 |
| 10 | 199.12 | 195.45 | 52.0 | 1.4 |
| CANADA | 284.17 | 270.76 | 70.5 | 3.1 |

* Health care cost information is based upon information from Health Economics and Statistics Division, Policy Development and Coordination Directorate, Health and Welfare Canada, Ottawa, 1976; the average length of hospital stay and complications associated with therapeutic abortions come from Statistics Canada.

** Relates to first complications only.

The health costs which would have been incurred if all of the reported therapeutic abortions in 1973 and 1974 had not been performed in Canadian hospitals, that is, if these pregnancies had been allowed to come to term, were estimated by the Health Economics and Statistics Division of the Department of National Health and Welfare. Allowance was made in these estimates for the expected number of foetal losses (stillbirths and spontaneous abortions) and the length of gestation in the calculation of the number of pregnancies which would have gone to term. No cost estimates were made of the expenditures involved in the treatment of patients who had had foetal losses or of the costs paid for by government for the transportation of patients in northern Canada. Likewise, no estimates were developed of the costs of pre-natal and post-natal care, the costs of well-baby care outside the hospital, or the treatment of special conditions such as congenital anomalies, premature births, or of other conditions of the newborn, or of women requiring further treatment. For these reasons the cost estimates associated with childbirth represented minimum expenditures.

In 1973 the total medical and hospital care expenditures involved (allowing for foetal losses), had the therapeutic abortions that year gone to term, would have been $27,164,000. This expenditure would have included $6,114,000 in medical care costs and $21,050,000 in hospital costs, or an average cost per patient of $728.22. In comparison with the estimated average cost of $284.17 in 1973 of performing a therapeutic abortion in eight provinces, there was a difference of $444.05 if routine treatment for pregnancy care had been provided. In 1974 the average cost per therapeutic abortion patient was $270.76 and the cost, allowing for stillbirths, if these pregnancies had continued to term, was estimated to be $865.47.

| Cost of Therapeutic Abortion | 1973 | 1974 |
|---|---|---|
| Total Estimate | $12,242,000 | $13,030,000 |
| Cost per Case | $284.17 | $270.76 |
| Costs Incurred in Routine Pregnancy Care of These Induced Abortion Patients | | |
| Total Estimate | $27,164,000 | $36,064,000 |
| Cost per Case | $728.22 | $865.47 |

**The costs involved from hospital and medical care insurance payments on a per capita basis for 22,095,000 individuals in Canada in 1973 were $0.55 per person for the therapeutic abortions done that year in Canadian hospitals. If the pregnancies of these women had gone to term, the cost would have been $1.23 for each person in the country. In 1974 this cost for each Canadian was $0.58 for all induced abortions, or $1.61 if these pregnancies had gone to term.**

## Contraceptive sales

In terms of information received by the Committee, the national sales of the various categories of contraceptive means to pharmacies and hospitals in 1975 were estimated to total $29,187,000. With an estimated price markup to the consumer, these sales amounted to $41,528,666. The volume of sales of contraceptives was distributed between six major categories, with oral contraceptives being the major component.

| Contraceptive Means | Percent of Sales, 1975 |
|---|---|
| Oral Contraceptives | 86.5 |
| Condoms | 8.3 |
| Vaginal Foams | 2.4 |
| Creams, Gels | 1.5 |
| Diaphragms | 0.3 |
| Intra-Uterine Devices | 1.0 |
| | 100.0 |

The usual price markup for oral contraceptives was 33.3 percent, while the customary markup for other contraceptive means was 50 percent or higher. The average oral contraceptive costs to a woman were $3.00 per cycle, which on an annual basis averaged between $36 and $40. Between 1974 and 1975, sales of condoms showed a 50 percent greater increase than sales for other types of contraceptives combined. Sales of oral contraceptives showed the next highest increase over this period. Relatively few condoms were sold through vending machines, with the majority being available at retail pharmacies, through which some of the largest distributors exclusively made their sales. The four remaining contraceptive means together accounted for 5.2 percent of this market in 1975, with the sales of vaginal foam decreasing by 18 percent between 1974 and 1975. The sales of intra-uterine devices in 1975 represented between 50,000 and 60,000 new users of this device during that year, but these sales did not include their distribution to surgical supply companies which sold directly to physicians.

TABLE 15.9

CONTRACEPTIVE SALES IN CANADA, 1975
DOLLAR SALES TO RETAIL PHARMACIES AND HOSPITALS

| Type of Contraceptive | Dollar Sales to Pharmacies and Hospitals | Estimated Consumer Expenditures |
|---|---|---|
| | | 33⅓ percent markup |
| Oral Contraceptive | $25,268,000 | =$33,690,666 |
| | | 50 percent markup |
| Condoms | $2,418,000 | =$4,836,000 |
| | | 50 percent markup |
| Vaginal Foam | $691,000 | =$1,382,000 |
| | | 50 percent markup |
| Spermicidal Creams & Gels | $430,000 | =$860,000 |
| | | 50 percent markup |
| Diaphragm | $80,000 | =$160,000 |
| | | 50 percent markup |
| Intra-uterine Device | $300,000 | =$600,000 |
| TOTAL | $29,187,000 | $41,528,666 |

Source: Committee survey, 1976.

In terms of sales of the contraceptive means used by women, and if only women between the ages of 15 and 49 years are considered, the average consumer expenditure was $6.14. **The per capita costs paid by Canadians in 1974 for the use of contraceptives was $1.85.**

## Expenditures on family planning

There has usually been a distinction made in public programs in Canada between services and programs involving: (1) abortion; (2) contraceptive counselling and services; and (3) family planning programs. The service and programs involved in family planning programs relate to the knowledge and

practices which enable individuals either to avoid or to terminate unwanted pregnancies, or to bring about wanted births.

Information about expenditures on family planning programs was obtained from the provincial and federal governments. No information on these types of programs was obtained from municipalities. A limited amount of information was available on the expenditures of a number of voluntary non-profit associations or organizations. The information which is available about the *designated* expenditures on family planning programs of the federal and provincial governments indicates the broad dimensions of what these activities cost. How health budgets approved by legislatures were administered and categorized varied between the provinces. In some instances specific family planning programs were identified, while in other cases public health staff were assumed to have the requisite competence in this field and family planning programs were included in the general operating budgets of public health agencies.

Newfoundland did not have a family planning program. While the provincial government had officially supported the Family Planning Association of Newfoundland, no direct financial support was granted to this agency. There was no designated program, separate staffing, or special budget for family planning in Prince Edward Island. It was reported that these activities were carried out by public health nurses in connection with pre-natal classes and post-natal visits to mothers.

The Nova Scotia Department of Public Health did not have separate staffing or a budget for family planning. As in Prince Edward Island, a family planning education program was undertaken by public health nurses which involved the distribution of pamphlets and the use of teaching aids. The Nova Scotia Department of Social Services made an annual grant of $10,000 to the Metro Area Family Planning Association. In New Brunswick the family planning program was carried out in the context of health promotion as part of the program of the Public Health Services Division. An annual grant of $4,000 was made to the Planned Parenthood Association of New Brunswick.

The organization of the Quebec Ministry of Social Affairs in 1976 was not structured on the basis of specialized programs. In conjunction with six senior professionals, one staff member had the designated responsibility for the review of family planning programs. While the Ministry had no annual budget specifically allotted to family planning, the Program for Preventive Information in Schools was assigned $122,629 in 1973, $176,000 in 1974, and $256,000 in 1975. A policy developed in 1972 committed the Ministry to finance a quarter of any funds which were granted to community associations from other sources. Amounts above these norms were granted from the second year onward of the operation of the programs. In 1974-75 the Ministry made the following grants for family planning.

| | |
|---|---|
| Quebec Family Planning Association | $ 72,600 |
| Séréna | 27,750 |
| S.O.S. Grossesse | 12,500 |
| TOTAL | $112,850 |

Based on a statement of the Minister of Health in December 1974, the provincial family planning program of the Ministry of Health of Ontario sought to promote comprehensive services in this field by providing financial support to local health agencies. All administrative units were included in the provincial program in 1976, with the interests of local communities and how they saw their needs in this field reflected in the scope of family planning services which were offered. An annual budget for family planning of $2,000,-000 in 1976 was allocated for distribution to local public health agencies. Among the provincial health units, 34 had counselling services and 28 provided some clinical services. Local health units at their discretion either could operate directly these family planning programs or provide financial support for this purpose to non-profit community associations. By 1976 this type of liaison had been established in five areas of Ontario.

A set of guidelines for the development of a family planning program was approved in 1970 in Manitoba. The Manitoba Department of Health and Social Development considered family planning information and counselling as an integral part of the more comprehensive services provided by public health nurses and social workers. Contraceptive devices were distributed, if requested, to low-income individuals through local health units. Where feasible, family planning clinics had been established in local health units. A full-time health educator was employed to arrange training sessions for Departmental personnel. The Department had no designated or separate budget items for its family planning activities. A grant of $15,000 was made in 1975 to the Family Planning Association of Manitoba.

The appointment of a family planning coordinator in the Saskatchewan Department of Public Health was made in March 1974. The provincial government's program in this field was started in the fiscal year 1973-74. At that time an advisory committee was appointed which subsequently tabled its report with policy recommendations for programs in the future. The 1975-76 budget for family planning was $93,120. In addition, the Family Planning Association of Saskatchewan received $25,337 in 1974-75.

The Alberta Minister of Health and Social Development approved a general statement on family planning policy in 1976. It was then estimated that the provincial Department would allocate $250,000 in 1976-77 to continue the family planning projects which had been previously funded by the federal government. The Department's Division of Local Health Services provided, when requested, the services of a medical consultant and a nursing consultant to community groups and agencies. Two community family planning associations were funded for an amount of $49,185 by the province's Preventive Social Services Program.

The Family Planning Program of the British Columbia Department of Health Services and Hospital Insurance had a budget of $100,000 in 1976 of which $20,000 was granted to the Planned Parenthood Association of British Columbia. This support was provided in order that the Association could seek federal funding for its educational and service programs. The Association established and staffed family planning clinics throughout the province whose operating expenses were paid for by the provincial government.

TABLE 15.10

FEDERAL AND PROVINCIAL GOVERNMENT DESIGNATED FAMILY PLANNING EXPENDITURES: 1975-1976*

| Branch of Government | Family Planning Expenditures | | |
|---|---|---|---|
| | Government Department | Community Agencies | Total |
| | dollars | | |
| Newfoundland | — | — | — |
| Prince Edward Island | — | — | — |
| Nova Scotia | — | 10,000 | 10,000 |
| New Brunswick | — | 4,000 | 4,000 |
| Quebec | 256,000 | 112,850 | 368,850 |
| Ontario** | 2,000,000 | — | 2,000,000 |
| Manitoba | — | 15,000 | 15,000 |
| Saskatchewan | 93,120 | 25,337 | 118,457 |
| Alberta | 250,000 | 49,185 | 299,185 |
| British Columbia | 80,000 | 20,000 | 100,000 |
| Canada: | | | |
| (1) Grants*** | 668,000 | 1,750,000 | 2,418,000 |
| (2) International**** (IDRC) | — | (1,108,798) | (1,108,798) |
| TOTAL | 3,347,120 | 1,986,372 | 5,333,492 |

* Based on information provided by federal and provincial health departments. These sources did not designate the costs of family planning programs which were considered to be integral to other health services' programs (e.g., public health nursing, health promotion).

** Allocated to programs operated by local health units and/or community agencies.

*** Designated expenditures for 1974-75.

**** International Development Research Centre (IDRC) expenditures are excluded from the total as this represents support given to other nations.

The Family Planning Grants Program of the Department of National Health and Welfare was established in May 1972. By April 1976 the staff of this program consisted of 8.5 positions and the program had an operating budget of $668,000. The senior staff of the federal program consisted of a director, a principal program officer, three consultants (nursing, community education, social work), and a resource centre officer. This program provided grants to assist the programs of national and local voluntary associations, universities, and provincial and municipal governments to develop and extend their family planning services. These grants were based on the principle of providing short-term "start-up" funds; the agencies which were supported were expected to obtain ongoing operating funds from provincial governments, philanthropic sources, or fund-raising campaigns.

The grants made under this federal program were in five categories: demonstration, fellowship, research, service, and training. In 1972-73 the program had a budget of $1,150,000, an amount which increased to $1,750,000 in 1974-75. In addition to this designated budget, the federal government

shared in the costs of family planning activities which were paid for under the federal-provincial cost-sharing programs of hospital and medical care insurance. The Department of National Health and Welfare in 1974 circulated 1,207,255 pamphlets on family planning. A total of 1,186,641 of these pamphlets was distributed in 1975. The objectives of the Family Planning Grants Program were:

1. to inform Canadians about the purpose and methods of family planning so that the exercise of free individual choice in this area will be based on adequate knowledge,
2. to promote the training of health and welfare professionals and other staff involved in family planning services,
3. to promote relevant research in family planning, including population studies,
4. to aid family planning programs operating under public and voluntary auspices through federal grants-in-aid and joint federal-provincial shared-cost programs.

The training and research grants program of the Department of National Health and Welfare is intended to advance the concepts of family planning.

There is no specific administrative division in the Department dealing with abortion. The reasons for this apparent deficiency may not appear clear initially; however, a review of the departmental position would serve to point out the "raison d'être". There is a full-time physician who maintains familiarity with current issues and problems and public reaction to the functions of existing abortion programs. In addition, statistical information on abortion is kept on file and up-to-date.

The Federal Government does not regard therapeutic abortion as an acceptable method of birth control. It does, however, support the concept of family planning whereby a couple may decide, according to their own beliefs and consciences, whether they want to use family planning methods to prevent unwanted pregnancies. To this end, the Department has a Family Planning Directorate, and supports a program directed to advancing the concepts of family planning practices in the general population across Canada.

The Federal Government recognizes that unwanted pregnancies may occur as a result of failure to abide by good family planning practices. In these situations, the pregnancy may have given rise to a condition which, in the opinion of a therapeutic abortion committee of an accredited or approved hospital, provides appropriate reasons for termination of the pregnancy in accordance with the terms of Section 251 of the Criminal Code regarding abortion.

As a health matter, abortion comes under provincial jurisdiction. The administation and operation of such programs and their implementation are responsibilities of the provinces. It should be added that the decision to establish or not establish a therapeutic abortion committee in an individual hospital is left to the discretion of the board of that hospital and the authorities of the province in which the hospital is located. This may explain, in part, the unevenness in distribution of hospital facilities for therapeutic abortion.

> The Health Insurance Directorate, Department of National Health and Welfare, receives requests from the provinces for shared medical costs under the terms of the Hospital Insurance and Diagnostic Services and Medical Care Acts. The charges for therapeutic abortions, when considered by a province to be a required medical service, would come, among others, under the terms of the shared Federal-Provincial Health Insurance Program. To date, all provinces consider therapeutic abortion as a required medical service. Under these circumstances, and considering the Departmental role, as described, it is not considered that there is any immediate need for a separate division of the Health Department to become involved solely in the subject of therapeutic abortion.

The review of grants which were made between 1972 and 1975 under the Family Planning Grants Program indicates that of a total of $4,029,203 disbursed during this period, $62,428, or 1.6 percent, dealt directly with three projects involving demonstration services for or research on induced abortion. One demonstration project which was funded at a university-affiliated teaching hospital was intended to assess the impact of professional counselling on the prevention of unwanted pregnancies. Two other projects dealt with the counselling or the follow-up of women who had induced abortions. From August 1973 to August 1974 the Department of National Health and Welfare received 204 requests for information on abortion, a number which dropped to 125 requests in 1975.

Two national voluntary associations, the Planned Parenthood Federation of Canada and Service de Régulation des Naissances (Séréna), were awarded the largest portion of the funds available under the Family Planning Grants Program. Between 1972 and 1975 these two national associations accounted for 50.6 percent of the federal program's funds, a proportion which declined from 58.4 percent in 1972-73 to 44.6 percent in 1974-75. The funds assigned to other national associations were $45,956 between 1972 and 1975, or 1.1 percent of the available funds. These two major national voluntary associations used the federal funds to establish and maintain their national headquarters and assigned funds obtained from the federal government to support the work of affiliated provincial and local programs. The two associations prepared annual reports which documented their services and expenditures. Much of their work during these years was contingent upon federal support. While extensive educational and counselling services were provided by these associations, little is known beyond the actual listing of these services about their immediate or long-range impact on the public whom they were intended to serve. There has been no independent audit of their public impact, nor is it apparent once the short-term federal funding has served its start-up function where replacement funding will be obtained.

Based on the findings of the national population survey and the national patient survey done for this inquiry, the services provided by these national agencies and their provincial affiliates had had little direct impact on the public. Their services had not been extensively used in terms of the total population to obtain information about family planning and contraception, or for advice and referral for abortion. This problem is not unique as it concerns the work of these two assocations. It poses the question faced by other public

programs of what is to be expected, how much, and over what length of time from designated public expenditures.

The remainder of the budget of the Family Planning Grants Program which had not been assigned to national associations was used to support a range of grant applications which were funded on a competitive review basis. In terms of regional averages involving the number of applications which had been approved, or rejected/withdrawn between 1972 and 1975, the craftsmanship in the preparation and the seeking of these grants was more effective in some parts of the country than in others. Of a total of 185 formal applications between 1972 and 1975, 57.3 percent were approved. The remainder were either rejected or withdrawn. Among the 10 provinces and two territories, the percentages of approved grants to all applications which had been submitted were: Yukon and the Northwest Territories, 0.0 percent; Saskatchewan, 33.3 percent; and Quebec, 34.9 percent. A larger proportion of applications for family planning projects had been approved for British Columbia (70.0 percent), Alberta (65.9 percent), Ontario (65.3 percent), and New Brunswick (63.6 percent).

Calculated on the basis of the 1974 population of Canada, **the average per capita amount of 9 cents for family planning grants involving competitively reviewed applications had been funded by the Department of National Health and Welfare between 1972 and 1975.** The amounts of grants on a per capita basis among the provinces were: 5 cents, Newfoundland; 14 cents, Prince Edward Island; 7 cents, Nova Scotia; 16 cents, New Brunswick; 8 cents, Quebec; 7 cents, Ontario; 9 cents, Manitoba; 9 cents, Saskatchewan; 18 cents, Alberta; 9 cents, British Columbia; and none, Yukon and the Northwest Territories.

TABLE 15.11

DISTRIBUTION OF FAMILY PLANNING GRANTS PROGRAM INVOLVING COMPETITIVE REVIEW OF APPLICATIONS 1972-1975*

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

| Province or Territory | Competitively Judged Grants | | | |
|---|---|---|---|---|
| | Approved Applications | Rejected/ Withdrawn Applications | Percent Approved Applications | Per Capita Dollar Amount Approved** |
| Newfoundland | 2 | 2 | 50.0 | 5 cents |
| Prince Edward Island | 1 | 1 | 50.0 | 14 cents |
| Nova Scotia | 5 | 4 | 55.6 | 7 cents |
| New Brunswick | 7 | 4 | 63.6 | 16 cents |
| Quebec | 8 | 15 | 34.9 | 8 cents |
| Ontario | 32 | 17 | 65.3 | 7 cents |
| Manitoba | 5 | 4 | 55.6 | 9 cents |
| Saskatchewan | 5 | 10 | 33.3 | 9 cents |
| Alberta | 27 | 14 | 65.9 | 18 cents |
| British Columbia | 14 | 6 | 70.0 | 9 cents |
| Yukon, Northwest Territories | 0 | 2 | 0.0 | 0 cents |
| CANADA | 106 | 79 | 57.3 | 9 cents |

* Social Service Programs Branch, Department of National Health and Welfare, Ottawa, December 1975. Support for national associations is excluded.

** Calculated on the basis of 1974 provincial population listing.

In its terms of reference and its objectives, the federal Family Planning Grants Program excludes abortion from its definition of family planning. In its work the Committee became aware of two sides of this situation. On the one hand, the virtual absence of federally supported projects which dealt directly with induced abortion resulted in part from the fact that there were relatively few projects dealing with this topic which had been submitted for review and potential funding. Between 1969 and 1975, 3 out of 7 submissions dealing directly with some aspect of induced abortion were funded. On the other hand, it was apparent that in its definition of family planning and how the operation of the federal program was seen by some professionals and agencies across Canada, applications dealing with induced abortion were not seen to have been encouraged.

On its site visits to hospitals across the country and in its meetings with experienced investigators, the Committee found there was considerable dissatisfaction that there was so little public support for demonstration programs and research dealing with induced abortion. Most of the provinces did not have a health grants research program. The Medical Research Council of Canada which provides support for basic medical research and graduate training fellowships had not received nor had it funded any projects dealing directly with induced abortion. This issue had not been supported by Canadian philanthropic foundations. In accord with its mandate, the federal Family Planning Grants Program was seen by many capable researchers as not dealing with induced abortion.

Several examples were cited to the Committee by researchers who said that they had been asked, if their projects dealt with induced abortion, to revise their submissions to granting sources. It was also alleged that senior civil servants were often put in a difficult position. If they became interested or developed competence in the field of induced abortion, they were likely to be re-assigned to other posts. As a result of the sensitive nature of the issue, it was asserted that the support which was given by federal and provincial agencies was allocated to socially safe stand-by services which did not deal directly with demonstration programs and research involving induced abortion or with the basic issues in family planning. These programs, it was suggested, had effectively pre-empted the field. For these several reasons the existing funding programs had little respect among many experienced researchers.

One senior researcher with an established international reputation and who had obtained a number of sizeable research grants observed to the Committee: "The situation for research and effective demonstration programs is a closed shop in Canada. If support for relevant work is to be obtained, the funding has to come from outside the country." This observer further noted: "It is easy to turn down grant applications on the basis that they are methodologically unsound. But until competence is built up, it is difficult to see how this can be otherwise. And competent researchers will not submit applications, because they know they have no chance of being funded."

In addition to monies made available under the Family Planning Grants Program of the Department of National Health and Welfare, $3,824,727 was funded for 22 international projects between September 1971 and March 1976 by the International Development Research Centre (IDRC). As part of

Canada's foreign aid program, these projects dealt directly with different aspects of family planning, abortion, and fertility regulation in 13 nations (Colombia, 1; Dominica, 1; Egypt, 3; India, 1; Mali, 1; Mexico, 2; Nigeria, 1; Philippines, 2; Singapore, 2; Thailand, 2; United States, Population Council, 2; West Indies, 1; and West Malaysia, 1). In addition, two grants had been made to the World Health Organization to support that United Nations agency in its work on human reproduction and fertility control. Two grants had been made by IDRC to the Canadian Committee on Fertility Research (affiliated with the World Health Organization) to develop a scientific advisory committee for the design and implementation of research studies and for the administration of an international collaborative research program on fertility control.

This foreign aid program provided direct financial support and, where appropriate, consultants to family planning programs of national and local health departments, universities, and voluntary agencies in these nations. Among the projects supported by the IDRC were:

- development of a national family planning program;
- assessment of the costs resulting from the use of different contraceptive means and from their long-term use;
- health promotion programs for fertility regulation;
- the effectiveness of different types of health workers and laymen in maternal and child health programs and family planning programs;
- the development of designated research centres for fertility research;
- epidemiological research on the extent of induced abortions;
- research on the social, clinical, and pathological factors involved in subfertility and infertility;
- study of the morbidity and mortality rates associated with early induced abortion;
- the impact of abortion on mothers and the family unit;
- the morbidity and mortality rates and the side effects of tubal ligation;
- the clinical trials of the use and effectiveness of various contraceptive means;
- the production of films on different aspects of family planning;
- the establishment of clinics and training programs in family planning.

While this exemplary foreign aid program provided assistance to other nations to develop training and research centres, to support demonstration projects, and to provide a broad range of research inquiries dealing with family planning, including abortion, for most of the topics for which foreign aid was given there were no comparable programs in Canada. Repeatedly in its work the Committee was told by experts about service programs or research which had been done abroad, but seldom about comparable work in Canada. If such studies were available dealing with the Canadian experience, they dealt with a small number of individuals or represented special circumstances. This point was verified by the search of the available research literature dealing with

family planning, the use of contraception, or induced abortion involving Canadians. Many of these reports were general statements, often having a charged intent. There were few studies which fully merited the designation of well undertaken scientific inquiries in terms of the research methods which had been used.

**In its work abroad Canada has helped to initiate on a cooperative basis with other nations the components of a comprehensive family planning program. This endeavour stands in sharp contrast to the efforts in these respects which have been undertaken in this country.** The work of this inquiry would have been facilitated at every stage had similar information been available dealing with family planning and abortion for which Canada has given assistance to other nations. **The research work to date in Canada has been fragmentary; most of the relevant questions have not been studied.**

## Allocation of expenditures

The review of health costs and expenditures associated with pregnancy, family planning, and abortion provides an overview of general trends. Not all of the sources of the information on these points are complete. In the case of women who obtained induced abortions, no cost estimates were made for individuals who obtained abortions from illegal sources or the costs associated with room and board and transportation when this operation was obtained out of the country. Likewise, in the calculation of the costs involved in childbirth, only the immediate expenditures were considered. No estimates for instance were made of the subsequent health costs which might be incurred or the costs resulting from specialized post-natal care. Because health accounting procedures vary, only the expenditures which were directly designated for family planning activities by government were listed. It was not fully known how much money was spent directly by individuals or voluntary community associations on these activities. It is within the context of these reservations that the general trends in the expenditures on family planning and induced abortion are considered.

From what is known about the expenditures on childbirth, family planning, and abortion, **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 normal childbirth. At the same time from designated expenditures, $0.24 was spent on federal and provincial family planning measures.**

The dilemma of providing a balance in expenditures and effort between treatment services and preventive measures has been long known. All too often, because the former presents an immediate problem which has to be resolved, it receives most of the public attention and garners most of the available resources. This has been the case in the distribution of public resources and expenditures for induced abortion. Most of the public funds have been allocat-

ed to provide treatment services for these patients, while considerably less public support has been turned to the reduction of unwanted pregnancies.

In *A New Perspective on the Health of Canadians: A Working Document*, a series of national health priorities were set for the future. This document recognized the complex interplay between social forces, the distribution of disease, and the life styles of individuals. On the point of establishing a balance between treatment and prevention services, this document observed:

> One point on which no quarter can be given is that difficulties in categorizing the contributing factors to a given health problem are no excuse for putting the problem aside; the problem does not disappear because of the difficulties in fitting it nicely into a conceptual framework.
>
> ...if the incidence of sickness can be reduced by prevention, then the cost of present services will go down, or at least the rate of increase will diminish. This will make money available to extend health insurance to more and more services and to provide needed facilities, such as ambulatory care centres and extended care institutions. To a considerable extent, therefore, the increased availability of health care services to Canadians depends upon the success that can be achieved in preventing illness through measures taken in human biology, environment and life style.[11]

These observations are relevant to the issue of therapeutic abortion. Its current prevalence is not likely to disappear by itself or to be reduced in the absence of public measures. **There is an imbalance between the expenditures and effort in this field. The resources which are devoted to its treatment in no way are matched by comparable public support for programs mounted for its prevention. As long as this situation involving induced abortion persists, there is little likelihood that there will be a reduction in its volume or its costs.**

[11] Hon. Marc Lalonde, *A New Perspective on the Health of Canadians: A Working Document* (Ottawa: Government of Canada, April 1974), pp. 36-37.

# Appendices

# Appendix 1

# STATISTICAL NOTES AND TABLES

## STATISTICAL NOTES

1. *Time taken to obtain a therapeutic abortion (Chapter 7)*

The multiple regression[1] relating to the time taken to obtain an abortion included variables which related to a woman's demographic characteristics (age, religion, level of education and marital status) and the use of health services (the time taken to see a physician, the number of physicians who were consulted, and the time from the initial medical contact to the abortion operation).

The results of the multiple regression excluded all variables which contributed less than 1 percent to the $r^2$ of the dependent variable (the total length of the pregnancy). In all cases the simple r indicated a positive relationship, i.e., that the delay in obtaining the induced abortion was increased if the variables increased in value. The results were:

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Time taken by a woman to see a physician | .123 | .123 |
| Number of physicians seen about a pregnancy | .097 | .220 |
| Time from initial medical consultation to abortion operation | .515 | .735 |

n = 4,221

for 73.5 percent of the variance.

For the women in this study who obtained therapeutic abortions in Canadian hospitals, almost three-quarters (73.5 percent) of the delay was attributable to health system factors. The relative importance of the demographic characteristics was, in all cases, below the 1 percent $r^2$ level. These results indicate that the impact of demographic characteristics of women seeking abortion on the length of time taken must be gauged by the ways in which these factors influence their access to the appropriate pathways in the medical care delivery system. While the group only included women who had obtained therapeutic abortions, the findings indicate that the delays which they had as a direct result of their demographic characteristics were negligible. It was the factors which occurred after a physician had been initially consulted which accounted for a significant proportion of the time, factors which went well beyond the individual attributes of the women who were involved.

[1] All references to regression imply multiple linear regression in Statistical Notes.

2. *Physicians' attitudes toward abortion (Chapter 9)*

To investigate the factors which might be associated with the attitudes of physicians toward induced abortion, an analysis which was comparable to the method used in the national population survey (Statistical Note 3) was used. The questions which were asked in the national physician survey were similar to those asked in the national population survey, but provided for more detailed replies. The questions asked were in the form "would you support a request for a therapeutic abortion under specified conditions" which were:

1. detrimental to the physical health of the mother;
2. detrimental to the mental health of the mother;
3. possibility of physical deformity in the baby;
4. pregnancy the result of rape or incest;
5. an economic inability to support the child;
6. to prevent the birth of an illegitimate child;
7. whenever an application is made for a therapeutic abortion during the first trimester of a pregnancy.

The first six of the conditions were divided into: (a) first trimester; (b) beyond first trimester length of gestation.

A three-point scale was used to evaluate the responses (0=refusal; 1=first-trimester support; 2=beyond first-trimester support) only after analogous procedures using point dichotomous (YES/NO) coding had been run. The point dichotomous coding was more rigourous than the use of the three-point scale, but the use of the three-point scale was felt to be more directly aligned to the original phrasing of the questions.

The results of the factor analysis of the attitudes of physicians toward induced abortions were comparable to the results of the national population survey. The first four conditions constituting the physical-mental health factor accounted for 17.9 percent of the variance, while the three social indications held 82.1 percent of the variance. The comparison between the findings of the two analyses was:

| | FACTOR 1 | FACTOR 2 |
|---|---|---|
| | *Social* | *Physical-mental* |
| National | 82.3 | 16.7 |
| Physicians | 82.1 | 17.9 |

n = 3,129

The two factors were defined (mathematically) in essentially the same way.

A series of follow-up analyses was done to complement the results of the factor analysis technique. The first of these was the reconstruction of the two factor-scales in a form which would allow their use as dependent variables for

multiple regression analytic techniques. The independent variables (used here as well as throughout this statistical note) were:

1. Religion;
2. Region of residence;
3. Marital status;
4. Sex;
5. Primary language spoken;
6. Type of medical practice;
7. Organization of practice;
8. Age;
9. Size of the community of practice;
10. Specialty training (general practitioner, obstetrician-gynaecologist).

Where the original variables were nominal or ordinal, standard dummy-variable techniques were used. Consequently, religion, marital status, sex, language, region of residence, type and organization of medical practice were reconstructed in a point-dichotomous fashion, while the age of the respondent and the size of the community of practice were left in their original categorical form. As a result of this recoding, 16 technically separate variables were derived and used. The previously established criterion was used of excluding any and all variables which did not make at least a 1 percent contribution to the final $r^2$ of the dependent variable. The cumulative $r^2$ in each instance was based solely on these variables.

The first regression was run on the social health factor. The results were:

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Catholic | .147 | .147 |
| Age of physician | .036 | .183 |
| Quebec residence | .016 | .199 |

For this and other results in this section, n = 2,570

for 19.9 percent of the variance.

Investigation of the simple r revealed that all of the three "variables", if present, decreased the likelihood of support for induced abortion (regarding age, the older the physician, the less the likelihood of support).

The second analysis considered indications involving the physical-mental health factor.

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Catholic | .040 | .040 |
| Protestant | .021 | .061 |

Two factors accounted for 6.1 percent of the variance. The simple r revealed that Catholic physicians were not likely to support induced abortions on these grounds, while Protestant physicians were more likely to do so. The low $r^2$ (6.1 percent) revealed, however, that while a relationship existed, 93.9 percent of the support for induced abortion on physical-mental health indications was not related to the religion of the physician (Catholic or Protestant).

The third analysis found that four variables related to the indication of "mental health" interpreted in relation to abortion accounted for 9.8 percent of the variance.

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Catholic | .032 | .032 |
| Quebec residence | .045 | .077 |
| Age of physician | .011 | .088 |
| Jewish | .010 | .098 |

The zero-order correlation (simple r) revealed that Catholic physicians and older physicians felt the indication of mental health was interpreted too liberally, while Jewish physicians and physicians who practiced in Quebec felt the issue was interpreted too restrictively. (The mathematical independence of these variables indicated that: e.g., Quebec Catholic physicians were more likely to find the interpretation more restrictive than Catholic physicians in other parts of the country.)

Abortion as a human right was the fourth analysis. Three variables accounted for 11.8 percent of the variance.

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Catholic | .067 | .067 |
| Quebec residence | .041 | .108 |
| Age of physician | .010 | .118 |

The simple r revealed that Catholic physicians and older physicians were more likely to disagree with the statement, while Quebec physicians in the national physician survey were more likely to agree.

The fifth analysis involving three variables which dealt with the view of physicians whether abortion lowers the value of human life accounted for 12.1 percent of the variance.

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Catholic | .074 | .074 |
| Quebec residence | .027 | .101 |
| Age of physician | .020 | .121 |

The simple r revealed that Catholic, Quebec residents and older physicians tended to agree with this statement.

Three variables accounted for 18.5 percent of the variance in the responses to the question about whether abortion is preferable to an unwanted child.

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Catholic | .155 | .155 |
| Age of physician | .017 | .172 |
| Quebec residence | .013 | .185 |

The simple r revealed that Catholics, older physicians and Quebec residents were more likely to disagree with this statement.

The single variable which accounted for 1.2 percent of the variance was related to whether physicians said they were willing to serve on a therapeutic abortion committee.

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Catholic | .012 | .012 |

However, the age of the physician was 0.9 percent in both cases. Being Catholic or an older physician showed a trend toward being less willing to serve on a therapeutic abortion committee.

In the remaining analyses considered in this statistical note, the seven general indications (four physical-mental health and three social health) were considered individually in relation to the extent of their association with physician attributes.

1. Detrimental to the physical health of the mother.

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Catholic | .117 | .117 |
| Age of physician | .041 | .158 |
| Anglophone | .019 | .177 |

Three variables accounted for 17.7 percent of the variance. The simple r showed that older physicians and Catholic physicians were less likely to support this indication, while anglophone physicians were more likely to do so.

2. Detrimental to the mental health of the mother.

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Catholic | .148 | .148 |
| Age of physician | .022 | .170 |

Two variables accounted for 17.0 percent of the variance. Younger physicians and Catholic physicians were less likely to support this indication.

3. Possibility of physical deformity in the baby.

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Catholic | .108 | .108 |
| Age of physician | .033 | .141 |
| Quebec residence | .020 | .161 |

Three variables accounted for 16.1 percent of the variance. Catholics, older physicians and Quebec residents were less likely to support this indication.

4. Pregnancy the result of rape or incest.

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Catholic | .115 | .115 |
| Age of physician | .021 | .136 |
| Quebec residence | .014 | .150 |

Three variables accounted for 15.0 percent of the variance. Catholics, older physicians and Quebec residents were less likely to support this indication.

5. An economic inability to support the child.

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Catholic | .088 | .088 |
| Age of physician | .017 | .105 |

Two variables accounted for 10.5 percent of the variance. Catholics and older physicians were less likely to support this indication.

6. To prevent the birth of an illegitimate child.

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Catholic | .040 | .040 |
| Jewish | .016 | .056 |

Two variables accounted for 5.6 percent of the variance. For most physicians none of their attributes which were included in the analysis were related to their responses to this indication. There was a trend toward Catholic physicians being less likely to support this indication while the reverse held for Jewish physicians.

7. Whenever an application is made for a therapeutic abortion during the first trimester of a pregnancy.

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Jewish | .022 | .022 |
| Quebec residence | .011 | .033 |

Two variables accounted for 3.3 percent of the variance. There was a trend for Jewish physicians and physicians living in Quebec to be more likely to support this indication.

8. Whenever an application is made for a therapeutic abortion.

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Jewish | .021 | .021 |
| Catholic | .010 | .031 |
| Quebec residence | .017 | .048 |

Three variables accounted for 4.8 percent of the variance. As was the case for support for the other six indications, most of the variance was unaccounted for (95.2 percent). Jewish physicians and physicians living in Quebec were more likely to support this indication while Catholic physicians were less likely to do so.

9. In your opinion is the current abortion legislation: (1) too liberal; (2) about right; (3) too restrictive; (4) no opinion.

| Independent Variable | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Catholic | .031 | .031 |
| Quebec residence | .070 | .101 |
| Age of physician | .019 | .120 |

Three variables accounted for 12.0 percent of the variance. Catholic physicians and physicians who were older were more likely to state that the abortion legislation was too liberal while more Quebec physicians found it was too restrictive.

From the preceding analyses of multiple regression, the $r^2$ component fluctuated from a low of 3.3 percent to a high of 19.9 percent (excluding the question relating to the willingness to serve on a therapeutic abortion committee). What emerged sharply was the low $r^2$ in all cases. The results of the regression technique indicate that while the social and demographic attributes of physicians in the national survey such as age, religion and province of residence had a part in the "prediction" of certain of their attitudes toward induced abortion, the majority of the differences (from a minimum of 80.1 percent to over 96 percent) were not related to their stated views about these issues or in the extent of their support or non-support of indications for induced abortion. In terms of the variables which were used, the physicians in the national physician survey had attitudes toward induced abortion which were demographically transcendent, i.e., they cut across the attributes which are often assumed to be related to stated views of the medical profession toward induced abortion. For the physicians in the national physician survey, what these findings mean is that their opinions on this issue are not readily categorized in terms of their personal or medical practice attributes.

3. *Public attitudes toward abortion (Chapter 11)*

To determine what factors might be related to the attitudes toward induced abortion of the individuals in the national population survey, the factor analysis technique which was used was that of the iterated principal components variety, using the varimax criterion to control orthogonal rotation. The results of the factor analysis showed that the two positions of "abortion on demand" and "never willing to support abortion" were polar to each other, but also defined an endpoint to a second dichotomization, i.e., the "polar" versus the "usual" view of support to induced abortion. The remaining questions (which were run separately to determine the impact of excluding the "polar" position) fell into two major clusters.

The first factor accounted for 80.6 percent of the variance. Its principal components were: the support of an abortion request with gestation under 12 weeks; the support for abortion to prevent illegitimate birth; and the support of abortion for reasons of financial hardship. This factor was labelled the ***social health*** indication factor. The second factor (which accounted for 19.4 percent of the variance in the replies to the questions) was labelled ***physical and mental health*** indication factor. The principal components of this factor were the questions which indicated: support for abortion if the pregnancy was the result of rape or incest; support for abortion if the baby might be physically deformed; and support if the continuation of the pregnancy might endanger the physical or mental health of the mother (asked as two separate questions).

The repetition of this factor analysis, leaving out the questions designated as "polar" produced the following results. The social factor on the restricted set of attitudinal questions accounted for 83.3 percent of the total variance of the remaining seven attitudinal questions, while the physical-mental health factor was reduced to 16.7 percent. To isolate the regional variants of these attitude clusters, individual factor analyses were generated for each of the five geographical regions in the country. The five regional factor analyses produced the following results.

| Region | Percent Variance Due to Social Health Indication Factor | Percent Variance Due to Physical-Mental Health Indication Factor |
|---|---|---|
| Maritimes ..... | 82.5 | 17.5 |
| Quebec..... | 81.7 | 18.3 |
| Ontario ..... | 83.8 | 16.2 |
| Prairies ..... | 80.8 | 19.2 |
| British Columbia .. | 83.3 | 16.7 |
| CANADA..... | 83.3 | 16.7 |

n = 4,128

It was assumed that the factors might be useful to distinguish demographically distinct groups in the population. For reasons of parsimony, only the national sample was used, with the regional variation of attitudes being included through the use of a dummy variable multiple-regression approach to the analysis of variance within these factors.

Although this approach was statistically significant, what was found was intuitively irrelevant. Using the two generated factors of social and physical-mental support for abortion as the dependent variables, attempts were made to predict the variations in these factors by the use of multiple regression. The dummy variable technique was used to indicate the sex, region, religion, and language of the respondents, while the variables of age (coded as "year of birth"), community size, and educational experience were entered as they were. Using this approach, the total $r^2$ for the social health factor was 5.5 percent, while that for the physical-mental health factor was 5.4 percent.

The combination of the factor analytic results with the multiple regression results indicated that while two distinct attitudinal groups existed in relation to the abortion issue, the attitudes themselves cut across the demographic lines of demarcation which are often assumed to "explain" or "to account for" the reasons why individuals hold a specific viewpoint. In both cases, the "accepted" or "stereotypic" relationships were found, and found to be of high statistical significance. But in each case, this high significance was more an artifact of the sample size than a reflection of the utility of these demographic factors as predictors of the attitudes which were held. In both cases, nearly 95 percent of the "reasons" for holding one of the two positions about the issue of induced abortion could not be traced back to the traditionally employed assumptions regarding this issue.

4. *Sexual behaviour (Chapter 14)*

To isolate the principal factors associated with the frequency of coitus of individuals in the national population survey, the statistical technique used was multiple regression. This approach used dummy variable replacements for those variables which did not meet the assumption of interval level data. All of the socio-economic variables available were used, as well as those relating to the use of contraception. The results reported were produced by an additional application of the multiple regression technique, this time excluding all variables which made up less than a 1 percent contribution to the final $r^2$ of the model. All of the terms of the model were linear except for the variable which designated the interaction of age and marital status. This interaction indicated that the impact of age could be most adequately gauged (relating to the frequency of sexual intercourse) if the individual was married.

The contributions to the overall variation were:

| | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Age-married (interaction) | .391 | .391 |
| Use of birth control pills | .029 | .420 |
| No use of contraceptives (any type) | .015 | .435 |
| No need for contraceptives | .011 | .446 |

n = 3,437

which yielded a total of 44.6 percent of the variance of the frequency of sexual intercourse.

No checks were made to allow for a distinction between heterosexual and homosexual contacts or to measure the extent of extra-marital intercourse. What this model provides is an estimate (44.6 percent) of the importance of: (a) the availability of a sex partner; and (b) the reliability of the contraceptive method perceived by the participants.

5. *Sterilization and induced abortion (Chapter 14)*

To analyze the multiple effects for women in the national patient survey of their marital status, their age and the number of previous live births, a multiple regression analysis was performed. Because a considerable degree of interaction between the age of those patients who had abortions and the number of live births was expected, a multiplicative model was adopted. As a further step in the analysis, partial correlations of sterilization and demographic factors were examined. Each of these analyses supported the conclusion that the number of previous live births was the major demographic factor determining whether a woman having an induced abortion was to be sterilized.

The multiple regression analysis was done in several steps beginning with age, number of live births and the dichotomized married-other marital status variables introduced alone. During the second stage these variables were cross multiplied and introduced into the equations. The cross-multiplied products were highly skewed, but had higher correlation coefficients and F-ratios with the dependent variable than did the single predictor items.

The proportion of explained variance in sterilization, which can be estimated by the square of the multiple-correlation coefficient ($r^2$), was not greatly increased in the interactive model. The three single criterion variables accounted for 27.0 percent of the variance in sterilization compared to 29.2 percent in the more complex model. The interaction between live births and age was evident and this variable contributed most significantly to the explanation of sterilization in the mixed single criterion—multiplicative items equation. The introduction of the multiple criterion items to estimate the degree of interaction between the single criterion predictors reduced the influence of age and number of live births to below the 1 percent level of contribution to the total $r^2$. When the effects of interaction were controlled, the independent influence of marital status was seen more clearly:

| | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Live births | .240 | .240 |
| Age | .020 | .260 |
| Married-other | .010 | .270 |

n = 3,817

for 27.0 percent of the variance.

| | $r^2$ (contrib) | $r^2$ (cum) |
|---|---|---|
| Live births-age | .270 | .270 |
| Age-married | .011 | .281 |
| Married-other | .011 | .292 |

n = 3,817

for 29.2 percent of the variance.

For the women having therapeutic abortions from whom information was obtained in the national patient survey, the analysis emphasizes the interaction of their age and the number of their previous live births in the decision about their surgical sterilization.

Investigation of the zero-order correlation (simple r) indicates that the likelihood of sterilization is augmented with increases in all of these variables. Interpreted more literally, among the women in the national patient survey, there was a greater likelihood of sterilization among older women, those women who had more live births, and women who were widowed, divorced or separated. The interaction model showed that the number of previous live births, age and age-married variables did not alter from this pattern. (Increases in both the number of live births and a woman's age, or older married women are more likely to be sterilized.) The second (interaction) model contained all of the original variables. The absence of the "age" and "live births" variables indicated that the inclusion of the interaction variables reduced their contribution to a value below 1 percent of the total $r^2$.

# STATISTICAL TABLES

TABLE 1

NATIONAL HOSPITAL SURVEY AND
HOSPITAL SITE VISITS BY COMMITTEE

| Region of Country | Eligible Hospitals | |
|---|---|---|
| | Response to National Hospital Survey | Site Visited by Committee |
| | percent | |
| Newfoundland | 90.9 | 27.3 |
| Prince Edward Island | 83.3 | 33.3 |
| Nova Scotia | 87.5 | 29.2 |
| New Brunswick | 62.5 | 25.0 |
| Quebec | 63.4 | 29.7 |
| Ontario | 85.9 | 29.6 |
| Manitoba | 79.5 | 20.5 |
| Saskatchewan | 91.3 | 34.7 |
| Alberta | 81.7 | 20.7 |
| British Columbia | 70.0 | 22.5 |
| Yukon and Northwest Territories | 66.6 | 33.3 |
| CANADA | 77.4 | 25.0 |

TABLE 2

CANADIAN POPULATION AND
NATIONAL POPULATION SURVEY
CHARACTERISTICS

| Population Characteristics | Canadian Population[1] | Canadian Institute Sample | Abortion Study Sample[2] |
|---|---|---|---|
| AGE | | | |
| 18-29 years | 31.1 | 29 | 31.5 |
| 30-49 years | 34.8 | 40 | 40.8 |
| 50 years and over | 34.1 | 31 | 27.7 |
| AREA | | | |
| Atlantic | 9.6 | 10 | 10.5 |
| Quebec | 28.0 | 28 | 29.1 |
| Ontario | 35.8 | 36 | 34.4 |
| Prairies | 16.5 | 16 | 15.0 |
| British Columbia | 10.1 | 10 | 11.0 |
| COMMUNITY SIZE | | | |
| Over 100,000 | 48 | 47 | 46.4 |
| 10,000-100,000 | 17 | 17 | 18.1 |
| Under 10,000 rural and farm | 35 | 36 | 35.5 |
| SEX | | | |
| Male | 50.1 | 50 | 46.2 |
| Female | 49.9 | 50 | 53.8 |

[1] The Canadian Institute of Public Opinion uses 1971 Canadian Census information as the basis for population sampling.

[2] Excludes 554 individuals between ages 15-17 years in a special sub-sample.

TABLE 3

SELECTED DEMOGRAPHIC CHARACTERISTICS, CANADA AND PROVINCES, 1970-1974

STATISTICS CANADA

| | | Canada | Nfld. | P.E.I. | N.S. | N.B. | Que. | Ont. | Man. | Sask. | Alta. | B.C. | Yukon | N.W.T. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Total Population (1,000s) | 1970 | 21,297.0 | 517.0 | 110.0 | 782.0 | 627.0 | 6,013.0 | 7,551.0 | 983.0 | 941.0 | 1,595.0 | 2,128.0 | 17.0 | 33.0 |
| | 1971 | 21,568.3 | 522.1 | 111.6 | 789.0 | 634.6 | 6,027.8 | 7,703.1 | 988.2 | 926.2 | 1,627.9 | 2,184.6 | 18.4 | 34.8 |
| | 1972 | 21,820.5 | 532.0 | 113.0 | 794.5 | 643.0 | 6,050.5 | 7,823.9 | 991.5 | 916.3 | 1,653.9 | 2,247.0 | 18.9 | 36.0 |
| | 1973 | 22,094.7 | 540.8 | 114.9 | 804.8 | 651.9 | 6,081.4 | 7,938.9 | 997.8 | 908.1 | 1,683.6 | 2,315.0 | 19.7 | 37.8 |
| | 1974 | 22,446.3 | 542.5 | 116.7 | 813.2 | 661.8 | 6,134.3 | 8,093.9 | 1,011.0 | 907.0 | 1,713.9 | 2,395.2 | 19.4 | 37.5 |
| 2. Population women 15-44 (1,000s) | 1970 | 4,550.8 | 103.9 | 20.7 | 157.2 | 126.8 | 1,354.2 | 1,619.7 | 199.3 | 180.3 | 339.3 | 438.8 | 3.8 | 6.8 |
| | 1971 | 4,656.1 | 106.1 | 21.3 | 160.1 | 129.9 | 1,371.7 | 1,668.6 | 202.2 | 178.5 | 351.0 | 455.3 | 4.0 | 7.4 |
| | 1972 | 4,766.5 | 110.3 | 22.2 | 163.8 | 133.6 | 1,394.9 | 1,710.9 | 204.6 | 178.2 | 360.7 | 475.3 | 4.3 | 7.7 |
| | 1973 | 4,890.5 | 114.0 | 23.2 | 169.0 | 138.5 | 1,418.8 | 1,755.4 | 208.4 | 178.4 | 371.9 | 500.5 | 4.4 | 8.0 |
| | 1974 | | | | | | | | | | | | | |
| 3. Married women 15-44 (1,000s) | 1970 | 2,858.8 | 63.5 | 12.3 | 97.6 | 76.3 | 789.2 | 1,061.8 | 125.8 | 114.4 | 223.2 | 287.6 | 7.1 | |
| | 1971 | 2,917.3 | 65.1 | 12.6 | 99.2 | 78.1 | 796.4 | 1,091.1 | 127.2 | 112.5 | 230.3 | 297.1 | 7.7 | |
| | 1972 | 2,967.2 | 67.6 | 13.0 | 100.0 | 80.7 | 804.2 | 1,111.3 | 128.2 | 110.9 | 234.9 | 307.5 | 8.0 | |
| | 1973 | N.A. | | | | | | | | | | | | |
| | 1974 | N.A. | | | | | | | | | | | | |
| 4. Marriages | 1970 | 188,428 | 4,466 | 913 | 6,800 | 5,696 | 49,606 | 68,874 | 9,008 | 7,317 | 15,285 | 20,026 | 201 | 236 |
| | 1971 | 191,324 | 4,685 | 961 | 6,883 | 6,149 | 49,695 | 69,590 | 9,127 | 7,813 | 15,614 | 20,389 | 166 | 252 |
| | 1972 | 200,470 | 5,106 | 1,013 | 7,291 | 6,455 | 53,830 | 72,278 | 9,181 | 7,877 | 16,345 | 20,659 | 181 | 254 |
| | 1973 | 199,064 | 5,048 | 1,014 | 7,273 | 6,357 | 51,943 | 72,371 | 9,196 | 7,847 | 16,280 | 21,303 | 206 | 226 |
| | 1974 | 198,824 | 4,276 | 990 | 7,112 | 6,108 | 51,532 | 72,716 | 9,231 | 7,988 | 16,691 | 21,734 | 190 | 256 |
| 5. Marriage Rates (per 1,000 population) | 1970 | 8.8 | 8.6 | 8.3 | 8.9 | 9.1 | 8.2 | 9.0 | 9.2 | 7.8 | 9.6 | 9.4 | 12.6 | 7.2 |
| | 1971 | 8.9 | 9.0 | 8.6 | 8.7 | 9.7 | 8.2 | 9.0 | 9.2 | 8.4 | 9.6 | 9.3 | 9.0 | 7.2 |
| | 1972 | 9.2 | 9.6 | 9.0 | 9.2 | 10.0 | 8.9 | 9.2 | 9.3 | 8.6 | 9.9 | 9.2 | 9.5 | 7.1 |
| | 1973 | 9.0 | 9.3 | 8.8 | 9.0 | 9.8 | 8.5 | 9.1 | 9.2 | 8.6 | 9.7 | 9.2 | 10.3 | 5.9 |
| | 1974 | 8.9 | 7.9 | 8.5 | 8.7 | 9.2 | 8.4 | 9.0 | 9.1 | 8.8 | 9.7 | 9.1 | 9.8 | 6.8 |

TABLE 3—*Continued*

STATISTICS CANADA

| | | Canada | Nfld. | P.E.I. | N.S. | N.B. | Que. | Ont. | Man. | Sask. | Alta. | B.C. | Yukon | N.W.T. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6. Median Age of Brides | 1970 | 21.4 | 20.7 | 21.3 | 21.2 | 20.9 | 22.1 | 21.3 | 21.1 | 20.6 | 20.8 | 21.1 | 20.6 | 20.5 |
| | 1971 | 21.3 | 20.6 | 21.5 | 21.1 | 20.8 | 22.0 | 21.3 | 21.0 | 20.5 | 20.7 | 21.0 | 21.3 | 20.9 |
| | 1972 | 22.3 | 21.2 | 21.8 | 21.8 | 21.5 | 22.6 | 22.4 | 21.9 | 21.1 | 21.9 | 22.5 | 22.9 | 22.4 |
| | 1973 | 21.2 | 20.5 | 21.1 | 22.0 | 20.6 | 21.9 | 21.2 | 20.9 | 20.3 | 20.7 | 21.1 | 21.6 | 20.4 |
| | 1974 | 21.3 | 20.6 | 21.0 | 21.0 | 20.6 | 21.8 | 21.3 | 20.9 | 20.8 | 20.8 | 21.2 | 22.4 | 21.0 |
| 7. Median Age of Grooms | 1970 | 23.5 | 23.0 | 23.2 | 22.8 | 23.0 | 24.0 | 23.4 | 23.3 | 22.9 | 23.0 | 23.4 | 23.9 | 23.0 |
| | 1971 | 23.5 | 22.9 | 23.1 | 23.1 | 22.9 | 24.0 | 23.5 | 23.2 | 22.8 | 23.1 | 23.5 | 24.2 | 23.1 |
| | 1972 | 24.1 | 23.2 | 23.5 | 23.7 | 23.4 | 24.1 | 24.2 | 23.8 | 23.4 | 23.9 | 24.6 | 25.2 | 24.1 |
| | 1973 | 23.5 | 22.7 | 23.3 | 23.1 | 22.8 | 23.9 | 23.4 | 23.1 | 22.6 | 23.0 | 23.6 | 24.8 | 23.7 |
| | 1974 | 23.5 | 22.6 | 23.1 | 23.1 | 22.7 | 23.9 | 23.5 | 23.1 | 22.9 | 23.0 | 23.7 | 25.2 | 23.8 |
| 8. Live Births | 1970 | 371,988 | 12,539 | 1,957 | 14,159 | 11,545 | 91,757 | 134,724 | 18,248 | 16,443 | 31,967 | 36,861 | 451 | 1,337 |
| | 1971 | 362,187 | 12,767 | 2,103 | 14,250 | 12,187 | 89,210 | 130,395 | 18.031 | 16,054 | 30.545 | 34,852 | 506 | 1,287 |
| | 1972 | 347,319 | 12,898 | 2,010 | 13,536 | 11,806 | 83,603 | 125,060 | 17,398 | 15,473 | 29,282 | 34,563 | 451 | 1,239 |
| | 1973 | 343,373 | 11,906 | 1,886 | 13,289 | 11,425 | 84,057 | 123,776 | 16,964 | 14,806 | 29,288 | 34,352 | 420 | 1,204 |
| | 1974 | 345,604 | 10,236 | 1,939 | 12,941 | 11,444 | 85,626 | 124,228 | 17,308 | 15,083 | 29,812 | 35,450 | 495 | 1,042 |
| 9. Crude Birth Rate (per 1,000 population) | 1970 | 17.5 | 24.3 | 18.8 | 18.1 | 18.4 | 15.3 | 17.8 | 18.6 | 17.5 | 20.0 | 17.3 | 26.5 | 40.5 |
| | 1971 | 16.8 | 24.5 | 18.8 | 18.1 | 19.2 | 14.8 | 16.9 | 18.2 | 17.3 | 18.8 | 16.0 | 27.5 | 37.0 |
| | 1972 | 15.9 | 24.2 | 17.8 | 17.0 | 18.4 | 13.8 | 16.0 | 17.6 | 16.9 | 17.7 | 15.4 | 23.9 | 34.4 |
| | 1973 | 15.5 | 22.0 | 16.4 | 16.5 | 17.5 | 13.8 | 15.6 | 17.0 | 16.3 | 17.4 | 14.8 | 21.3 | 31.9 |
| | 1974 | 15.4 | 18.9 | 16.6 | 15.9 | 17.3 | 14.0 | 15.3 | 17.1 | 16.6 | 17.4 | 14.8 | 25.5 | 27.8 |
| 10. Total Fertility Rate | 1970 | 2,331 | N.A. | 2,807 | 2,571 | 2,640 | 1,974 | 2,401 | 2,654 | 2,730 | 2,674 | 2,380 | 3,135 | 5,419 |
| | 1971 | 2,187 | N.A. | 2,909 | 2,503 | 2,667 | 1,878 | 2,221 | 2,540 | 2,688 | 2,434 | 2,135 | 3,229 | 4,761 |
| | 1972 | 2,024 | N.A. | 2,606 | 2,302 | 2,460 | 1,727 | 2,051 | 2,384 | 2,554 | 2,244 | 2,002 | 2,775 | 4,364 |
| | 1973 | 1,931 | N.A. | 2,270 | 2,147 | 2,237 | 1,683 | 1,960 | 2,241 | 2,391 | 2,153 | 1,874 | 2,518 | 3,994 |
| | 1974 | 1,832 | N.A. | 2,219 | 2,002 | 2,136 | 1,657 | 1,884 | 2,179 | 2,385 | 2,110 | 1,819 | 3,106 | 3,474 |

TABLE 3—*Continued*

STATISTICS CANADA

| | | Canada | Nfld. | P.E.I. | N.S. | N.B. | Que. | Ont. | Man. | Sask. | Alta. | B.C. | Yukon | N.W.T. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 11. Gross Reproduction Rate | 1970 | 1.132 | N.A. | 1.371 | 1.249 | 1.288 | 0.956 | 1.168 | 1.287 | 1.329 | 1.296 | 1.152 | 1.474 | 2.444 |
| | 1971 | 1.060 | N.A. | 1.375 | 1.212 | 1.294 | 0.908 | 1.078 | 1.243 | 1.322 | 1.171 | 1.032 | 1.468 | 2.308 |
| | 1972 | 0.982 | N.A. | 1.237 | 1.133 | 1.176 | 0.836 | 0.993 | 1.160 | 1.251 | 1.087 | 0.979 | 1.329 | 2.103 |
| | 1973 | 0.937 | N.A. | 1.060 | 1.050 | 1.091 | 0.812 | 0.952 | 1.081 | 1.170 | 1.047 | 0.912 | 1.271 | 1.858 |
| | 1974 | 0.891 | N.A. | 1.048 | 0.968 | 1.054 | 0.806 | 0.915 | 1.046 | 1.170 | 1.033 | 0.884 | 1.475 | 1.633 |
| 12. General Fertility | 1970 | 71.2 | N.A. | 84.0 | 79.4 | 80.6 | 60.2 | 72.8 | 79.9 | 79.6 | 83.6 | 73.3 | 107.4 | 180.7 |
| | 1971 | 67.7 | N.A. | 88.0 | 78.7 | 83.2 | 57.8 | 68.4 | 78.0 | 78.5 | 77.4 | 67.0 | 115.0 | 160.9 |
| | 1972 | 63.4 | N.A. | 81.0 | 73.4 | 78.7 | 53.3 | 64.1 | 74.6 | 76.0 | 72.3 | 63.9 | 96.0 | 149.3 |
| | 1973 | 61.5 | N.A. | 73.1 | 70.2 | 73.9 | 52.8 | 62.1 | 71.9 | 72.9 | 70.4 | 60.8 | 87.5 | 140.0 |
| | 1974 | 60.6 | N.A. | 72.4 | 66.7 | 71.9 | 52.6 | 60.6 | 71.7 | 73.7 | 69.6 | 59.8 | 105.3 | 121.2 |
| 13. Stillbirths 20+ weeks (28+ weeks)* | 1970 | 4,708 | 137* | 23 | 198 | 171 | 1,203 | 1,679 | 245 | 223 | 392 | 407 | 4* | 26* |
| | 1971 | 4,399 | 158 | 24 | 172 | 171 | 1,070 | 1,576 | 222 | 205 | 332 | 442 | 8 | 19 |
| | 1972 | 3,950 | 121 | 27 | 141 | 170 | 888 | 1,534 | 226 | 173 | 293 | 356 | 7 | 14 |
| | 1973 | 3,634 | 151 | 19 | 141 | 153 | 814 | 1,362 | 194 | 177 | 268 | 339 | 3 | 13 |
| | 1974 | 3,579 | 127 | 31 | 148 | 147 | 798 | 1,335 | 190 | 169 | 242 | 364 | 10 | 18 |
| 14. Infant Deaths | 1970 | 7,001 | 273 | 43 | 245 | 227 | 1,888 | 2,271 | 344 | 368 | 612 | 623 | 16 | 91 |
| | 1971 | 6,356 | 293 | 46 | 265 | 204 | 1,640 | 1,990 | 316 | 325 | 548 | 653 | 13 | 63 |
| | 1972 | 5,938 | 267 | 39 | 228 | 204 | 1,500 | 1,908 | 329 | 300 | 511 | 580 | 12 | 60 |
| | 1973 | 5,339 | 230 | 30 | 206 | 173 | 1,378 | 1,740 | 278 | 261 | 416 | 575 | 7 | 45 |
| | 1974 | 5,192 | 181 | 34 | 185 | 173 | 1,291 | 1,666 | 272 | 313 | 449 | 572 | 12 | 44 |
| 15. Infant Death Rates per 1,000 live births | 1970 | 18.8 | 21.8 | 22.0 | 17.3 | 19.7 | 20.6 | 16.9 | 18.9 | 22.4 | 19.1 | 16.9 | 35.5 | 68.1 |
| | 1971 | 17.5 | 22.9 | 21.9 | 18.6 | 16.7 | 18.4 | 15.3 | 17.5 | 20.2 | 17.9 | 18.7 | 25.7 | 49.0 |
| | 1972 | 17.1 | 20.7 | 19.4 | 16.8 | 17.3 | 17.9 | 15.3 | 18.9 | 19.4 | 17.5 | 16.8 | 26.6 | 48.4 |
| | 1973 | 15.5 | 19.3 | 15.9 | 15.5 | 15.1 | 16.4 | 14.1 | 16.4 | 17.6 | 14.2 | 16.7 | 16.7 | 37.4 |
| | 1974 | 15.0 | 17.7 | 17.5 | 14.3 | 15.1 | 15.1 | 13.4 | 15.7 | 20.7 | 15.1 | 16.1 | 24.2 | 42.2 |

TABLE 3—*Continued*

STATISTICS CANADA

| | | Canada | Nfld. | P.E.I. | N.S. | N.B. | Que. | Ont. | Man. | Sask. | Alta. | B.C. | Yukon | N.W.T. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16. All Pregnancy Related Deaths | 1970 | 75 | 5 | — | 2 | 2 | 22 | 27 | 4 | 3 | 4 | 5 | — | 1 |
| | 1971 | 66 | 1 | — | 7 | — | 20 | 25 | 2 | 2 | 3 | 6 | — | — |
| | 1972 | 54 | 2 | 1 | 1 | 1 | 18 | 14 | 1 | 5 | 4 | 4 | 1 | 2 |
| | 1973 | 37 | 2 | — | — | 1 | 10 | 14 | — | 1 | 4 | 5 | — | — |
| | 1974 | 35 | 1 | — | 1 | 1 | 12 | 12 | — | 3 | 1 | 3 | — | 1 |
| 17. Neonatal Deaths | 1970 | 5,017 | 182 | 38 | 180 | 160 | 1,352 | 1,711 | 240 | 258 | 433 | 422 | 13 | 28 |
| | 1971 | 4,485 | 207 | 37 | 180 | 145 | 1,190 | 1,424 | 204 | 222 | 388 | 459 | 6 | 23 |
| | 1972 | 4,117 | 174 | 26 | 129 | 147 | 1,057 | 1,392 | 210 | 208 | 364 | 381 | 6 | 23 |
| | 1973 | 3,692 | 164 | 19 | 135 | 122 | 995 | 1,238 | 169 | 180 | 266 | 380 | 4 | 20 |
| | 1974 | 3,506 | 118 | 30 | 115 | 122 | 924 | 1,163 | 176 | 191 | 278 | 364 | 5 | 20 |
| 18. Neonatal Death Rates (per 1,000 live births) | 1970 | 13.5 | 14.5 | 19.4 | 12.7 | 13.9 | 14.7 | 12.7 | 13.2 | 15.7 | 13.5 | 11.4 | 28.8 | 20.9 |
| | 1971 | 12.4 | 16.2 | 17.6 | 12.6 | 11.9 | 13.3 | 10.9 | 11.3 | 13.8 | 12.7 | 13.2 | 11.9 | 17.9 |
| | 1972 | 11.9 | 13.5 | 12.9 | 9.5 | 12.5 | 12.6 | 11.1 | 12.1 | 13.4 | 12.4 | 11.0 | 13.1 | 18.5 |
| | 1973 | 10.8 | 13.8 | 10.1 | 10.2 | 10.7 | 11.8 | 10.0 | 10.0 | 12.2 | 9.1 | 11.1 | 9.5 | 16.6 |
| | 1974 | 10.1 | 11.5 | 15.5 | 8.9 | 10.7 | 10.8 | 9.4 | 10.2 | 12.6 | 9.3 | 10.3 | 10.1 | 19.2 |
| 19. Perinatal Deaths | 1970 | 8,192 | 305 | 51 | 319 | 276 | 2,153 | 2,845 | 409 | 411 | 687 | 670 | 14 | 52 |
| | 1971 | 7,352 | 333 | 57 | 287 | 273 | 1,866 | 2,476 | 341 | 358 | 588 | 727 | 10 | 36 |
| | 1972 | 6,672 | 282 | 44 | 224 | 269 | 1,615 | 2,405 | 351 | 325 | 550 | 567 | 10 | 30 |
| | 1973 | 6,087 | 291 | 30 | 226 | 245 | 1,532 | 2,127 | 296 | 300 | 433 | 576 | 5 | 26 |
| | 1974 | 5,835 | 228 | 49 | 217 | 239 | 1,440 | 2,039 | 274 | 304 | 422 | 577 | 11 | 35 |
| 20. Perinatal Death Rates (per 1,000 total births) | 1970 | 21.8 | 24.1 | 25.8 | 22.3 | 23.6 | 22.3 | 20.9 | 22.2 | 24.7 | 21.3 | 18.0 | 30.8 | 38.2 |
| | 1971 | 20.1 | 25.8 | 26.8 | 19.9 | 22.2 | 20.7 | 18.8 | 18.7 | 22.1 | 19.1 | 20.7 | 19.5 | 27.6 |
| | 1972 | 19.0 | 21.7 | 21.7 | 16.4 | 22.5 | 19.2 | 19.1 | 20.0 | 20.8 | 18.6 | 16.3 | 21.9 | 24.0 |
| | 1973 | 17.6 | 24.1 | 15.8 | 16.9 | 21.2 | 18.1 | 17.0 | 17.3 | 20.1 | 14.7 | 16.6 | 11.8 | 21.4 |
| | 1974 | 16.7 | 22.0 | 24.9 | 16.6 | 20.6 | 16.7 | 16.2 | 15.7 | 19.9 | 14.0 | 16.1 | 21.8 | 33.0 |

TABLE 3—*Concluded*

STATISTICS CANADA

| | | Canada | Nfld. | P.E.I. | N.S. | N.B. | Que. | Ont. | Man. | Sask. | Alta. | B.C. | Yukon | N.W.T. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 21. Abortions | 1970 | 11,152 | 25 | 17 | 261 | 72 | 534 | 5,568 | 238 | 215 | 1,154 | 2,901 | 6 | — |
| | 1971 | 30,923 | 78 | 39 | 643 | 146 | 1,881 | 16,173 | 827 | 756 | 3,116 | 7,045 | 8 | — |
| | 1972 | 38,853 | 133 | 45 | 837 | 183 | 2,847 | 20,272 | 1,178 | 1,043 | 3,887 | 8,179 | 48 | 44 |
| | 1973 | 43,201 | 193 | 41 | 932 | 341 | 3,141 | 22,603 | 1,259 | 1,219 | 4,047 | 9,176 | 76 | 51 |
| | 1974 | 48,136 | 184 | 50 | 1,062 | 440 | 4,453 | 24,795 | 1,411 | 1,176 | 4,391 | 10,024 | 63 | 75 |
| 22. Abortion Rates (per 1,000 total population) | 1970 | 0.5 | — | 0.2 | 0.3 | 0.1 | 0.1 | 0.7 | 0.2 | 0.2 | 0.7 | 1.4 | 0.4 | N.A. |
| | 1971 | 1.4 | 0.1 | 0.3 | 0.3 | 0.2 | 0.3 | 2.1 | 0.8 | 0.8 | 1.9 | 3.2 | 0.4 | N.A. |
| | 1972 | 1.8 | 0.2 | 0.4 | 1.0 | 0.3 | 0.5 | 2.6 | 1.2 | 1.1 | 2.4 | 3.6 | 2.5 | 0.3 |
| | 1973 | 2.0 | 0.4 | 0.4 | 1.2 | 0.5 | 0.5 | 2.8 | 1.3 | 1.3 | 2.4 | 4.0 | 3.8 | 1.3 |
| | 1974 | 2.1 | 0.3 | 0.4 | 1.3 | 0.7 | 0.7 | 3.1 | 1.4 | 1.3 | 2.6 | 4.2 | 3.3 | 2.0 |
| 23. Abortion Rates (per 1,000 women 15-44) | 1970 | 2.5 | 0.2 | 0.8 | 1.7 | 0.6 | 0.4 | 3.4 | 1.2 | 1.2 | 3.4 | 6.6 | 1.6 | N.A. |
| | 1971 | 6.7 | 0.7 | 1.8 | 4.0 | 1.1 | 1.4 | 9.7 | 4.1 | 4.2 | 8.9 | 15.5 | 2.0 | N.A. |
| | 1972 | 8.2 | 1.1 | 2.0 | 5.0(1) | 1.3 | 2.0(1) | 11.6(1) | 5.6 | 5.7 | 10.2 | 16.8(1) | 10.9 | 5.6 |
| | 1973 | 8.8 | 1.7 | 1.8 | 5.5 | 2.5 | 2.2 | 12.9(1) | 6.0 | 6.8 | 10.9 | 18.3(1) | 17.3 | 6.4 |
| | 1974 | 9.5 | 1.6 | 2.1 | 6.1 | 3.1 | 3.1 | 13.7 | 6.6 | 6.5 | 11.4 | 19.0 | 14.6 | 9.4 |

(1) Estimated figures.

*Provisional figures.

TABLE 4

INDEX OF CHANGE IN SELECTED DEMOGRAPHIC CHARACTERISTICS, CANADA AND PROVINCES, 1970-1974
(CONSIDERING IN EACH CASE THE FIGURES FOR BASE YEAR 1970=100)

STATISTICS CANADA

| | | Canada | Nfld. | P.E.I. | N.S. | N.B. | Quebec | Ont. | Man. | Sask. | Alta. | B.C. | Yukon | N.W.T. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Total Population | 1970 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | 1971 | 101.3 | 101.0 | 101.5 | 100.9 | 101.2 | 100.2 | 102.0 | 100.5 | 98.4 | 102.1 | 102.7 | 108.2 | 105.5 |
| | 1972 | 102.5 | 102.9 | 102.7 | 101.6 | 102.6 | 100.6 | 103.6 | 100.9 | 97.4 | 103.7 | 105.6 | 111.2 | 109.1 |
| | 1973 | 103.7 | 104.6 | 104.5 | 102.9 | 104.0 | 101.1 | 105.1 | 101.5 | 96.5 | 105.6 | 108.8 | 115.9 | 114.5 |
| | 1974 | 105.4 | 104.9 | 106.1 | 104.0 | 105.6 | 102.0 | 107.2 | 103.0 | 96.4 | 107.5 | 112.6 | 114.1 | 113.6 |
| 2. Population women 15-44 | 1970 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | 1971 | 102.3 | 102.1 | 102.9 | 101.8 | 102.4 | 101.3 | 103.0 | 101.5 | 99.0 | 103.4 | 103.8 | 105.3 | 108.8 |
| | 1972 | 104.7 | 106.2 | 107.2 | 104.2 | 105.4 | 103.0 | 105.6 | 102.7 | 98.8 | 106.3 | 108.3 | 113.2 | 113.2 |
| | 1973 | 107.5 | 109.7 | 112.1 | 107.5 | 109.2 | 104.8 | 108.4 | 104.6 | 98.9 | 109.6 | 114.1 | 115.8 | 117.6 |
| | 1974 | | | | | | | | | | | | | |
| 3. Married women 15-44 | 1970 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | |
| | 1971 | 102.1 | 102.6 | 102.5 | 101.7 | 102.4 | 100.9 | 102.8 | 101.1 | 98.3 | 103.2 | 103.3 | 109.0 | |
| | 1972 | 103.8 | 106.5 | 105.7 | 103.4 | 105.8 | 101.9 | 104.7 | 101.9 | 96.9 | 105.2 | 106.9 | 112.7 | |
| | 1973 | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | |
| | 1974 | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | |
| 4. Marriages | 1970 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | 1971 | 101.5 | 104.9 | 105.3 | 101.2 | 108.0 | 100.2 | 101.0 | 101.3 | 106.8 | 102.2 | 101.8 | 82.6 | 106.8 |
| | 1972 | 106.4 | 114.3 | 111.0 | 107.2 | 113.3 | 108.5 | 104.9 | 101.9 | 107.7 | 106.9 | 103.2 | 90.0 | 107.6 |
| | 1973 | 105.6 | 113.0 | 111.1 | 107.0 | 111.6 | 104.7 | 105.1 | 102.1 | 107.2 | 106.5 | 106.4 | 102.5 | 95.8 |
| | 1974* | 105.5 | 95.7 | 108.4 | 104.6 | 107.2 | 103.9 | 105.6 | 102.5 | 109.2 | 109.2 | 108.5 | 94.5 | 108.5 |

TABLE 4—*Continued*

STATISTICS CANADA

| | | Canada | Nfld. | P.E.I. | N.S. | N.B. | Quebec | Ont. | Man. | Sask. | Alta. | B.C. | Yukon | N.W.T. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 5. Marriage Rates (per 1,000 population) | 1970 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | 1971 | 101.1 | 104.7 | 103.6 | 97.8 | 106.6 | 100.0 | 100.0 | 100.0 | 107.7 | 100.0 | 98.9 | 71.4 | 100.0 |
| | 1972 | 104.5 | 111.6 | 108.4 | 103.4 | 109.9 | 108.5 | 102.2 | 101.1 | 110.3 | 103.1 | 97.9 | 75.4 | 98.6 |
| | 1973 | 102.3 | 108.1 | 106.0 | 101.1 | 107.7 | 103.7 | 101.1 | 100.0 | 110.3 | 101.0 | 97.9 | 81.7 | 81.9 |
| | 1974* | 101.1 | 91.9 | 102.4 | 97.8 | 101.1 | 102.4 | — | 98.9 | 112.8 | 101.0 | 96.8 | 77.8 | 94.4 |
| 6. Live Births | 1970 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | 1971 | 97.4 | 101.8 | 107.5 | 100.6 | 105.6 | 97.2 | 96.8 | 98.8 | 97.6 | 95.6 | 94.5 | 112.2 | 96.3 |
| | 1972 | 93.4 | 102.9 | 102.7 | 95.6 | 102.3 | 91.1 | 92.8 | 95.3 | 94.1 | 91.6 | 93.8 | 100.0 | 92.7 |
| | 1973 | 92.3 | 95.0 | 96.4 | 93.9 | 99.0 | 91.6 | 91.9 | 93.0 | 90.0 | 91.6 | 93.2 | 93.1 | 90.1 |
| | 1974* | 92.9 | 81.6 | 99.1 | 91.4 | 99.1 | 93.3 | 92.2 | 94.8 | 91.7 | 93.3 | 96.2 | 109.8 | 77.9 |
| 7. Crude Birth Rate (per 1,000 population) | 1970 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | 1971 | 96.0 | 100.8 | 105.6 | 100.0 | 104.3 | 96.7 | 94.9 | 97.8 | 98.9 | 94.0 | 92.5 | 103.8 | 91.4 |
| | 1972 | 90.9 | 99.6 | 100.0 | 93.9 | 100.0 | 90.2 | 89.9 | 94.6 | 96.6 | 88.5 | 89.0 | 90.2 | 84.9 |
| | 1973 | 88.6 | 90.5 | 92.1 | 91.2 | 95.1 | 90.2 | 87.6 | 91.4 | 93.1 | 87.0 | 85.5 | 80.4 | 78.8 |
| | 1974* | 88.0 | 77.8 | 93.3 | 87.8 | 94.0 | 91.5 | 86.0 | 91.9 | 94.9 | 87.0 | 85.5 | 96.2 | 68.6 |
| 8. Total Fertility Rate | 1970 | 100.0 | N.A. | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | 1971 | 93.8 | N.A. | 103.6 | 97.4 | 101.0 | 95.1 | 92.5 | 95.7 | 98.5 | 91.0 | 89.7 | 103.0 | 87.9 |
| | 1972 | 86.8 | N.A. | 92.8 | 89.5 | 93.2 | 87.5 | 85.4 | 89.8 | 93.6 | 83.9 | 84.1 | 88.5 | 80.5 |
| | 1973 | 82.8 | N.A. | 80.9 | 83.5 | 84.7 | 85.3 | 81.6 | 84.4 | 87.6 | 80.5 | 78.7 | 80.3 | 73.7 |
| | 1974 | 78.6 | N.A. | 79.1 | 77.9 | 80.9 | 83.9 | 78.5 | 82.1 | 87.4 | 78.9 | 76.4 | 99.1 | 64.1 |
| 9. Gross Reproduction Rate | 1970 | 100.0 | N.A. | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | 1971 | 93.6 | N.A. | 100.3 | 97.0 | 100.5 | 95.0 | 92.3 | 96.6 | 99.5 | 90.4 | 89.6 | 99.6 | 94.4 |
| | 1972 | 86.7 | N.A. | 90.2 | 90.7 | 91.3 | 87.4 | 85.0 | 90.1 | 94.1 | 83.9 | 85.0 | 90.2 | 86.0 |
| | 1973 | 82.8 | N.A. | 77.3 | 84.1 | 84.7 | 84.9 | 81.5 | 84.0 | 88.0 | 80.8 | 79.2 | 86.2 | 76.0 |
| | 1974 | 78.7 | N.A. | 76.4 | 77.5 | 81.8 | 84.3 | 78.3 | 81.3 | 88.0 | 79.7 | 76.7 | 100.1 | 66.8 |

TABLE 4—*Continued*

STATISTICS CANADA

| | | Canada | Nfld. | P.E.I. | N.S. | N.B. | Quebec | Ont. | Man. | Sask. | Alta. | B.C. | Yukon | N.W.T. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 10. General Fertility Rate | 1970 | 100.0 | N.A. | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | 1971 | 95.1 | N.A. | 104.8 | 99.1 | 103.2 | 96.0 | 94.0 | 97.6 | 98.6 | 92.6 | 91.4 | 107.1 | 89.0 |
| | 1972 | 89.0 | N.A. | 96.4 | 92.4 | 97.6 | 88.5 | 88.0 | 93.4 | 95.5 | 86.5 | 87.2 | 89.4 | 82.6 |
| | 1973 | 86.4 | N.A. | 87.0 | 88.4 | 91.7 | 87.7 | 85.3 | 90.0 | 91.6 | 84.2 | 82.9 | 81.5 | 77.5 |
| | 1974 | 85.1 | N.A. | 86.2 | 84.0 | 89.2 | 87.4 | 83.2 | 89.7 | 92.6 | 83.3 | 81.6 | 98.0 | 67.1 |
| 11. Stillbirths 20+ | 1970 | 100.0 | 100.0* | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0* | 100.0* |
| (*28+) | 1971 | 93.4 | 115.3 | 104.3 | 86.9 | 100.0 | 88.9 | 93.9 | 90.6 | 91.9 | 84.7 | 108.6 | 200.0 | 73.1 |
| | 1972 | 83.9 | 88.3 | 117.4 | 71.2 | 99.4 | 73.8 | 91.4 | 92.2 | 77.6 | 74.7 | 87.5 | 175.0 | 53.8 |
| | 1973 | 77.2 | 110.2 | 82.6 | 71.2 | 89.5 | 67.6 | 81.1 | 79.2 | 79.4 | 68.4 | 83.3 | 75.0 | 50.0 |
| | 1974 | 76.0 | 92.7 | 134.7 | 74.7 | 86.0 | 66.3 | 79.5 | 77.6 | 75.8 | 61.7 | 89.4 | 250.0 | 69.2 |
| 12. Infant Deaths | 1970 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | 1971 | 90.8 | 107.3 | 107.0 | 108.2 | 89.9 | 86.9 | 87.6 | 91.9 | 88.3 | 89.5 | 104.8 | 81.2 | 69.2 |
| | 1972 | 84.8 | 97.8 | 90.7 | 93.1 | 89.9 | 79.4 | 84.0 | 95.6 | 81.5 | 83.5 | 93.1 | 75.0 | 65.9 |
| | 1973 | 76.3 | 84.2 | 69.8 | 84.1 | 76.2 | 73.0 | 76.6 | 80.8 | 70.9 | 68.0 | 92.3 | 43.8 | 49.5 |
| | 1974 | 74.2 | 66.3 | 79.1 | 75.5 | 76.2 | 68.4 | 73.4 | 79.1 | 85.1 | 73.4 | 91.8 | 75.0 | 48.4 |
| 13. Infant Death Rates | 1970 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.00 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| (per 1,000 | 1971 | 93.1 | 105.0 | 99.5 | 107.5 | 84.8 | 89.3 | 90.5 | 92.6 | 90.2 | 93.7 | 110.7 | 72.4 | 72.0 |
| live births) | 1972 | 91.0 | 95.0 | 88.2 | 97.1 | 87.8 | 86.9 | 90.5 | 100.0 | 86.6 | 91.6 | 99.4 | 74.9 | 71.1 |
| | 1973 | 82.4 | 88.5 | 72.3 | 89.6 | 76.6 | 79.6 | 83.4 | 86.8 | 78.6 | 74.3 | 98.8 | 47.0 | 54.9 |
| | 1974 | 79.8 | 81.2 | 79.5 | 82.7 | 76.6 | 73.3 | 79.3 | 83.1 | 92.4 | 79.1 | 95.3 | 68.2 | 62.0 |
| 14. All Pregnancy Related | 1970 | 100.0 | 100.0 | — | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | — | 100.0 |
| Deaths | 1971 | 88.0 | 20.0 | — | 350.0 | — | 90.9 | 92.6 | 50.0 | 66.7 | 75.0 | 120.0 | — | — |
| | 1972 | 72.0 | 40.0 | — | 50.0 | 50.0 | 81.8 | 51.9 | 25.0 | 166.7 | 100.0 | 80.0 | — | 200.0 |
| | 1973 | 49.3 | 40.0 | — | — | 50.0 | 45.5 | 51.9 | — | 33.3 | 100.0 | 100.0 | — | — |
| | 1974 | 46.7 | 20.0 | — | 50.0 | 50.0 | 54.5 | 44.4 | — | 100.0 | 25.0 | 60.0 | — | 100.0 |

TABLE 4—*Continued*

STATISTICS CANADA

| | | Canada | Nfld. | P.E.I. | N.S. | N.B. | Quebec | Ont. | Man. | Sask. | Alta. | B.C. | Yukon | N.W.T. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 15. Neonatal Deaths | 1970 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | 1971 | 89.4 | 113.7 | 97.4 | 100.0 | 90.6 | 88.0 | 83.2 | 85.0 | 86.0 | 89.6 | 108.8 | 46.2 | 82.1 |
| | 1972 | 82.1 | 95.6 | 68.4 | 71.7 | 91.9 | 78.2 | 81.4 | 87.5 | 80.6 | 84.1 | 90.3 | 46.2 | 82.1 |
| | 1973 | 73.6 | 90.1 | 50.0 | 75.0 | 76.3 | 73.6 | 72.4 | 70.4 | 69.8 | 61.4 | 90.0 | 30.8 | 71.4 |
| | 1974 | 69.9 | 64.8 | 78.9 | 63.9 | 76.3 | 68.3 | 68.0 | 73.3 | 74.0 | 64.2 | 86.3 | 38.5 | 71.4 |
| 16. Neonatal Death Rates (per 1,000 live births) | 1970 | 100.00 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | 1971 | 91.8 | 111.7 | 90.6 | 99.4 | 85.9 | 90.5 | 86.0 | 86.0 | 88.1 | 93.8 | 115.0 | 41.1 | 85.3 |
| | 1972 | 87.9 | 92.9 | 66.6 | 74.8 | 89.8 | 85.8 | 87.6 | 91.8 | 85.4 | 91.8 | 96.3 | 45.5 | 88.1 |
| | 1973 | 79.7 | 94.9 | 51.9 | 79.9 | 77.0 | 80.3 | 78.8 | 75.7 | 77.5 | 67.1 | 96.6 | 33.0 | 79.3 |
| | 1974 | 74.8 | 79.3 | 79.9 | 70.1 | 77.0 | 73.5 | 74.0 | 77.3 | 80.3 | 68.9 | 90.4 | 35.1 | 91.9 |
| 17. Perinatal Deaths | 1970 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | 1971 | 89.7 | 109.2 | 111.8 | 90.0 | 98.9 | 86.7 | 87.0 | 83.4 | 87.1 | 85.6 | 108.5 | 71.4 | 69.2 |
| | 1972 | 81.4 | 92.5 | 86.3 | 70.2 | 97.5 | 75.0 | 84.5 | 85.8 | 79.1 | 80.1 | 84.6 | 71.4 | 57.7 |
| | 1973 | 74.3 | 95.4 | 58.8 | 70.8 | 88.8 | 71.2 | 74.8 | 72.4 | 73.0 | 63.0 | 86.0 | 35.7 | 50.0 |
| | 1974 | 71.2 | 74.8 | 96.1 | 68.0 | 86.6 | 66.9 | 71.7 | 67.0 | 74.0 | 61.4 | 86.1 | 78.6 | 67.3 |
| 18. Perinatal Death Rates (per 1,000 live births) | 1970 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| | 1971 | 92.2 | 107.1 | 103.9 | 89.2 | 94.1 | 92.8 | 90.0 | 84.2 | 89.5 | 89.7 | 115.0 | 63.3 | 72.3 |
| | 1972 | 87.2 | 90.0 | 84.1 | 73.5 | 95.3 | 86.1 | 91.4 | 90.1 | 84.2 | 87.3 | 90.6 | 71.1 | 62.8 |
| | 1973 | 80.7 | 100.0 | 61.2 | 75.8 | 89.8 | 81.2 | 81.3 | 77.9 | 81.4 | 69.0 | 92.2 | 38.3 | 56.0 |
| | 1974 | 76.6 | 91.3 | 96.5 | 74.4 | 87.3 | 74.9 | 77.5 | 70.7 | 80.6 | 65.7 | 89.4 | 70.8 | 86.4 |

TABLE 4—*Concluded*

STATISTICS CANADA

| | | Canada | Nfld. | P.E.I. | N.S. | N.B. | Que. | Ont. | Man. | Sask. | Alta. | B.C. | Yukon | N.W.T. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 19. Abortions | 1970 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | N.A. |
| | 1971 | 277.3 | 312.0 | 229.4 | 246.4 | 202.8 | 352.2 | 290.5 | 347.5 | 351.6 | 270.0 | 242.8 | 133.3 | N.A. |
| | 1972 | 348.4 | 532.0 | 264.7 | 320.7 | 254.2 | 533.1 | 364.1 | 495.0 | 485.1 | 336.8 | 281.9 | 800.0 | N.A. |
| | 1973 | 387.4 | 772.0 | 241.2 | 357.1 | 473.6 | 588.2 | 405.9 | 529.0 | 567.0 | 350.7 | 316.3 | 1,266.7 | N.A. |
| | 1974 | 431.6 | 736.0 | 294.1 | 406.9 | 611.1 | 833.9 | 445.3 | 592.9 | 547.0 | 380.5 | 345.5 | 1,050.0 | N.A. |
| 20. Abortion Rates (per 1,000 total population) | 1970 | 100.0 | N.A. | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | N.A. |
| | 1971 | 280.0 | N.A. | 150.0 | 266.7 | 200.0 | 300.0 | 300.0 | 400.0 | 400.0 | 271.4 | 228.6 | 100.0 | N.A. |
| | 1072 | 360.0 | N.A. | 200.0 | 333.3 | 300.0 | 500.0 | 371.4 | 600.0 | 550.0 | 342.9 | 257.1 | 625.0 | N.A. |
| | 1973 | 400.0 | N.A. | 200.0 | 400.0 | 500.0 | 500.0 | 400.0 | 650.0 | 650.0 | 342.9 | 285.7 | 950.0 | N.A. |
| | 1974 | 420.0 | N.A. | 200.0 | 433.3 | 700.0 | 700.0 | 442.9 | 700.0 | 650.0 | 371.4 | 300.0 | 825.0 | N.A. |
| 21. Abortion Rates (per 1,000 women in 15-44 yrs.) | 1970 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | N.A. |
| | 1971 | 268.0 | 350.0 | 225.0 | 235.3 | 183.3 | 350.0 | 285.3 | 341.7 | 350.0 | 261.8 | 234.8 | 125.0 | N.A. |
| | 1972 | 328.0 | 550.0 | 250.0 | 294.1 | 216.7 | 500.0 | 341.2 | 466.7 | 475.0 | 300.0 | 524.5 | 681.3 | N.A. |
| | 1973 | 352.0 | 850.0 | 225.0 | 323.5 | 416.7 | 550.0 | 379.4 | 500.0 | 566.7 | 320.6 | 277.3 | 1,081.3 | N.A. |
| | 1974 | 380.0 | 800.0 | 262.5 | 358.8 | 516.7 | 775.0 | 402.9 | 550.0 | 541.7 | 335.3 | 287.9 | 912.5 | N.A. |

*Provisional figures.

TABLE 5

NUMBER OF HOSPITALS BY ABORTION RANGES AND BY PROVINCE, 1970 AND 1974

STATISTICS CANADA

| Area | | Total | 0 | 1-20 | 21-50 | 51-100 | 101-200 | 201-400 | Over 400 |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Number of Hospitals | | | | |
| Newfoundland | 1970 | 4 | 2 | 2 | — | — | — | — | — |
| | 1974 | 6 | 1 | 4 | — | — | 1 | — | — |
| Prince Edward Island | 1970 | 2 | — | 2 | — | — | — | — | — |
| | 1974 | 2 | — | 1 | 1 | — | — | — | — |
| Nova Scotia | 1970 | 6 | 2 | 3 | — | 1 | — | — | — |
| | 1974 | 12 | 1 | 5 | 2 | 2 | 1 | — | 1 |
| New Brunswick | 1970 | 7 | 4 | 3 | — | — | — | — | — |
| | 1974 | 8 | 3 | 2 | 1 | 1 | — | 1 | — |
| Québec | 1970 | 16 | 6 | 8 | — | 2 | — | — | — |
| | 1974 | 27 | 12 | 7 | 1 | 2 | 1 | 1 | 3 |
| Ontario* | 1970 | 48 | 10 | 21 | 9 | 4 | 1 | 1 | 2 |
| | 1974 | 110 | 21 | 24 | 18 | 11 | 15 | 6 | 15 |
| Manitoba | 1970 | 4 | — | 3 | — | 1 | — | — | — |
| | 1974 | 9 | 3 | 2 | 1 | 1 | — | — | 2 |
| Saskatchewan | 1970 | 8 | 1 | 5 | 2 | — | — | — | — |
| | 1974 | 10 | — | 4 | 1 | 2 | — | 2 | 1 |
| Alberta | 1970 | 18 | 6 | 6 | 4 | 2 | — | — | — |
| | 1974 | 25 | — | 12 | 1 | 3 | 4 | 1 | 4 |
| British Columbia | 1970 | 29 | — | 17 | 8 | 1 | 2 | — | 1 |
| | 1974 | 54 | 5 | 10 | 11 | 14 | 3 | 4 | 7 |
| Yukon | 1970 | 1 | — | 1 | — | — | — | — | — |
| | 1974 | 1 | — | — | — | 1 | — | — | — |
| Northwest Territories | 1970 | — | — | — | — | — | — | — | — |
| | 1974 | 1 | — | — | 1 | — | — | — | — |
| CANADA | 1970 | 143 | 31 | 71 | 23 | 11 | 3 | 1 | 3 |
| | 1974 | 265 | 46 | 71 | 38 | 37 | 25 | 15 | 33 |

*For the year 1974, the province of Ontario reported by hospital for the period April to December only.

TABLE 6

NUMBER OF HOSPITALS BY ABORTION RANGES AND BY PROVINCE, 1970 AND 1974

STATISTICS CANADA

| Area | | Total | 0 | 1-20 | 21-50 | 51-100 | 101-200 | 201-400 | Over 400 |
|---|---|---|---|---|---|---|---|---|---|
| | | Percent distribution of hospitals | | | | | | | |
| Newfoundland | 1970 | 100 | 50 | 50 | — | — | — | — | — |
| | 1974 | 100 | 17 | 67 | — | — | 17 | — | — |
| Prince Edward Island | 1970 | 100 | — | 100 | — | — | — | — | — |
| | 1974 | 100 | — | 50 | 50 | — | — | — | — |
| Nova Scotia | 1970 | 100 | 33 | 50 | — | 17 | — | — | — |
| | 1974 | 100 | 18 | 42 | 17 | 17 | 8 | — | 8 |
| New Brunswick | 1970 | 100 | 57 | 43 | — | — | — | — | — |
| | 1974 | 100 | 38 | 25 | 12 | 12 | — | 12 | — |
| Québec | 1970 | 100 | 38 | 50 | — | 12 | — | — | — |
| | 1974 | 100 | 44 | 26 | 4 | 7 | 4 | 4 | 11 |
| Ontario* | 1970 | 100 | 21 | 44 | 19 | 8 | 2 | 2 | 4 |
| | 1974 | 100 | 19 | 22 | 16 | 10 | 14 | 5 | 14 |
| Manitoba | 1970 | 100 | — | 75 | — | 25 | — | — | — |
| | 1974 | 100 | 33 | 22 | 11 | 11 | — | — | 22 |
| Saskatchewan | 1970 | 100 | 12 | 62 | 25 | — | — | — | — |
| | 1974 | 100 | — | 40 | 10 | 20 | — | 20 | 10 |
| Alberta | 1970 | 100 | 33 | 33 | 22 | 11 | — | — | — |
| | 1974 | 100 | — | 48 | 4 | 12 | 16 | 4 | 16 |
| British Columbia | 1970 | 100 | — | 59 | 28 | 3 | 7 | — | 3 |
| | 1974 | 100 | 9 | 18 | 20 | 26 | 6 | 7 | 13 |
| Yukon | 1970 | 100 | — | 100 | — | — | — | — | — |
| | 1974 | 100 | — | — | — | 100 | — | — | — |
| Northwest Territories | 1970 | — | — | — | — | — | — | — | — |
| | 1974 | 100 | — | — | 100 | — | — | — | — |
| CANADA | 1970 | 100 | 22 | 50 | 16 | 8 | 2 | 1 | 2 |
| | 1974 | 100 | 17 | 27 | 14 | 14 | 9 | 6 | 12 |

*For the year 1974, the province of Ontario reported by hospital for the period April to December only.

TABLE 7

NUMBER OF ABORTIONS BY ABORTION RANGES AND BY PROVINCE, 1970 AND 1974.

STATISTICS CANADA

| Area | | Total | 1-20 | 21-50 | 51-100 | 101-200 | 201-400 | Over 400 |
|---|---|---|---|---|---|---|---|---|
| | | | | Number of abortions | | | | |
| Newfoundland | 1970 | 9 | 9 | — | — | — | — | — |
| | 1974 | 158 | 18 | — | — | 140 | — | — |
| Prince Edward Island | 1970 | 12 | 12 | — | — | — | — | — |
| | 1974 | 45 | 13 | 32 | — | — | — | — |
| Nova Scotia | 1970 | 111 | 13 | — | 98 | — | — | — |
| | 1974 | 1,065 | 68 | 49 | 155 | 111 | — | 682 |
| New Brunswick | 1970 | 31 | 31 | — | — | — | — | — |
| | 1974 | 415 | 35 | 24 | 72 | — | 284 | — |
| Québec | 1970 | 181 | 27 | — | 154 | — | — | — |
| | 1974 | 4,460 | 58 | 32 | 146 | 102 | 354 | 3,768 |
| Ontario* | 1970 | 2,249 | 157 | 256 | 261 | 123 | 261 | 1,191 |
| | 1974 | 18,629 | 249 | 609 | 774 | 2,454 | 1,560 | 12,983 |
| Manitoba | 1970 | 109 | 27 | — | 82 | — | — | — |
| | 1974 | 1,417 | 11 | 42 | 53 | — | — | 1,311 |
| Saskatchewan | 1970 | 91 | 23 | 68 | — | — | — | — |
| | 1974 | 1,144 | 47 | 27 | 145 | — | 488 | 437 |
| Alberta | 1970 | 318 | 29 | 136 | 153 | — | — | — |
| | 1974 | 4,462 | 86 | 36 | 242 | 631 | 215 | 3,252 |
| British Columbia | 1970 | 1,260 | 94 | 279 | 77 | 328 | — | 482 |
| | 1974 | 10,084 | 121 | 353 | 942 | 460 | 1,248 | 6,960 |
| Yukon | 1970 | 4 | 4 | — | — | — | — | — |
| | 1974 | 63 | — | — | 63 | — | — | — |
| Northwest Territories | 1970 | — | — | — | — | — | — | — |
| | 1974 | 41 | — | 41 | — | — | — | — |
| CANADA | 1970 | 4,375 | 426 | 739 | 825 | 451 | 261 | 1,673 |
| | 1974 | 41,983 | 706 | 1,245 | 2,592 | 3,898 | 4,149 | 29,393 |

* For the year 1974, the province of Ontario reported by hospital for the period April to December only.

TABLE 8

NUMBER OF ABORTIONS BY ABORTION RANGES AND BY PROVINCE, 1970 AND 1974.

STATISTICS CANADA

| Area | | Total | 1-20 | 21-50 | 51-100 | 101-200 | 201-400 | Over 400 |
|---|---|---|---|---|---|---|---|---|
| | | | | Percent distribution of abortions | | | | |
| Newfoundland | 1970 | 100 | 100 | — | — | — | — | — |
| | 1974 | 100 | 11 | — | — | 89 | — | — |
| Prince Edward Island | 1970 | 100 | 100 | — | — | — | — | — |
| | 1974 | 100 | 29 | 71 | — | 00 | 00 | 00 |
| Nova Scotia | 1970 | 100 | 12 | — | 88 | — | — | — |
| | 1974 | 100 | 6 | 5 | 14 | 10 | — | 64 |
| New Brunswick | 1970 | 100 | 100 | — | — | — | — | — |
| | 1974 | 100 | 8 | 6 | 17 | — | 68 | — |
| Québec | 1970 | 100 | 15 | — | 85 | — | — | — |
| | 1974 | 100 | 1 | 1 | 3 | 2 | 8 | 84 |
| Ontario* | 1970 | 100 | 7 | 11 | 12 | 5 | 12 | 53 |
| | 1974 | 100 | 1 | 3 | 4 | 13 | 8 | 70 |
| Manitoba | 1970 | 100 | 25 | — | 75 | — | — | — |
| | 1974 | 100 | 1 | 3 | 4 | — | — | 92 |
| Saskatchewan | 1970 | 100 | 25 | 75 | — | — | — | — |
| | 1974 | 100 | 4 | 2 | 13 | — | 43 | 38 |
| Alberta | 1970 | 100 | 9 | 43 | 48 | — | — | — |
| | 1974 | 100 | 2 | 1 | 5 | 14 | 5 | 73 |
| British Columbia | 1970 | 100 | 7 | 22 | 6 | 26 | — | 38 |
| | 1974 | 100 | 1 | 4 | 9 | 4 | 12 | 69 |
| Yukon | 1970 | 100 | 100 | — | — | — | — | — |
| | 1974 | 100 | — | — | 100 | — | — | — |
| Northwest Territories | 1970 | — | — | — | — | — | — | — |
| | 1974 | 100 | — | 100 | — | — | — | — |
| CANADA | 1970 | 100 | 10 | 17 | 19 | 10 | 6 | 38 |
| | 1974 | 100 | 2 | 3 | 6 | 9 | 10 | 70 |

*For the year 1974, the province of Ontario reported by hospital for the period April to December only.

TABLE 9

## RESIDENCE OF WOMEN OBTAINING INDUCED ABORTION ON IN-HOSPITAL BASIS BY LOCATION OF HOSPITALS IN NEW BRUNSWICK, 1974

STATISTICS CANADA

| Census District | Induced Abortion by Residence: Local No. | Local % | Not Local No. | Not Local % | Total No. | Total % |
|---|---|---|---|---|---|---|
| 1 | — | 0.0 | 5 | 100.0 | 5 | 100.0 |
| 2 | — | 0.0 | 8 | 100.0 | 8 | 100.0 |
| 3 | — | 0.0 | 2 | 100.0 | 2 | 100.0 |
| 4 | — | 0.0 | 12 | 100.0 | 12 | 100.0 |
| 5 | — | 0.0 | 9 | 100.0 | 9 | 100.0 |
| 6 | — | 0.0 | 14 | 100.0 | 14 | 100.0 |
| 7 | 2 | 22.2 | 7 | 77.8 | 9 | 100.0 |
| 8 | 7 | 87.5 | 1 | 12.5 | 8 | 100.0 |
| 9 | 16 | 94.1 | 1 | 5.9 | 17 | 100.0 |
| 10 | 10 | 83.3 | 2 | 16.7 | 12 | 100.0 |
| 11 | — | 0.0 | — | 0.0 | — | 0.0 |
| 12 | 87 | 100.0 | — | 0.0 | 87 | 100.0 |
| 13 | 54 | 98.2 | 1 | 1.8 | 55 | 100.0 |
| TOTAL | 176 | 73.9 | 62 | 26.1 | 238 | 100.0 |

TABLE 10

RESIDENCE OF WOMEN OBTAINING INDUCED ABORTIONS ON IN-HOSPITAL BASIS BY LOCATION OF HOSPITALS IN QUEBEC, 1974

STATISTICS CANADA

| Census District | Induced Abortion by Residence | | | Census District | Induced Abortion by Residence | | |
|---|---|---|---|---|---|---|---|
| | Local | Not Local | Total | | Local | Not Local | Total |
| 1 | — | 7 | 7 | 31 | — | 11 | 11 |
| 2 | — | 18 | 18 | 32 | — | 5 | 5 |
| 3 | 1 | 1 | 2 | 33 | — | 2 | 2 |
| 4 | — | 1 | 1 | 34 | — | 2 | 2 |
| 5 | — | 6 | 6 | 35 | — | 1 | 1 |
| 6 | — | 2 | 2 | 36 | 1 | 3 | 4 |
| 7 | — | 8 | 8 | 37 | — | 19 | 19 |
| 8 | — | 1 | 1 | 38 | — | 2 | 2 |
| 9 | — | 8 | 8 | 39 | — | 1 | 1 |
| 10 | — | 153 | 153 | 40 | — | 6 | 6 |
| 11 | — | 6 | 6 | 41 | — | 1 | 1 |
| 12 | — | 21 | 21 | 42 | — | 46 | 46 |
| 13 | — | 16 | 16 | 43 | — | 6 | 6 |
| 14 | — | 21 | 21 | 44 | — | 3 | 3 |
| 15 | — | 2 | 2 | 45 | — | 5 | 5 |
| 16 | — | 13 | 13 | 46 | — | 3 | 3 |
| 17 | — | 2 | 2 | 47 | — | 14 | 14 |
| 18 | — | 6 | 6 | 48 | — | 13 | 13 |
| 19 | — | 2 | 2 | 49 | — | 1 | 1 |
| 20 | — | 10 | 10 | 50 | — | 6 | 6 |
| 21 | — | 15 | 15 | 51 | 1 | 12 | 13 |
| 22 | — | 8 | 8 | 52 | 16 | 22 | 38 |
| 23 | — | 3 | 3 | 53 | — | 2 | 2 |
| 24 | 2,113 | 2 | 2,115 | 54 | — | 8 | 8 |
| 25 | — | 3 | 3 | 55 | — | 7 | 7 |
| 26 | — | 11 | 11 | 56 | — | 3 | 3 |
| 27 | — | 1 | 1 | 57 | — | 54 | 54 |
| 28 | — | 7 | 7 | 58 | — | 6 | 6 |
| 29 | — | 1 | 1 | 59 | — | 6 | 6 |
| 30 | — | 38 | 38 | | | | |
| TOTAL | | 2,132 (local) | | 663 (not local) | 2,795 (total) | | |
| PERCENTAGE | | 76.3 (local) | | 23.7 (not local) | 100.0 (total) | | |

Residence unknown for 118 induced abortion patients.

TABLE 11

RESIDENCE OF WOMEN OBTAINING INDUCED ABORTIONS ON IN-HOSPITAL BASIS BY LOCATION OF HOSPITAL IN SASKATCHEWAN, 1974

STATISTICS CANADA

| Census District | Abortion by Residence | | | | | |
|---|---|---|---|---|---|---|
| | Local | | Not Local | | Total | |
| | No. | % | No. | % | No. | % |
| B1 | — | 0 | 21 | 100.0 | 21 | 100.0 |
| 1 | — | 0 | 9 | 100.0 | 9 | 100.0 |
| 2 | 12 | 70.5 | 5 | 29.5 | 17 | 100.0 |
| 3 | — | 0 | 17 | 100.0 | 17 | 100.0 |
| 4 | — | 0 | 9 | 100.0 | 9 | 100.0 |
| 5 | — | 0 | 12 | 100.0 | 12 | 100.0 |
| 6 | 12 | 14.1 | 73 | 85.9 | 85 | 100.0 |
| 7 | 56 | 78.9 | 15 | 21.1 | 71 | 100.0 |
| 8 | — | 0 | 30 | 100.0 | 30 | 100.0 |
| 9 | 5 | 19.2 | 21 | 80.8 | 26 | 100.0 |
| 10 | — | 0 | 12 | 100.0 | 12 | 100.0 |
| 11 | 293 | 99.0 | 3 | 1.0 | 296 | 100.0 |
| 12 | — | 0 | 28 | 100.0 | 28 | 100.0 |
| 13 | — | 0 | 29 | 100.0 | 29 | 100.0 |
| 14 | — | 0 | 38 | 100.0 | 38 | 100.0 |
| 15 | 56 | 56.0 | 44 | 44.0 | 100.0 | 100.0 |
| 16 | 15 | 31.3 | 33 | 68.7 | 48 | 100.0 |
| 17 | 8 | 22.2 | 28 | 77.8 | 36 | 100.0 |
| 18 | — | 0 | 9 | 100.0 | 9 | 100.0 |
| TOTAL | 457 | 51.2 | 436 | 48.8 | 893 | 100.0 |

TABLE 12

RESIDENCE OF WOMEN OBTAINING INDUCED ABORTIONS ON IN-HOSPITAL BASIS BY LOCATION OF HOSPITALS IN BRITISH COLUMBIA, 1974

STATISTICS CANADA

| Census District | Abortion by Residence: Local No. | Local % | Not Local No. | Not Local % | Total No. | Total % |
|---|---|---|---|---|---|---|
| NR | — | 0 | 81 | 100.0 | 81 | 100.0 |
| NS | — | 0 | 1 | 100.0 | 1 | 100.0 |
| 1 | 13 | 50.0 | 13 | 50.0 | 26 | 100.0 |
| 2 | 16 | 43.2 | 21 | 56.8 | 37 | 100.0 |
| 3 | 148 | 94.9 | 8 | 5.1 | 156 | 100.0 |
| 4 | 75 | 96.2 | 3 | 3.8 | 78 | 100.0 |
| 5 | 67 | 78.8 | 18 | 21.2 | 85 | 100.0 |
| 6 | 103 | 72.5 | 39 | 27.5 | 142 | 100.0 |
| 7 | 15 | 62.5 | 9 | 37.5 | 24 | 100.0 |
| 8 | 45 | 90.0 | 5 | 10.0 | 50 | 100.0 |
| 9 | 69 | 92.0 | 6 | 8.0 | 75 | 100.0 |
| 10 | 38 | 38.4 | 61 | 61.6 | 99 | 100.0 |
| 11 | 49 | 80.3 | 12 | 19.7 | 61 | 100.0 |
| 12 | 85 | 92.4 | 7 | 7.6 | 92 | 100.0 |
| 13 | 14 | 56.0 | 11 | 44.0 | 25 | 100.0 |
| 14 | 72 | 91.1 | 7 | 8.9 | 79 | 100.0 |
| 15 | 2,855 | 99.5 | 15 | 0.5 | 2,870 | 100.0 |
| 16 | 104 | 92.0 | 9 | 8.0 | 113 | 100.0 |
| 17 | 43 | 93.5 | 3 | 6.5 | 46 | 100.0 |
| 18 | — | 0 | 23 | 100.0 | 23 | 100.0 |
| 19 | 17 | 73.9 | 6 | 26.1 | 23 | 100.0 |
| 20 | 6 | 22.2 | 21 | 77.8 | 27 | 100.0 |
| 22 | 48 | 90.6 | 3 | 9.4 | 51 | 100.0 |
| 23 | 47 | 85.5 | 8 | 14.5 | 55 | 100.0 |
| 24 | 30 | 71.4 | 12 | 28.6 | 42 | 100.0 |
| 25 | 17 | 31.5 | 37 | 68.5 | 54 | 100.0 |
| 26 | — | 0 | 12 | 100.0 | 12 | 100.0 |
| 28 | 6 | 50.0 | 6 | 50.0 | 12 | 100.0 |
| 29 | 54 | 87.0 | 8 | 13.0 | 62 | 100.0 |
| TOTAL | 4,036 | 89.7 | 465 | 10.3 | 4,501 | 100.0 |

TABLE 13

## LEGAL STATUS OF INDUCED ABORTION: OPINIONS OF WOMEN AND MEN

NATIONAL POPULATION SURVEY

| Characteristics of Individuals | Legal Status of Induced Abortion | | | | | |
|---|---|---|---|---|---|---|
| | Women | | | Men | | |
| | Legal | Illegal | Don't Know | Legal | Illegal | Don't Know |
| | percent | | | percent | | |
| AGE | | | | | | |
| 19 years & under | 31.4 | 48.2 | 20.4 | 32.3 | 46.5 | 21.2 |
| 20-29 years | 41.9 | 46.3 | 11.8 | 39.1 | 50.6 | 10.3 |
| 30-39 years | 41.3 | 46.6 | 12.1 | 42.2 | 48.4 | 9.4 |
| 40-49 years | 33.5 | 50.1 | 16.4 | 41.0 | 50.6 | 8.4 |
| 50-59 years | 30.0 | 48.1 | 21.9 | 37.7 | 51.8 | 10.5 |
| 60 years & older | 27.8 | 43.3 | 28.9 | 30.3 | 55.7 | 14.0 |
| EDUCATION | | | | | | |
| elementary | 20.8 | 52.8 | 26.4 | 23.7 | 59.0 | 17.3 |
| high school | 35.9 | 47.2 | 16.9 | 34.0 | 50.8 | 15.2 |
| technical college | 46.8 | 47.6 | 5.6 | 41.0 | 52.2 | 6.8 |
| college/university | 51.8 | 39.0 | 9.2 | 54.8 | 40.7 | 4.5 |
| LANGUAGE | | | | | | |
| English | 45.9 | 35.8 | 18.3 | 45.1 | 42.3 | 12.6 |
| French | 16.9 | 69.0 | 14.1 | 22.1 | 67.4 | 10.5 |
| MARITAL STATUS | | | | | | |
| single | 31.7 | 51.2 | 17.1 | 36.3 | 46.8 | 16.9 |
| married | 36.9 | 46.8 | 16.3 | 37.7 | 52.1 | 10.2 |
| widowed, divorced, separated | 38.4 | 40.9 | 20.7 | 36.5 | 49.2 | 14.3 |
| REGION | | | | | | |
| Maritimes | 33.7 | 47.7 | 18.6 | 30.2 | 55.0 | 14.8 |
| Quebec | 16.9 | 68.6 | 14.5 | 22.0 | 67.9 | 10.1 |
| Ontario | 46.2 | 35.7 | 18.1 | 45.3 | 40.6 | 14.1 |
| Prairies | 32.0 | 47.2 | 20.8 | 41.2 | 46.8 | 12.0 |
| British Columbia | 60.0 | 26.2 | 13.8 | 52.4 | 33.4 | 14.2 |
| RELIGION | | | | | | |
| Catholic | 36.4 | 36.4 | 27.2 | 29.2 | 54.2 | 16.6 |
| Jewish | 23.9 | 59.8 | 16.3 | 25.7 | 61.6 | 12.7 |
| Protestant | 48.5 | 33.4 | 18.1 | 46.0 | 41.6 | 12.4 |
| AVERAGE | 35.9 | 47.3 | 16.8 | 37.5 | 50.3 | 12.2 |

TABLE 14

## OPINIONS ON THE ACCESSIBILITY OF ABORTION TREATMENT SERVICES

NATIONAL POPULATION SURVEY

| Characteristics of Individuals | Accessibility of Services | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | WOMEN | | | | MEN | | | |
| | Too Accessible | Adequately Accessible | Too Inaccessible | No Opinion | Too Accessible | Adequately Accessible | Too Inaccessible | No Opinion |
| | percent | | | | percent | | | |
| AGE | | | | | | | | |
| 19 years & under | 10.5 | 15.6 | 16.2 | 57.7 | 4.4 | 14.6 | 14.3 | 66.7 |
| 20-29 years | 10.0 | 19.8 | 21.7 | 48.5 | 7.4 | 17.5 | 22.1 | 53.0 |
| 30-39 years | 11.3 | 21.1 | 18.9 | 48.7 | 7.5 | 18.4 | 21.3 | 52.8 |
| 40-49 years | 13.6 | 17.1 | 12.1 | 57.2 | 9.3 | 21.3 | 19.8 | 49.6 |
| 50-59 years | 11.6 | 14.2 | 12.4 | 61.8 | 9.1 | 17.9 | 14.8 | 58.2 |
| 60 years & older | 12.0 | 12.5 | 5.7 | 69.8 | 10.5 | 11.5 | 14.2 | 63.8 |
| EDUCATION | | | | | | | | |
| elementary | 8.0 | 9.7 | 10.0 | 72.3 | 8.4 | 13.3 | 12.6 | 65.7 |
| high school | 11.1 | 19.1 | 16.2 | 53.6 | 7.5 | 14.4 | 18.7 | 59.4 |
| technical college | 11.2 | 18.4 | 17.6 | 52.8 | 5.9 | 22.4 | 17.6 | 54.1 |
| college/university | 15.8 | 22.5 | 20.7 | 41.0 | 9.1 | 24.8 | 22.4 | 43.6 |
| LANGUAGE | | | | | | | | |
| English | 11.7 | 21.0 | 13.5 | 53.8 | 7.1 | 18.0 | 15.9 | 59.0 |
| French | 8.9 | 11.8 | 22.6 | 56.7 | 6.6 | 17.0 | 24.0 | 52.4 |
| MARITAL STATUS | | | | | | | | |
| single | 9.5 | 17.5 | 19.1 | 53.9 | 4.2 | 17.2 | 18.6 | 60.0 |
| married | 12.6 | 17.2 | 15.2 | 55.0 | 9.7 | 17.4 | 17.4 | 55.5 |
| widowed, divorced, separated | 8.1 | 19.7 | 12.8 | 59.4 | 8.1 | 12.9 | 29.0 | 50.0 |
| REGION | | | | | | | | |
| Maritimes | 8.1 | 11.6 | 22.7 | 57.6 | 7.4 | 14.7 | 15.3 | 62.6 |
| Quebec | 6.8 | 12.2 | 24.7 | 56.3 | 6.9 | 17.3 | 26.4 | 49.4 |
| Ontario | 13.5 | 20.4 | 12.4 | 53.7 | 7.5 | 16.5 | 15.7 | 60.3 |
| Prairies | 12.7 | 14.4 | 11.4 | 61.5 | 10.0 | 12.8 | 13.6 | 63.6 |
| British Columbia | 16.3 | 31.7 | 4.4 | 47.6 | 8.1 | 25.1 | 14.2 | 52.6 |
| RELIGION | | | | | | | | |
| Catholic | 11.1 | 12.6 | 17.8 | 58.5 | 9.3 | 15.2 | 19.2 | 56.3 |
| Jewish | 9.0 | 0.0 | 45.5 | 45.5 | 0.0 | 16.6 | 41.7 | 41.7 |
| Protestant | 11.2 | 23.5 | 12.6 | 52.7 | 7.1 | 18.6 | 14.3 | 60.0 |
| AVERAGE | 11.2 | 17.7 | 16.1 | 55.0 | 7.7 | 17.3 | 18.4 | 56.6 |

TABLE 15

## OPINIONS OF THE ABORTION LAW

NATIONAL POPULATION SURVEY

| Characteristics of Individuals | Opinions of the Abortion Law — WOMEN: Too Liberal | About Right | Too Restrictive | Don't Know | MEN: Too Liberal | About Right | Too Restrictive | Don't Know |
|---|---|---|---|---|---|---|---|---|
| | percent | | | | percent | | | |
| AGE | | | | | | | | |
| 19 years & under | 11.3 | 29.0 | 19.7 | 40.0 | 7.8 | 19.6 | 31.4 | 41.2 |
| 20-29 years | 11.9 | 22.9 | 38.4 | 26.8 | 11.6 | 19.4 | 44.0 | 25.0 |
| 30-39 years | 17.7 | 28.0 | 29.7 | 24.6 | 9.2 | 28.8 | 42.2 | 19.8 |
| 40-49 years | 19.1 | 27.1 | 23.8 | 30.0 | 17.9 | 23.9 | 36.6 | 21.6 |
| 50 years & older | 23.1 | 17.9 | 21.0 | 38.0 | 15.7 | 25.4 | 32.0 | 26.9 |
| EDUCATION | | | | | | | | |
| elementary | 15.6 | 14.3 | 14.6 | 55.5 | 17.7 | 21.1 | 21.1 | 40.1 |
| high school | 15.9 | 27.1 | 25.6 | 31.4 | 12.0 | 21.6 | 34.4 | 32.0 |
| technical college | 17.8 | 29.0 | 37.1 | 16.1 | 7.9 | 28.1 | 44.3 | 19.7 |
| college/university | 15.0 | 29.7 | 40.3 | 15.0 | 12.5 | 26.1 | 47.4 | 14.0 |
| LANGUAGE | | | | | | | | |
| English | 15.5 | 28.3 | 26.8 | 29.4 | 11.1 | 24.7 | 38.0 | 26.2 |
| French | 16.0 | 21.0 | 27.3 | 35.7 | 14.2 | 22.1 | 33.1 | 30.6 |
| MARITAL STATUS | | | | | | | | |
| single | 11.5 | 26.0 | 28.1 | 34.4 | 8.7 | 18.9 | 38.6 | 33.8 |
| married | 18.4 | 24.6 | 26.2 | 30.8 | 15.2 | 25.2 | 34.5 | 25.1 |
| widowed, divorced, separated | 13.8 | 25.0 | 22.8 | 38.4 | 4.9 | 26.2 | 36.1 | 32.8 |
| REGION | | | | | | | | |
| Maritimes | 12.1 | 24.2 | 26.3 | 37.4 | 15.0 | 22.5 | 33.7 | 28.8 |
| Quebec | 14.8 | 20.9 | 28.5 | 35.8 | 13.7 | 21.7 | 35.5 | 29.1 |
| Ontario | 17.4 | 25.7 | 24.8 | 32.1 | 9.5 | 23.4 | 37.2 | 29.9 |
| Prairies | 15.4 | 27.2 | 23.8 | 33.6 | 16.5 | 21.3 | 32.5 | 29.7 |
| British Columbia | 18.8 | 31.8 | 27.8 | 21.4 | 10.9 | 28.0 | 38.9 | 22.2 |
| RELIGION | | | | | | | | |
| Catholic | 18.2 | 22.9 | 23.3 | 35.6 | 16.1 | 22.1 | 28.9 | 32.9 |
| Jewish | 9.1 | 0.0 | 81.8 | 9.1 | 4.2 | 33.3 | 41.7 | 20.8 |
| Protestant | 13.9 | 29.3 | 26.0 | 30.8 | 10.5 | 25.5 | 38.4 | 25.6 |
| AVERAGE | 16.2 | 24.9 | 26.5 | 32.4 | 12.8 | 23.0 | 36.6 | 27.6 |

TABLE 16

DISTRIBUTION OF PHYSICIANS BY SPECIALTY, 1974*

| Province | Medical Specialty | | | |
|---|---|---|---|---|
| | Family Medicine | Obstetrics-Gynaecology | General Surgery | Total |
| Newfoundland | 344 | 13 | 35 | 392 |
| Prince Edward Island | 73 | 5 | 8 | 86 |
| Nova Scotia | 714 | 25 | 95 | 834 |
| New Brunswick | 360 | 25 | 62 | 447 |
| Quebec | 3,680 | 347 | 638 | 4,665 |
| Ontario | 6,265 | 503 | 850 | 7,618 |
| Manitoba | 866 | 53 | 100 | 1,019 |
| Saskatchewan | 625 | 28 | 58 | 711 |
| Alberta | 1,312 | 100 | 143 | 1,555 |
| British Columbia | 2,153 | 118 | 253 | 2,524 |
| Yukon, Northwest Territories | 47 | 2 | 5 | 54 |
| CANADA | 16,439 | 1,219 | 2,247 | 19,905 |

* *Canada Health Manpower Inventory, 1975* (Ottawa: Health and Welfare Canada, 1976).

TABLE 17

DISTRIBUTION OF PHYSICIANS BY SPECIALTY
PER 1000 POPULATION 1974*

| Province | Medical Specialty | | | |
|---|---|---|---|---|
| | Family Medicine | Obstetrics-Gynaecology | General Surgery | Total |
| Newfoundland | 1:1587 | 1:41993 | 1:15600 | 1:1393 |
| Prince Edward Island | 1:1613 | 1:23552 | 1:14720 | 1:1369 |
| Nova Scotia | 1:1142 | 1:32604 | 1: 8580 | 1: 977 |
| New Brunswick | 1:1861 | 1:26804 | 1:10808 | 1:1499 |
| Quebec | 1:1676 | 1:17770 | 1: 9665 | 1:1322 |
| Ontario | 1:1305 | 1:16253 | 1: 9618 | 1:1073 |
| Manitoba | 1:1178 | 1:19240 | 1:10197 | 1:1001 |
| Saskatchewan | 1:1483 | 1:33123 | 1:15990 | 1:1304 |
| Alberta | 1:1332 | 1:17479 | 1:12223 | 1:1124 |
| British Columbia | 1:1134 | 1:20698 | 1: 9660 | 1: 968 |
| Yukon, Northwest Territories | 1:1217 | 1:28605 | 1:11442 | 1:1059 |
| CANADA | 1:1378 | 1:18579 | 1:10079 | 1:1138 |

* Ratios calculated from *Canada Health Manpower Inventory, 1975* (Ottawa: Health and Welfare Canada, 1976).

TABLE 18

## INDICATIONS FOR INDUCED ABORTION: OPINIONS OF WOMEN

NATIONAL POPULATION SURVEY

| Characteristics of Individuals | Indications for Induced Abortion | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Danger to Life | Rape, Incest | Mental Health | Deformity of Foetus | On Request Less Than 12 Weeks | Economic Circumstances | Illegitimacy | Anytime On Request | Never |
| | percent | | | | | | | | |
| AGE | | | | | | | | | |
| 19 years & under | 67.6 | 64.0 | 56.3 | 45.8 | 23.5 | 19.6 | 18.5 | 16.1 | 14.0 |
| 20-29 years | 77.4 | 66.3 | 63.6 | 58.8 | 31.1 | 28.0 | 17.4 | 20.5 | 7.2 |
| 30-39 years | 74.8 | 66.2 | 61.5 | 57.6 | 27.0 | 22.9 | 17.0 | 18.1 | 7.7 |
| 40-49 years | 70.8 | 60.1 | 56.7 | 54.4 | 20.4 | 20.7 | 18.1 | 13.6 | 13.3 |
| 50-59 years | 68.4 | 59.4 | 60.2 | 51.2 | 17.2 | 17.2 | 18.4 | 10.7 | 13.5 |
| 60 years & older | 57.2 | 43.3 | 49.5 | 43.3 | 13.5 | 16.3 | 16.3 | 9.1 | 18.8 |
| EDUCATION | | | | | | | | | |
| elementary | 57.8 | 44.1 | 47.1 | 44.7 | 15.5 | 13.1 | 13.7 | 12.5 | 21.6 |
| high school | 72.9 | 65.5 | 60.4 | 54.3 | 23.3 | 22.2 | 18.1 | 14.8 | 9.9 |
| technical college | 83.2 | 66.4 | 72.0 | 60.8 | 32.0 | 23.2 | 20.8 | 20.0 | 4.8 |
| college/university | 73.0 | 64.3 | 60.9 | 54.3 | 35.7 | 30.0 | 19.1 | 27.7 | 7.8 |
| LANGUAGE | | | | | | | | | |
| English | 72.7 | 65.1 | 60.6 | 51.0 | 28.7 | 23.6 | 19.6 | 17.5 | 8.0 |
| French | 69.7 | 58.3 | 57.5 | 57.8 | 15.1 | 20.5 | 16.1 | 14.3 | 16.1 |
| MARITAL STATUS | | | | | | | | | |
| single | 67.3 | 62.8 | 57.6 | 46.0 | 25.7 | 23.0 | 18.3 | 18.7 | 12.8 |
| married | 73.5 | 62.6 | 59.4 | 56.5 | 23.0 | 20.8 | 17.3 | 14.5 | 10.8 |
| widowed, divorced, separated | 64.1 | 55.1 | 57.6 | 51.4 | 24.1 | 23.7 | 19.6 | 17.6 | 11.4 |
| REGION | | | | | | | | | |
| Maritimes | 72.0 | 57.5 | 50.0 | 43.5 | 21.0 | 19.0 | 17.5 | 15.0 | 10.5 |
| Quebec | 68.5 | 58.6 | 57.3 | 59.3 | 16.3 | 20.1 | 16.6 | 14.2 | 16.1 |
| Ontario | 68.2 | 61.5 | 57.5 | 47.5 | 27.6 | 21.0 | 17.4 | 17.4 | 10.8 |
| Prairies | 74.3 | 61.7 | 60.5 | 52.1 | 20.6 | 21.5 | 17.4 | 14.1 | 9.3 |
| British Columbia | 78.1 | 72.8 | 70.2 | 62.7 | 38.6 | 31.1 | 22.8 | 20.2 | 3.9 |
| RELIGION | | | | | | | | | |
| Catholic | 64.5 | 55.2 | 52.3 | 49.6 | 15.8 | 16.5 | 14.2 | 12.9 | 17.3 |
| Jewish | 81.8 | 72.7 | 81.8 | 72.7 | 63.6 | 54.5 | 36.4 | 54.5 | 0.0 |
| Protestant | 77.7 | 68.8 | 64.8 | 55.9 | 29.9 | 26.0 | 21.1 | 17.0 | 5.1 |
| AVERAGE | 71.0 | 61.7 | 58.9 | 53.2 | 23.7 | 21.8 | 17.6 | 15.8 | 11.4 |

*Note*: Non-accumulative as more than one category could be selected.

TABLE 19

## INDICATIONS FOR INDUCED ABORTION: OPINIONS OF MEN

NATIONAL POPULATION SURVEY

| Characteristics of Individuals | Indications for Induced Abortion | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Danger to Life | Rape, Incest | Mental Health | Deformity of Foetus | On Request Less than 12 Weeks | Economic Circumstances | Illegitimacy | Anytime On Request | Never |
| | percent | | | | | | | | |
| AGE | | | | | | | | | |
| 19 years & under | 60.5 | 58.1 | 49.8 | 40.2 | 27.2 | 15.6 | 18.9 | 31.2 | 9.6 |
| 20-29 years | 70.5 | 63.1 | 60.8 | 51.4 | 32.0 | 27.7 | 16.7 | 26.1 | 6.8 |
| 30-39 years | 75.3 | 65.6 | 64.9 | 56.8 | 29.5 | 26.9 | 19.5 | 20.5 | 7.8 |
| 40-49 years | 68.0 | 56.7 | 56.7 | 51.6 | 25.8 | 21.5 | 22.9 | 22.2 | 10.9 |
| 50-59 years | 65.4 | 55.6 | 57.1 | 48.8 | 21.0 | 18.0 | 20.0 | 19.5 | 10.7 |
| 50 years & older | 56.5 | 47.0 | 45.2 | 45.7 | 22.6 | 14.3 | 20.0 | 15.2 | 16.1 |
| EDUCATION | | | | | | | | | |
| elementary | 56.9 | 47.1 | 45.1 | 43.5 | 18.0 | 13.3 | 17.6 | 11.4 | 19.2 |
| high school | 66.0 | 58.8 | 55.3 | 48.3 | 26.7 | 20.1 | 19.0 | 24.3 | 9.5 |
| technical college | 70.0 | 61.9 | 61.4 | 54.3 | 31.0 | 25.2 | 21.0 | 27.6 | 6.2 |
| college/university | 75.0 | 65.7 | 66.9 | 55.7 | 36.1 | 31.6 | 22.3 | 26.8 | 5.1 |
| LANGUAGE | | | | | | | | | |
| English | 68.0 | 61.6 | 59.7 | 32.6 | 24.0 | 21.5 | 26.3 | 7.2 | |
| French | 65.8 | 56.2 | 53.8 | 51.1 | 19.9 | 19.2 | 18.5 | 19.4 | 13.9 |
| MARITAL STATUS | | | | | | | | | |
| single | 63.6 | 58.2 | 54.4 | 45.8 | 32.1 | 23.1 | 18.5 | 29.3 | 8.3 |
| married | 68.4 | 58.8 | 57.4 | 51.6 | 24.8 | 21.4 | 19.9 | 19.7 | 10.6 |
| widowed, divorced, separated | 69.8 | 54.0 | 60.3 | 50.8 | 33.3 | 17.5 | 25.4 | 27.0 | 7.9 |
| REGION | | | | | | | | | |
| Maritimes | 65.3 | 49.2 | 53.4 | 39.9 | 26.4 | 16.1 | 15.0 | 18.7 | 13.5 |
| Quebec | 65.5 | 56.5 | 53.3 | 51.4 | 19.4 | 19.0 | 17.7 | 10.0 | 13.4 |
| Ontario | 67.0 | 60.0 | 58.2 | 50.7 | 33.7 | 26.0 | 22.1 | 27.0 | 7.6 |
| Prairies | 67.7 | 59.9 | 56.0 | 47.5 | 26.8 | 20.2 | 19.1 | 21.4 | 10.1 |
| British Columbia | 68.1 | 65.3 | 62.0 | 52.6 | 33.3 | 23.5 | 21.6 | 27.2 | 2.3 |
| RELIGION | | | | | | | | | |
| Catholic | 64.7 | 53.7 | 51.0 | 46.3 | 19.6 | 16.1 | 14.7 | 16.9 | 15.3 |
| Jewish | 52.0 | 48.0 | 48.0 | 44.0 | 32.0 | 28.0 | 28.0 | 52.0 | 4.0 |
| Protestant | 69.2 | 62.8 | 61.3 | 52.5 | 33.6 | 24.9 | 23.6 | 26.9 | 5.4 |
| AVERAGE | 66.8 | 58.7 | 56.6 | 49.4 | 27.3 | 21.7 | 19.3 | 23.2 | 9.8 |

*Note:* Non-accumulative as more than one category could be selected.

# Appendix 2

## REFERENCES


Adams, D., *Therapeutic Abortion: An Annotated Bibliography* (Hamilton: McMaster University Medical Centre, 1973)

Allingham, J.D.; Balakrishnan, T.R.; and Kantner, J.F., "The End of Rapid Increase in the Use of Oral Anovulants? Some Problems in the Interpretation of Time Series of Oral Use Among Married Women", *Demography* 7 (1970):31-41

———. "Time Series of Growth in Use of Oral Contraceptives and the Differential Diffusion of Oral Anovulants", *Population Studies* 23 (1969):43-51

Andison, A.W., "Conception Control", *Manitoba Medical Review* 47 (1967):96-99

Bacon, H., "Psychiatric Aspects of Therapeutic Abortion", *Canada's Mental Health* 17 (1969):18-21

Balakrishnan, T.R.; Allingham, J.D.; and Kantner, J.F., "Analysis of Oral Contraceptive Use Through Multiple Decrement Life Table Techniques", *Demography* 7 (1970):459-465

Balakrishnan, T.R.; Kantner, J.F.; and Allingham, J.D., *Fertility in a Canadian Metropolis* (Montreal and London: McGill-Queen's University Press, 1975)

Barrett, M.; and Fitz-Earle, M., "Student Opinion on Legalized Abortion at the University of Toronto", *Canadian Journal of Public Health* 64 (1973):294-299

Bell, L.; Brock, B.; Carson, S.; et al., "Contraceptive Knowledge Among Undergraduates at a Canadian University", *American Journal of Obstetrics and Gynaecology* 124 (1976):499-503

Black, E.F.E., "Abortion and Sterilization", *Manitoba Bar News* 33 (1961):33

Bogg, R., "Therapeutic Abortion at the University of Alberta Hospital: A Sociological Analysis" (Ball State University, Muncie, Indiana, 1973)

Bordeleau, J.M., "Psychiatric Consultation and Interruption of Pregnancy", *Union Médicale du Canada* 102 (1973):2326-2328

Bowker, W. F., "Experimentation on Humans and Gifts of Tissue: Articles 20-23 of the Civil Code", *McGill Law Journal* 19 (1973):161

Boyce, R. M., and Osborn, R. W., "Therapeutic Abortion in a Canadian City", *Canadian Medical Association Journal* 103 (1970):310-327

Boydell, C.L., and Grindstaff, C.F., "Public Attitudes Toward Legal Sanctions for Drug and Abortion Offences", *Canadian Journal of Criminology and Correction* 13 (1971):208-232

British Columbia, Royal Commission on Family and Children's Law, Twelfth Report, *The Medical Consent of Minors*, August 1974

Brody, H.; Meikle, S.; and Gerritse, R., "Therapeutic Abortion: A Prospective Study", *American Journal of Obstetrics and Gynaecology* 109 (1971):347-353

Burt, J. J., and Brower, L. A., *Education for Sexuality: Concepts and Programs for Training* (Toronto: W. B. Saunders, 1970)

Callahan, D., ed., *The Catholic Case for Contraception* (Toronto: Collier-Macmillan, 1969)

Canada, Department of National Health and Welfare, Family Planning Division, *A Guide to Family Planning Grants* (Ottawa, 1974)

———, *National Conference on Family Planning, 1972* (Ottawa, 1972)

Canada, Department of National Health and Welfare, Health Programs Branch, Health Economics and Statistics Division, *Pilot Survey of Hospital Therapeutic Abortion Committees, British Columbia, 1971-1972* (Ottawa, 1974)

Canada, Department of National Health and Welfare, Research and Statistics Directorate, *Review of Abortion Legislation and Experience in Selected Countries* (Ottawa, 1970)

Canada, Department of National Health and Welfare, "Oral Contraceptives", *Rx Bulletin*, 1970, No. 10

Canada, Dominion Bureau of Statistics, Health and Welfare Division, *Special Statement: Therapeutic Abortion in Canada, August 26, 1969, to August 25, 1970* (Ottawa, 1970)

———, "Therapeutic Abortions in Canada, 1970", *DBS News* (Ottawa, 1971)

Canada, International Development Research Centre, "Population and Health Sciences", *International Development Research Centre Reports*, 1972

Canada, Royal Commission on the Status of Women in Canada, *Report* (Information Canada, 1970)

———, Unpublished Reports (Public Archives Canada, R.G. 33/89, volumes 25-30):
Gaudette, M., La stérilisation au Canada: sa légalité (vol. 27)

———, La notion d'âge en matière d'infraction d'ordre sexuel (vol. 27)

———, La notion de «mœurs antérieurement chastes» en droit pénal canadien (vol. 27)

———, La notion de vagabondage dans le droit pénal canadien (vol. 27)

Picard, C., Birth Control and Abortion (vol. 28)

Rommer, R., Abortion and the Law (vol. 29)

Canada, Statistics Canada, *Therapeutic Abortions, 1971* (Ottawa: Department of Industry, Trade and Commerce, 1972)

———, *Therapeutic Abortions, 1972* (Ottawa: Department of Industry, Trade and Commerce, 1973)

———, *Therapeutic Abortions, 1973* (Ottawa: Department of Industry, Trade and Commerce, 1974)

———, *Therapeutic Abortions, Canada, 1974: Advance Information* (Ottawa: Department of Industry, Trade and Commerce, 1975)

———, *Therapeutic Abortions, 1974* (Ottawa: Department of Industry, Trade and Commerce, 1976)

Canadian Association of Schools of Social Work, *Human Sexuality and Fertility Services: Social Policy and Social Work Education* (Ottawa, 1973)

Canadian Broadcasting Corporation, Research Department, *Public Opinion in Canada on Certain Aspects of the Law Relating to Abortion: A Fact-finding Survey, December 1970* (Ottawa, 1971)

"Canadian Medical Association Resolutions on Abortion", *Canadian Medical Association Journal* 105 (1971):441-444

"Canadian Public Health Association, Council Policy Position on Abortion", *Canadian Journal of Public Health* 63 (1972):370-371

"The Care and Treatment of Therapeutic Abortion Patients in Canadian Hospitals, January 1 to September 20, 1971", *Hospital Administration in Canada* 14 (1972):25-31

Carr, D.H., "Chromosome Studies in Selected Spontaneous Abortions: Conception After Oral Contraceptives", *Canadian Medical Association Journal* 103 (1970):343-348

Catholic Hospital Association of Canada, *Survey of Medico-Moral Committees Established in Catholic Hospitals Across Canada* (Ottawa, 1972)

———, *Medical-Moral Guide* (Ottawa, 1970)

———, "Response to the Canadian Medical Association's Statement on Abortion", *Catholic Hospital* 3 (1975):13-14

Cherniak, D., and Feingold, A., *Birth Control Handbook* (Montreal: McGill University Student Society, 1970)

Cheung, K.W., "The Abortion Decision—A Qualified Constitutional Right in the United States: Whither Canada?", *Canadian Bar Review* 51 (1973):643

Christensen, J. C., "Saline Abortion: A Study of Female Behaviour in a Crisis Situation" (M.Sc. thesis, McGill University, Montreal, 1972)

Claman, D. A.; Wakeford, J. R.; Turner, J. M. M.; and Hayden, B., "Impact on Hospital Practice of Liberalizing Abortions and Female Sterilizations", *Canadian Medical Association Journal* 105 (1971):35-41, 83

Claman, D. A.; Williams, B. J.; and Wogan, L., "Reaction of Unmarried Girls to Pregnancy", *Canadian Medical Association Journal* 101(1969):328-334

Coffey, P. G., "Therapeutic Abortion", *Advocate* (Vancouver Bar Association) 31 (1973):99

Cohen, M.; Rapson, L.; and Watters, W. W., *Survey of Hospital Abortion Committees in Canada* (Toronto: Doctors for Repeal of the Abortion Law, 1975)

Collins, J. A. "Outpatient Management of First Trimester Therapeutic Abortions With and Without Tubal Ligation", *Canadian Medical Association Journal* 106 (1972):1077-1080

Collins, L. D., "The Legal Aspects of Abortion", *Canadian Journal of Public Health* 66 (1975):234-236

Conseil des affaires sociales et de la famille, *Dossier sur l'avortement* (Québec: l'éditeur officiel du Québec, 1973)

Corneau, A.-G. «Un comité d'avortement thérapeutique: légalement constitué?», *Hôpital d'aujourd'hui* 17, No. 10 (1971):15-19

Crépeau, P.-A., «Le consentement du mineur en matière de soins et traitements médicaux ou chirurgicaux selon le droit civil canadien», *Canadian Bar Review* 52(1974):247

Daley, T. T., "The Rights of the Unborn—A CAS Looks at Abortion", *Canadian Welfare* 48 (1972):19-21

DeJager, N. S. T., "Attempted Abortion by the Use of Bishydroxycoumarin", *Canadian Medical Association Journal* 107 (1972):50-53

de Valk, A., *Abortion Politics in Canada: Several Arguments* (Saskatoon: The Chelsea Bulletin, 1971)

———, *Morality and Law in Canadian Politics: The Abortion Controversy* (Montreal: Palm Publishers, 1974)

de Veber, L. L., "Point of View: Canadian Physicians for Life and the Abortion Issue", *University of Western Ontario Medical Journal* 46 (1975):5

Diner, M. C., "Survey of Ottawa Area General Practitioners and Obstetrician-Gynaecologists on Abortion", *Canadian Journal of Public Health* 65 (1974):351-358

Dodds, D. J., "Vasectomy: Performing the Operation and Counselling Your Anxious Patient", *Canadian Family Physician* 17 (1971):39-41, 89

Domnick, K. M., "Male Involvement in Contraception" (Master's thesis, University of Toronto, Toronto, 1975)

Doyle, R., "Family Planning is for Somebody Else", *Canadian Welfare* 48 (1972):12-13, 18

Elford, R. W., "Therapeutic Abortion", *Canadian Medical Association Journal* 105 (1971):638-639

Emson, H. E., "The Age of Consent", *Canadian Medical Association Journal* 109 (1973):687-688

«Étude sur l'avortement provoqué», *Bulletin pour l'infirmière catholique du Canada* 38 (1971):141-146

Fleming, J. G., *The Law of Torts*, 4th ed. (1971)

Fontaine, J. G. "Work of the Therapeutic Abortion Committee at Notre-Dame Hospital", *Union Médicale du Canada* 102 (1973):2328-2330

Fortier, L., «Le Droit à la vie . . . doit être laissé à chacun», *Canadian Bar Association Journal (N.S.)* 3, No. 4 (1972):23

———, "Needed: A Change in Attitudes Towards Elective Sterilization", *Canadian Nurse* 69 (1973):21-23

———, «Panorama de l'avortement à travers le temps», *Union Médicale du Canada* 98 (1969):1534-1539

Friedenberg, E. Z., "Evolution of Canadian Justice: The Morgentaler Case", *The Canadian Forum* (June 1975):28-30

Gagnon, L. R., «Face à l'avortement», *Bulletin pour l'infirmière catholique du Canada* 40 (1973):89-100

Garrett, N., *Nurse Education for Family Planning* (Ottawa: Canadian National Conference on Family Planning, 1972)

Geekie, D. A., "Abortion: A Review of CMA Policy and Positions", *Canadian Medical Association Journal* 111 (1974):1-4

Gélinas, G., «L'avortement thérapeutique», *Bulletin pour l'infirmière catholique du Canada* 35 (1968):123-128

Gendron, L., *Contraception* (Montreal: Harvest House, 1971)

Gosse, R., "Consent for Medical Treatment: A Minor Digression", *University of British Columbia Law Review* 9 (1974):56

Grauer, H., "A Study of Contraception as Related to Multiple Unwanted Pregnancies", *Canadian Medical Association Journal* 111 (1974): 1083-1084, 1087

Green, L. M., "Perspectives on the Attitudes of Health Professionals Towards Issues of Population and Family Planning" (M.Sc. thesis, University of Toronto, Toronto, 1976)

Greenglass, E., *After Abortion* (Toronto: Longman Canada, 1976)

———, "Therapeutic Abortion and Its Psychological Implications: The Canadian Experience", *Canadian Medical Association Journal* 113 (1975):754-757

Grindstaff, C. F., ed., *Population Issues in Canada* (Toronto: Holt, Rinehart & Winston of Canada, 1971)

Grindstaff, C. F., and Ebanks, G. E., "Male Sterilization in Canada", in *Social Process and Institution: The Canadian Case*, eds. J. E. Gallagher and R. Lambert (Toronto: Holt, Rinehart & Winston of Canada, 1971)

Guyatt, D., "Adolescent Pregnancy: A Study of Pregnant Teenagers in a Suburban Community in Ontario" (D.S.W. thesis, University of Toronto, 1976)

Hackett, J. D., and Barza, D., "The Clinical Management of the Unwed Mother", *Laval Médical* 12 (1971):84-90

Hannah, W., "The Family Doctor's Role in Preventing Unwanted Pregnancies", *Canadian Family Physician* 18 (1972):70-72

Harrison, C. P., "Abortion and the Law", *Canadian Medical Association Journal* 98 (1968):973

———, "The Doctor and the Patient Under Legalized Abortion", *Canadian Medical Association Journal* 97 (1967):249-51

———, "Therapeutic Abortion", *Canadian Medical Association Journal* 102 (1970):1209-1211

Heath, D. S., "Psychiatry and Abortion", *Canadian Psychiatric Association Journal* 16 (1971):55-63

Henripin, J., *Trends and Factors of Fertility in Canada* (Ottawa: Statistics Canada, 1972)

Henripin, J., and Legare, J., "Recent Trends in Canadian Fertility", *The Canadian Review of Sociology and Anthropology* 8 (1971):106-118

Hepworth, H. P., *Family Planning and Abortion Services and Family Life Education Programs* (Ottawa: The Canadian Council on Social Development, 1975)

Hirsch, S., "Observations in Illegitimacy", in *Social Problems: A Canadian Profile*, ed. R. Laskin (Toronto: McGraw-Hill, 1964)

Hodge, K. E., "Therapeutic Abortion and Ultrasound", *Canadian Medical Association Journal* 105 (1971):1021

Holt, S., *Sex and the Teenage Revolution* (Toronto: McClelland and Stewart, 1967)

Howells, J., "Extended Birth Control: Abortion on Request", *Canada's Mental Health* 18 (1970):3-8

Hunter, M. E., "Applications for Abortion in a Community Hospital", *Canadian Medical Association Journal* 111 (1974):1088, 1089, 1092

Isaacs, N. F., "Abortion and the Just Society", *Thémis* 5 (1970):25

Isaac, N., «L'aspect légal», *Infirmière canadienne* 14 (June 1972):27-29

Jobin, M., «L'avortement: toujours un problème», *Québec Médical* 12:7(1972):1-2

Kalbach, W. E., *Impact of Immigration of Canada's Population* (1961 Census)

Kalbach, W. E., and McVey, W. W., *The Demographic Bases of Canadian Society* (Toronto: McGraw-Hill, 1971)

Kerr, M. G., "Current Birth Control Methods", *Canadian Family Physician* 17 (1971):37-41

Knapp, R. D., "Abortion, a Threat to the Medical Profession", *Canadian Family Physician* 17 (1971):51-53

Kremer, E. J., and Synan, E. A., eds., *Death Before Birth: Canada and the Abortion Question* (Toronto: Griffin House, 1974)

Krever, H., "Minors and Consent for Medical Treatment", lecture, University of Toronto, March 18, 1974

Krotki, K., and Lapierre, E., «La fécondité au Canada selon la religion, l'origine ethnique et l'état matrimonial», *Population* 23 (1968):815-834

La ligue des droits de l'homme, *La société québécoise face à l'avortement* (Montréal: Éditions Leméac, 1974)

Lavis, D., "Ontario: The Pill and the Birth Rate, 1960-1967" (Master's thesis, University of Western Ontario, 1970)

Lederman, J. J., "The Doctor, Abortion and the Law—a Medico-Legal Dilemma", *Canadian Bar Journal* 6 (1963):136

Lederman, J. J., and Parker, G. E., "Therapeutic Abortion and the Canadian Criminal Code", *Criminal Law Quarterly* 6 (1963):36

*Le livre blanc de l'avortement* (Club de l'OBS, 1971)

Lipper, I.; Cvejic, H.; Benjamin, P.; and Kinch, R. A., "Abortion and the Pregnant Teenager", *Canadian Medical Association Journal* 109 (1973):852-856

Livingstone, E. S. "Vasectomy: A Review of 3200 Operations", *Canadian Medical Association Journal* 105 (1971):1065

London Board of Education, *Family Planning: A Curriculum* (London, Ontario: 1973)

MacKenzie, C. J. G., "The Vancouver Family Planning Clinic: A Comparison of Two Years' Experience", *Canadian Journal of Public Health* 59 (1968):257-265

———, *Teaching Population Dynamics, Conception Control, Human Sexuality and Related Subjects in Canadian Medical Schools* (Ottawa: Canadian National Conference on Family Planning, 1972)

MacKenzie, C. J. G.; Evans, G. P.; and Peck, J. G., "The Vancouver Family Planning Clinic: A Cost Study", *Canadian Journal of Public Health* 58 (1967):53-60

MacKenzie, P., "Before and After Therapeutic Abortion", *Canadian Medical Association Journal* 111 (1974):667-671

Mahon, R., «L'avortement volontaire», *Bulletin pour l'infirmière catholique du Canada* 37 (1970):219-225

Maki, M., et al., «Soins infirmiers dans les cas d'avortement», *L'infirmière canadienne* 61 (1965):646-647

Mann, W. E., "Sex at York University", in *Social Deviance in Canada,* ed. W. E. Mann (Toronto: Copp Clark, 1971)

Marcotte, M., «L'avortement, la morale et la loi», *Bulletin pour l'infirmière catholique du Canada* 35 (1968): 53-58; 101-121

———, *L'avortement libre* (Montréal: Édition Bellarmin, 1973)

Marko, J., "Investigation of Infertility", *Canadian Family Physician* 16 (1970):54-57

Marsden, L., *Population Probe: Canada* (Toronto: Copp Clark, 1972)

Mayrand, A., *L'inviolabilité de la personne humaine* (Montréal: Wilson & Lafleur, 1975)

Maxwell, I.D., "Medico-legal Inquiries: Therapeutic Abortion and Sterilization", *Nova Scotia Medical Bulletin* 46 (1967):116

McHarg, L., "Affect Changes Pre and Post Abortion" (M. Ed. thesis, McGill University, Montreal, 1973)

McKay, R.L., "Expressed Needs of Women Having Abortions" (M.Sc. thesis, University of British Columbia, Vancouver, 1974)

Meikle, S., and Gerritse, R., "A Comparison of Husband-Wife Responses to Pregnancy", *Journal of Psychology* 83 (1973):17-23

Miller, J., and Poland, B., "The Value of Human Abortuses in the Surveillance of Developmental Abnormalities", *Canadian Medical Association Journal* 103 (1970):501-505

Milton, I.C. "Contraceptive Practices Past and Present", *The Canadian Nurse* 63 (1967):29-31

Mitton, D.M., and Macleod, S.C., "Recent Advances in the Management of Infertility in Women", *Canadian Family Physician* 16 (1970): 51-56

Mongeau, S., "The Abortion Problem" *McGill Medical Journal* 39 (1971): 81-85

Mongeau, S., and Cloutier, R., *L'avortement* (Montréal: Les Editions du Jour, 1968)

Morgentaler, H., "Report on 5,641 Outpatient Abortions by Vacuum Suction Curettage", *Canadian Medical Association Journal* 109 (1973): 1202-1205

Mountain, E., *Teaching Family Planning in Canadian Schools of Nursing* (Ottawa: Canadian National Conference on Family Planning, 1972)

Mulvaney, J.N., "Voluntary Sterilization: A Lawyer's Perspective", *Medical Aspects of Human Sexuality* 3 (1972): 37-40

National Canadian Conference on Abortion, *A Selected Annotated Bibliography on Abortion*, S. N. Wojcichowsky, ed. (Toronto, St. Michael's College, 1972)

Neubardt, S., *Contraception* (Toronto: Pocket Books, 1968)

"Nurses Have Right to Refuse to Perform Abortions—CNA", *Hospital Administration in Canada* 14 (1972):13

Ontario Association of Professional Social Workers, Committee on Sexuality and Fertility, *Fertility and Sexuality*, Annual Report, 1974/1975 (Toronto)

Ortho Pharmaceutial (Canada) Limited, *An Exploration of the Limitations of Contraception*, proceedings of a conference (Toronto, 1975)

Page, H.G., "Changes in the Fertility Pattern in Quebec", *Canadian Journal of Public Health* 58 (1967):197-203

Palerme, G.R., and Nash, L.D., «Avortement habituel», *L'infirmière canadienne* 61 (1965):644-645

Palko, M.E.; Lennox, R.H.; and McQuarrie, C.R., "Current Status of Family Planning in Canada", *Canadian Journal of Public Health* 62 (1971):509-519

Parakulam, G., "Wives Who Have Unwanted Children" (M.A. thesis, University of Western Ontario, 1970)

Parker, G.E., "Bill C-150: Abortion Reform (1969)", *Criminal Law Quarterly 11:267*

Patriarche, E.M., "The Victoria Family Life Education Program", *Canadian Family Physician* 18 (1972):72-75

Paupst, J.C., *The Pill: A True Perspective* (Toronto: Clarke Irwin, 1973)

Pelrine, E.W., *Morgentaler, the Doctor Who Couldn't Turn Away* (Toronto: Gage Publishing, 1975)

———, *Abortion in Canada* (Toronto: New Press, 1971)

Philippe, P., «Les mesures de la consultation eugénique», *Union Médicale du Canada* 103 (1974): 1100-1107

Philippe, P., and D'ésilets-Boulay, M., «Genetic Epidemiology of Intra-Uterine Mortality: Results of an Analysis in a Rural Population in Quebec», *Union Médicale du Canada* 104 (1975): 763-767

Poland, B.J., "Teenagers, Illicit Drugs and Pregnancy", *Canadian Medical Association Journal* 107 (1972):955-958

Poland, B.J., and Ash, K.A., "The Influence of Recent Use of an Oral Contraceptive on Early Intrauterine Development", *American Journal of Obstetrics and Gynecology* 116 (1973):1138-1142

Poszonyi, J., *A Longitudinal Study of Unmarried Mothers Who Kept Their First Born Children* (Ottawa: Department of National Health and Welfare, 1973)

Potts, D.M., "Liberalization of Abortions and Female Sterilizations", *Canadian Medical Association Journal* 105 (1971):901

Proulx, A., «Position catholique face à l'avortement», *Hôpital Catholique* 2, No.6 (1971):1

Prosser, W., *Handbook of the Law of Torts,* 4th ed. (St. Paul: West Publishing, 1971)

Ptolemy, C.G., "Family Planning Interpretation: The Nurse's Role", *Canadian Journal of Public Health* 60 (1969):402-408

Resch, C., and Robinson, S.C., "Therapeutic Abortion and its Complications in Halifax, Nova Scotia", *The Nova Scotia Medical Bulletin* 52 (1973):67-70

Rinfret, M., et al., *100 femmes devant l'avortement* (Montréal: Centre de Planning Familial du Québec, 1972)

Rioux J., and Collins, J., "Abortion: Attitude and Methods", in *A Practical Manual on Reproduction* (Québec: Les Presses de l'Université Laval, 1973)

"The Risks of Abortion", *Canadian Medical Association Journal* 106 (1972):295-298

Rogers, J.M., and Adams, D.W., "Therapeutic Abortion: A Multidisciplined Approach to Patient Care from Social Work Perspective", *Canadian Journal of Public Health* 64 (1973):254-259

Ross, S.A., "Abortion: The Attitudes of Married Women" (M.A. thesis, University of Western Ontario, London, 1968)

Roulston, T.M., "Abortion: Causes and Management", *Canadian Nurse* 61 (1965):808-810

Rowe, J.F., "Pregnancy Loss Among British Columbia Mothers", *Canadian Journal of Public Health* 64 (1973):25-35

Rozovsky, L.E., "Canadian Law vs. Catholic Hospitals", *Dimensions in Health Services* 51 (1974):12, 14, 16

———, "Morgentaler vs. The Queen", *Dimensions of Health Services* 52 (1975):8-9

———, "Legal Abortions in Canada", *Canadian Hospital* 108 (1971):39-41

Saint-Blanquat, H. de, «Contraception, avortement, démographie», *Revue pour l'infirmière en assistance sociale* 22 (1972):107-115

Salmond, Sir J., *The Law of Torts*, 15th ed. (1969).

Saunders, T.C., "Therapeutic Abortion", *Canadian Medical Association Journal* 105 (1971):638-639

Schlesinger, B., ed., *Family Planning: A Source Book* (Toronto: University of Toronto Press, 1974)

———, "Social Work Education and Family Planning", *The Social Worker* 41 (1973):93-99

Schwenger, C.W., "Abortion in Canada as a Public Health Problem and as a Community Health Measure", *Canadian Journal of Public Health* 64 (1973):223-229

Seguy, B., «Les avortements provoqués», *Revue pour l'infirmière en assistance sociale* 19 (1969):1073-1078

Serenda, M.M., "Abortion: Where Is It At?" *Canadian Bar Association Journal* (N.S.) 3, No. 3 (1972):12

Sisler, G.C., "The Psychiatrist and Therapeutic Abortion", *Canadian Psychiatric Association Journal* 16 (1971):275-277

Skegg, P.D.G., "Consent to Medical Procedures on Minors", *Modern Law Review* 36 (1973): 370

Smiley, C.W., "Sterilization and Therapeutic Abortion Counselling for the Mentally Retarded", *Canadian Psychiatric Association Journal* 19 (1974):65-68

Smith, M., "A Young Pregnant Girl Tells Her Story", *Canadian Nurse* 71 (1975):31-35

Smith, D.F., "Therapeutic Abortion—Should the Law be Changed?", *Nova Scotia Medical Bulletin* 46 (1967):118-120

Smith, K.D., and Wineberg, H.S., "A Survey of Therapeutic Abortion Committees ", *Criminal Law Quarterly* 12(1970):279-306

Smith, S.L., "Canadian Doctors: Victims of the Abortion Laws", *Canadian Family Physician* 16 (1970):58-61

Smyth, H.S., *Biblical Allusions to Life Before Birth* (London: Christian Medical Fellowship Publication, 1975)

Spivak, M., "Therapeutic Abortion—A 12 Year Review at the Toronto General Hospital, 1954-1965", *American Journal of Obstetrics and Gynecology* 97 (1964):316-323

"Statement of the Canadian Bishops on Abortion", *Canadian Hospital* 2 (1971): 1, 8

Starkman, B., "The Control of Life: Unexamined Law and the Life Worth Living", *Osgoode Hall Law Journal* 11 (1973):175

Stephenson, B., "Abortion: An Open Letter", *Canadian Medical Association Journal* 112 (1975): 492, 494, 497

Stone, S., and Scott, K., "The Unwanted Pregnancy", *Canadian Medical Association Journal* 111 (1974):1093-1097

Sullivan, G., and Watt, S., "Legalized Abortion: Myths and Misconceptions", *The Social Worker* 43 (1975):78-86

Summerhill, L., *The Story of Birthright: The Alternative to Abortion* (Kenosha, Wisconsin: Prow Books, 1973)

Szasz, G., "Sex Education of the Family Physician", *Canadian Family Physician* 18 (1972):48-50

"Therapeutic Abortion", *Canadian Medical Association Journal* 105 (1971):638-639

Thomas, W.D.S., "Abortion Deaths in British Columbia: 1955 to 1968", *British Columbia Medical Journal* 12 (1970):111-112

Thomas, W.D.S., and Yuen, B.H., "An Analysis of Maternal Deaths in British Columbia: 1963 to 1970", *Canadian Medical Association Journal* 110 (1974):783-784

Tierney, B., "Abortion: Where It's At, Where It's Going (1972)", *Canadian Bar Association Journal* (N.S.) 3, No. 2 (1972):26

Tittley, J.R., «Le médecin catholique et l'avortement», *Bulletin pour l'infirmière catholique du Canada* 35 (1968):67-70

Todd, I.A.D., "Vasectomy", *Canadian Nurse* 67 (1971):20-23

Toronto, Board of Education, *Human Sexuality: Family Planning, Birth Control, Abortion* (Toronto, 1972)

Toronto, Mayor's Task Force on the Status of Women in Toronto, Steering Committee, *Report on Abortion Counselling Services Currently Operating in Metropolitan Toronto* (Toronto, 1974)

Tyson, J.E.A., and Washburn, H.H., "Canadian County-Sponsored Family Planning: A Second Survey", *Obstetrics and Gynecology* 35 (1970):377-380

"United Church Advocates Abortion Law Change", *Canadian Hospital* 48 (1971):10

"Uphold Nurses' Right to Refuse to Take Part in Abortion Cases", *Hospital Administration of Canada* 13, No. 10 (1971):13

Veevers, J., "The Liberalization of the Canadian Abortion Laws", in C. L. Boydell, ed., *Critical Issues in Canadian Society* (Toronto: Holt, Rinehart and Winston, 1971), pp. 33-39

Verdoux, Ch., «Avortement ou contraception», *Revue pour l'infirmière* 22 (1972):117-121

Wadlington, W., "Minors and Health Care: The Age of Consent", *Osgoode Hall Law Journal* 11 (1973):115

Waisglass, B. R., "The Sexual Behaviour of 'Street People' in Ottawa: A Report of a Survey Conducted in the Summer of 1971", *University of Ottawa Medical Journal* 2:9

Warnes, H., "Delayed After-Effects of Medically Induced Abortion", *Canadian Psychiatric Association Journal* 16 (1971):537-541

Watters, W.W., *Compulsory Parenthood: The Truth About Abortion* (Toronto: McClelland and Stewart, 1976)

Watts, J.M.E., "An Exploratory Study to Identify Preconception Contraceptive Patterns of Abortion Patients" (M.S.N. thesis, University of British Columbia, Vancouver, 1974)

Werman, D., and Spencer, R.F., "Some Problems of Evaluation of Women for Therapeutic Abortion", *Canadian Psychiatric Association Journal* 17 (1972):249-251

Wilson, E., "The Organization and Function of Therapeutic Abortion Committees", *Canadian Hospital* 48 (1971):38-40

Wilson, R.; Moss, G.W.O.; Laugharne, E.G.; and Read, E.M., "Family Planning in a Co-ordinated Hospital and Community Health Setting", *Canadian Journal of Public Health* 58 (1967): 527-534

Wolfish, M.G., "Adolescent Sexuality: Counselling, Contraception, Pregnancy", *Clinical Pediatrics* 12 (1973):226-231

Young, G.S., "Family Life Services in Catholic Hospitals in Ontario" (Master's thesis, University of Toronto, Toronto, 1975)

Yuzpe, A.A.; Allen, H.H.; and Collins, J.A., "Total Sterilization: Methodology, Post-Operative Management and Follow-up of 2,934 Cases", *Canadian Medical Association Journal* 107 (1972):115-117

# Appendix 3

## THE ABORTION LAW

**Criminal Code, Revised Statutes of Canada 1970, Chapter c-34. Section 251.**

**251.** (1) Every one who, with intent to procure the miscarriage of a female person, whether or not she is pregnant, uses any means for the purpose of carrying out his intention is guilty of an indictable offence and is liable to imprisonment for life.

(2) 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.

(3) In this section, "means" includes

(*a*) the administration of a drug or other noxious thing,

(*b*) the use of an instrument, and

(*c*) manipulation of any kind.

(4) Subsections (1) and (2) do not apply to

(*a*) a qualified medical practitioner, other than a member of a therapeutic abortion committee for any hospital, who in good faith uses in an accredited or approved hospital any means for the purpose of carrying out his intention to procure the miscarriage of a female person, or

(*b*) a female person who, being pregnant, permits a qualified medical practitoner to use in an accredited or approved hospital any means described in paragraph (*a*) for the purpose of carrying out her intention to procure her own miscarriage,

if, before the use of those means, the therapeutic abortion committee for that accredited or approved hospital, by a majority of the members of the committee and at a meeting of the committee at which the case of such female person has been reviewed,

(*c*) has by certificate in writing stated that in its opinion the continuation of the pregnancy of such female person would or would be likely to endanger her life or health, and

(*d*) has caused a copy of such certificate to be given to the qualified medical practitioner.

(5) The Minister of Health of a province may by order

(*a*) require a therapeutic abortion committee for any hospital in that province, or any member thereof, to furnish to him a copy of any certificate described in paragraph (4) (*c*) issued by that committee, together with such other information relating to the circumstances surrounding the issue of that certificate as he may require, or

(*b*) require a medical practitioner who, in that province, has procured the miscarriage of any female person named in a certificate described in paragraph (4) (*c*), to furnish to him a copy of that certificate, together with such other information relating to the procuring of the miscarriage as he may require.

(6) For the purposes of subsections (4) and (5) and this subsection

"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;

"approved hospital" means a hospital in a province approved for the purposes of this section by the Minister of Health of that province;

"board" means the board of governors, management or directors, or the trustees, commission or other person or group of persons having the control and management of an accredited or approved hospital;

"Minister of Health" means

(*a*) in the Provinces of Ontario, Quebec, New Brunswick, Manitoba, Alberta, Newfoundland and Prince Edward Island, the Minister of Health,

(*b*) in the Province of British Columbia, the Minister of Health Services and Hospital Insurance,

(*c*) in the Provinces of Nova Scotia and Saskatchewan, the Minister of Public Health, and

(*d*) in the Yukon Territory and the Northwest Territories, the Minister of National Health and Welfare;

"qualified medical practitioner" means a person entitled to engage in the practice of medicine under the laws of the province in which the hospital referred to in subsection (4) is situated;

"therapeutic abortion committee" for any hospital means a committee, comprised of not less than three members each of whom is a qualified medical

practitioner, appointed by the board of that hospital for the purpose of considering and determining questions relating to terminations of pregnancy within that hospital.

(7) 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. 1953-54, c. 51, s. 237; 1968-69, c. 38, s. 18.