Report of the Committee on the Operation of the Abortion Law

1977

Available by mail from

Printing and Publishing
Supply and Services Canada
Ottawa, Canada K1A 0S9

or through your bookseller.

Catalogue No. J2-30/1977
ISBN 0-660-00529-8

Price: Canada: $6.75
Other countries: $8.10

Price subject to change without notice.

Committee on the Operation
of the Abortion Law

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

January, 1977

Dear Mr. Basford:

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

Robin F. Badgley

Robin F. Badgley
Chairman

Denyse Fortin Caron

Denyse Fortin Caron

Marion G. Powell

Marion G. Powell

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Chapter 1

Work of the Committee

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

Establishment of the Committee

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

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

Collection of information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> Your questionnaire is excellent! I am very impressed. Your questions are very searching and very well designed to draw out a person's opinion and thoughts. Good luck in your fact-finding.
>
> • • •
>
> None of the government's business.
>
> • • •
>
> I think this is a useful Committee. I hope these results will be published. We must continue to examine and explore the issues—not avoid them.
>
> • • •
>
> After you get your salaries, appoint a Royal Commission, then shelf it with the other crap.
>
> • • •
>
> The Committee is approaching a difficult area very reasonably. We need more information and less emotion.
>
> • • •
>
> This questionnaire is slanted and not impartial at all. With great reservation I submit this information realizing I may be giving fuel to people who can quickly shade it to their own cause.

Good questionnaire—covers most if not all the bases.

• • •

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

• • •

Send out questionnaires like this to all the doctors.

• • •

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

• • •

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

• • •

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

• • •

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

• • •

1) Read the Lane Report.[1]

2) Grow up!

• • •

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Confidentiality of information

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

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

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

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

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

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

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

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

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

Staff of the Committee

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

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

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Chapter 2

Abortion in Canada

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 3
Terms of Reference and Summary of Findings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Related findings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Three meetings of the inter-departmental committee were held.

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

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

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

(https://www.law.utoronto.ca/sites/default/files/documents/reprohealth/badgley-report-480-pages-first-half.pdf) Accessed 2021-12-14

Part II

Findings

Chapter 4

Induced Abortion: Classification and Number

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

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

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

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

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

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

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

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

Demographic trends

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Classification of abortions

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

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

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

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

650—Abortion without mention of sepsis or toxemia

651—Abortion with sepsis

652—Abortion with toxemia without mention of sepsis.

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

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

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

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

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

640—Abortion induced for medical indications.

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

641—Abortion induced for other legal indications.

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

642—Abortion induced for other reasons.

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

643—Spontaneous abortion.

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

Habitual abortion.

Diagnosis of miscarriage.

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

644—Abortion not specified as induced or spontaneous.

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

645—Other abortion.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) No acknowledgement of communication—one province;

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

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

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

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

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

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

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

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

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

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

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

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

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

I. General Items

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

II. Demographic Items Concerning the Patient

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

III. Medical Items Concerning the Patient

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Indices and trends: 1961-1974

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

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

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

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

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

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

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

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

TABLE 4.1

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

STATISTICS CANADA

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

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

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

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

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

Induced, spontaneous, and other abortions

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

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

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

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

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

644—Abortion not specified as induced or spontaneous.

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

The listing for category 645 is:

645—Other abortion

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

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

TABLE 4.2

ABORTION RATES PER 1000 POPULATION, 1973

STATISTICS CANADA

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

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

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

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

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

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

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

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

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

TABLE 4.3

ABORTIONS PER 1000 LIVE BIRTHS, 1973

STATISTICS CANADA

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

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

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

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

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

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

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

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

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

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

TABLE 4.4

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

NATIONAL HOSPITAL SURVEY

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

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

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

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

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

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

Illegal abortions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TABLE 4.5

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

STATISTICS CANADA

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

*Justice Statistics Division, Statistics Canada.

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

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

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

TABLE 4.6

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Out-of-country abortions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Maritimes to New England and New York City.

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

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

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

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

   Illinois: Chicago.

   Michigan: Ann Arbor, Detroit, Grand Rapids.

   Upstate New York: Buffalo.

4. Manitoba to Midwest States.

   Minnesota: Minneapolis, St. Louis Park.

   North Dakota: Grand Forks.

5. Western Provinces to Northwest States.

   California: Oakland, San Jose.

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

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

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

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

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

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

TABLE 4.7

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

SURVEY OF CENTRES IN THE UNITED STATES

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

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

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

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

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

Volume of induced abortions

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

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

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

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

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

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

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

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

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

Chapter 5

Provincial Requirements and Hospital Practices

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

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

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

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

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

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

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

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

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

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

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

Terms of the abortion law

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

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

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

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

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

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

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

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

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

Accredited hospitals

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

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

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

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

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

Medicine
Obstetrics-Gynaecology*
Paediatrics
Psychiatry
Surgery*

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

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

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

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

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

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

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

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

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

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

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

TABLE 5.1

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

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

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

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

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

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

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

Provincial requirements

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

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

1. Beds—approximately 100 beds or more;

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

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

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

TABLE 5.2

DISTRIBUTION OF CIVILIAN HOSPITALS BY PROVINCE, 1975*

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

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

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

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

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

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

TABLE 5.3

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Specialty and private hospitals

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

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

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

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

TABLE 5.4

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

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

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

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

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

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

Requirements for federal hospitals and services

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

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

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

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

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

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

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

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

2. facilities and staffing for major surgery, including

3. facilities for emergency blood transfusion.

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

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

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

Hospital practices

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

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

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

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

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

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

Listing of therapeutic abortion committees

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

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

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

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

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

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

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

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

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

Eligible hospitals

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

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

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

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

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

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

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

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

Chapter 6

Distribution and Availability

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

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

Distribution of eligible hospitals

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

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

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

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

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

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

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

TABLE 6.1

POPULATION SERVED BY ELIGIBLE GENERAL HOSPITALS*

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

* Based on 1971 Census and 1976 distribution of hospitals.

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

Hospitals with committees

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Eligible hospitals without committees

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

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

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

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

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

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

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

• • •

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

• • •

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

• • •

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

• • •

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

• • •

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

• • •

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

• • •

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

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

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

• • •

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

• • •

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In Salvation Army Hospitals it is required that:

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

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

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

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

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

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

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

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

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

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

Preamble

As Christians we wish to affirm:

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

We also affirm that:

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

2. *Abortion*

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

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

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

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

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

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

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

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

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

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

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

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

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

• • •

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

• • •

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

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

• • •

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

• • •

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

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

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

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

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

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

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

• • •

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

• • •

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

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

Ownership of hospitals

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

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

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

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

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

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

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

• • •

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

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

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

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

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

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

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

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

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

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

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

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

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

Public knowledge of induced abortion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TABLE 6.2

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

NATIONAL POPULATION SURVEY

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

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

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

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

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

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

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

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

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

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

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

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

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

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[5] *Appendix 1: Statistical Notes and Tables*, see Note 3 and Tables 15, 18 and 19. The results of factor analysis and multiple regression analyses are the basis of these findings.

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

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

Physicians doing induced abortions

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

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

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

TABLE 6.3

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

PROVINCIAL HEALTH DEPARTMENTS

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

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

TABLE 6.4

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

PROVINCIAL HEALTH DEPARTMENTS

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

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

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

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

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

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

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

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

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

TABLE 6.5

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

Fiscal Year 1974-75*

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

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

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

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

Distribution of accessible services

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

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

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

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

TABLE 6.6

DISTRIBUTION OF HOSPITAL SERVICES
FOR THERAPEUTIC ABORTION
BY REGION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 7

Patient Pathways

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

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

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

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

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

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

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

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

Pathway one: Abortion in Canadian hospitals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pathway two: Community agencies

Approximately 1 out of 5 women in the national patient survey had contacted one of a number of community agencies about their pregnancies. This step accounted for less than 1 percent of the difference in the length of gestation of all of these patients, or in other words, for most of the patients in the survey, this step neither speeded up nor delayed their obtaining an induced abortion in a Canadian hospital. But these community agencies served a broader group of women, some of whom were advised to go to the United States to obtain an abortion, while others subsequently bore children.

The most frequently used source turned to by 1 out of 14 patients in the national patient survey (7.1 percent) were the branches of the Planned Parenthood Federation of Canada. This resource was used somewhat more by single women or women who had been previously married than by married women. The next most frequently used counselling service which had been used by the abortion patients were the various abortion referral agencies whose distribution was limited primarily to Quebec and Ontario. These agencies, used by 1 out of 15 patients (6.5 percent), drew more of their clients from among women who had a college or university education than from women with an elementary school training. The remaining sources of counsel were turned to by

only a handful of the patients, with 4.0 percent turning to general social service agencies; 2.5 percent to school nurses or counsellors; 0.9 percent to Birthright; and 0.5 percent to a religious leader such as a priest, a rabbi, or a minister. What emerges from these findings is that most of the women who decided to have an abortion in Canada did not turn to any of these community resources, but they made their decisions to obtain this operation either by themselves or through discussion with their families and friends. While the contacts made by the patients with community agencies provided some assistance, they served an "expediting" function, that of routing patients to hospitals, advising them on the selection of physicians who should be consulted about an abortion, or recommending that they go to the United States for this purpose. The type of counselling which was provided is illustrated by the experiences of women using these services—some of whom were well satisfied, while others left feeling they had not been fully or well advised.

> I was taken to a private room at the back of the offices where I was interviewed by a counsellor. I advised the counsellor that I was frightened and upset as I thought I was pregnant. The counsellor asked me whether I had had a pregnancy test. When I told her I had not, she suggested that I could go to a drugstore, the _____ Clinic (which she advised me was free), or to a doctor. She suggested I should go the next day, but from the description of my symptoms she stated that she thought that I was very likely pregnant.
>
> The counsellor asked me what I planned to do, and I replied that I did not know and that I was confused and scared. She told me that I could: (1) keep the baby, or, (2) have an abortion. I told the counsellor that I knew nothing about abortion and she then proceeded to describe what she called the two basic kinds of abortion:
>
> (a) D & C—the counsellor referred to this as "dusting and cleaning", and emphasized it was a very simple and commonly used procedure in which the womb was scraped and that there would be no serious repercussions to me.
>
> (b) Saline abortion—which is the injection of a salt solution into the fluid surrounding the baby. She stated that she would not advise this type of abortion because it was like an actual birth, as one goes into contractions, i.e., labour, but the baby is born dead and the hospital stay is longer.
>
> The counsellor urged that I shouldn't leave it too long, and that if I decided to have an abortion, I should do so very soon—before I was three months pregnant. She further advised me that I would have no problem in getting an abortion in _____ since all major hospitals, except the Catholic ones, performed abortions.
>
> I was also advised that if I went to _____ hospital, they would not use the word "abortion" on my chart, but would use the word "family planning", since she stated that abortion means "planning a family". She also stated that she thought that the _____ hospital does about twelve abortions every two weeks, and that I would be placed in the gynaecology wing and that no one would know me there.
>
> The counsellor then proceeded to fill in a questionnaire in which she recorded my birth date, address, religion, income bracket, education, profession, and type of birth control I had used.

The counsellor next explained the female anatomy and the various methods of birth control—she mentioned specifically the I.U.D., foam, jelly, condom, and the diaphragm. She showed me a chart of the female anatomy and what birth control devices looked like. I found her explanation to be somewhat less than clear. Before I left the premises, the counsellor gave me some pamphlets on birth control.

• • •

I advised the counsellor that I thought I was pregnant and wanted to talk the matter over with someone. The counsellor advised me that I could: (1) keep the baby; (2) have an abortion, and that she could not tell me what to do. I then asked the counsellor what was involved in an abortion and she stated that it was an easy operation and would only take five minutes and that, statistically speaking, it was safer than childbirth. She further stated that it was as easy as having tonsils or an appendix removed, and that my only complication might be feeling "blue" for a few days afterwards. She also stated that abortion was legal and that I did not have to feel guilty about it.

The counsellor advised me that I could either have an abortion at _____ or, at _____ in _____ where I would have to stay overnight. Or, I could go to the _____ in the United States, which she advised me would be preferable in my case since it was faster and I could be in and out in a day.

The counsellor then advised me that if I chose to have an abortion in _____ that the therapeutic abortion committees, in the aforementioned hospitals, were merely a formality and that I could obtain an abortion at _____ in three weeks or less, but at _____ it would take longer since the latter was very busy since it was doing the bulk of the abortions in _____ . I then discussed with the counsellor the question of _____ paying for the abortion and my husband finding out about the abortion. She advised me that if I had a tubal ligation performed at the same time as the abortion, the doctor would then not have to record my abortion as such, but that the _____ computer would register the abortion as a sterilization, with the result that my husband would not have to know about my abortion.

The counsellor, then, for a period of approximately 5 to 7 minutes, discussed birth control with me. She described the pill, I.U.D., diaphragm and foam. She also showed me a plastic model of the female anatomy and indicated to me how the birth control devices were used.

The counsellor then completed a form in which she recorded my name, birth date, doctor's name, income, religion, education, place of employment, and type of birth control I had been using.

The counsellor also gave me a list of doctors' names and their addresses. Apart from the time spent discussing birth control and completing the above mentioned form, the entire interview was directed to the discussion of abortion. I was never counselled about the possibility of keeping the child and no other alternative, except abortion, was discussed with me.

The services of the referral agencies were provided in most instances without charge to the women who sought them out. In the national patient survey, women who obtained abortions were asked if they had paid fees for the assistance which they had been given by community services. While most had not been charged for this assistance, 1 out of 10 women (10.7 percent) had paid

for these services, a factor which contributed to the overall expense of obtaining an abortion. Among a group of four agencies (community agencies, Planned Parenthood, Séréna, and commercial agencies), most (79.0 percent) distributed pamphlets to make their services known to the public. A second means of publicizing an agency's services was through listings in telephone directories. Three out of four (73.0 percent) agencies were listed, usually under the heading of family planning, contraception information, birth control, as well as the actual title of the agency. The heading of birth control services is sometimes given in the yellow pages of telephone directories. Advertising in newspapers and public places, such as public transit, was done by half (50.0 percent) of the community agencies. The Planned Parenthood Federation of Canada through a national birth control advertising campaign used this form of publicity. Advertisements in the personal columns of newspapers were widely used by Séréna (82.3 percent) and the commercial agencies. Commercial agencies usually paid for larger advertisements which listed their services. Public meetings including television and radio guest appearances were used by 61.2 percent of the agencies.

Many of the agencies directly contacted other community services to make known their availability and the types of services which they offered. Two-thirds (64.8 percent) of the Planned Parenthood groups, many of the Séréna groups (58.8 percent), and approximately half of the community agencies (42.5 percent) had contacts with other community resources. Additional resources most frequently contacted were social and family service agencies. Of these agencies, 51.0 percent had contacts with social agencies, while 39.0 percent had regular contacts with health agencies including family planning clinics and public health agencies. Other community resources including ministers, churches, Birthright, Children's Aid societies were routinely contacted by 29.0 percent of the agencies.

These centres were asked what difficulties had been encountered by the women seeking abortions who had used their services. Among the 214 agencies the problems listed were: 82.2 percent, length of gestation set by the hospitals; 75.0 percent, consent of minors or spouses; 73.9 percent, requirements set by hospital therapeutic abortion committees; 68.1 percent, the financial difficulties of women; 64.3 percent, obtaining an appointment with a physician or involving the advice given by a physician; and 57.8 percent, the distance travelled by the women seeking an abortion.

> In our province many women live in rural areas where they are isolated from access to the therapeutic abortion committee or in many cases isolated from information. Even in 1975 women still called asking if abortion is legal.
>
> • • •
>
> Hospital _____ in our city treats all therapeutic abortion applications as emergencies, but this is just not the case in the other hospitals. For example, Hospital _____ requires all patients to consult a psychiatrist prior to making application.
>
> • • •
>
> In this province the abortion law is not operating. Only a minute minority of hospitals have set up therapeutic abortion committees. Actually, no such

committee has been set up outside of _____ . And in City _____ itself, only one hospital performs a sizeable number of abortions.

• • •

Over the last year we have had two instances of local M.D.s telling clients some pretty gross misinformation about abortions. One M.D. told a patient that she would bleed to death if she had an abortion. Another M.D. told a patient that she would be sterile if she had an abortion.

• • •

Women do not even know what the legal procedures are or how involved they are. Learning about the red tape and following along it is one more difficulty for a woman with already more difficulties than she can handle.

• • •

The _____ Hospital has placed geographic and residency restrictions on therapeutic abortion cases. This has put a great hardship on women in the south of the province as the committees in _____ have always been extremely harsh in their judgments. Many _____ women have found it necessary to give a false residence and apply through the _____ committee or to fly to the United States after having spent prior time unsuccessfully applying to the _____ committee.

• • •

Our follow-up on abortions shows that in general women who have abortions are placed on the maternity ward and that they are treated unsympathetically, if not downright ignored by nursing and service staff.

• • •

We have found that in general, M.D.s are reluctant to discuss abortion as an alternative to unplanned/unwanted pregnancy, either because of moral stance or lack of time.

• • •

Quite a few of the social agencies and doctors we have talked with are very concerned about the "blacklash" they are expecting from hospitals in _____ . That hospital is starting to resent being called an "abortion mill", and rightfully so. The hospital committee in _____ is, at best, a hit and miss effort, depending on the personal beliefs of whatever doctors happen to be on the committee in any three month period. As all doctors are required to serve at one time or another, it is conceivable to have a couple of anti-abortionist doctors serving together, thereby allowing no abortions for a three month period. _____ doctors don't use _____ Hospital.

• • •

We have learned directly of one doctor in particular in this province who forced his abortion patients to sign sterilization papers, or no abortion.

• • •

We have found women who come in for an abortion past 12 weeks are invariably from out-of-town, particularly from _____ . Several

of these women have talked about the difficulty getting an abortion in that city, i.e., doctor will not refer, doctor refers to another doctor who will not perform the abortion, doctor charges $250 for a D&C (although this is covered by _____).

• • •

This Hospital has geographical limits and out-of-town women must lie about their address to be considered by the therapeutic abortion committee. There is only one doctor that I am aware of, that does abortion past 12 weeks . . . he will perform prostaglandin abortions.

The 214 agencies which variously provided for pregnancy and abortion counselling (125 community agencies, 76 Planned Parenthood, and 13 commercial agencies) were located in 86 cities across Canada.

TABLE 7.1

POPULATION SERVED BY COMMUNITY RESOURCES
FOR PREGNANCY COUNSELLING AND ABORTION REFERRAL*

COMMUNITY AGENCY SURVEY

Province	Number of Resources	Number of Communities Served	Proportion of Population Served*
			percent
Newfoundland	8	4	20.2
Prince Edward Island	1	1	17.1
Nova Scotia	7	4	31.0
New Brunswick	12	10	33.1
Quebec	32	11	52.5
Ontario	62	24	60.4
Manitoba	15	2	57.3
Saskatchewan	18	9	40.6
Alberta	13	3	54.2
British Columbia	38	15	55.9
Yukon	5	1	61.0
Northwest Territories	3	2	25.3
CANADA	214	86	53.2

* Based on the size of the communities in which the agencies were located; 84.3 percent of the individuals who were served came from within a radius of 20 miles. These resources were located in communities which made up 53.2 percent of the population and their distribution varied from province to province. The proportion of the Canadian population that had immediate access to these agencies was the highest in Ontario. It was below the national average in the Maritimes. There were 62 agencies in 24 Ontario communities serving 60.4 percent of that province's population. In New Brunswick, 12 agencies in 11 communities reached an estimated 33.1 percent of the population. Seven of these agencies in four communities in Nova Scotia served 31.0 percent of its population. In Prince Edward Island, an agency operated in one city which had 17.1 percent of the province's population. Newfoundland had eight community agencies in four cities which totalled 20.2 percent of its population. The proportion of the population in the western provinces which had immediate access to these agencies for abortion counselling and referral varied little from the national average. In British Columbia, 55.9 percent of the population had access to 38 resources in 15 centres. In Alberta, 13 programs operated in three cities which had 54.2 percent of the population. With 18 agencies in nine cities, 40.6 percent of Saskatchewan's population had immediate access to these agencies.

The majority of the community agencies were located in large cities where hospitals had established therapeutic abortion committees, while their distribution was negligible in cities where no abortions were done by local hospitals, except in Quebec where most therapeutic abortions were done in two cities and the agencies were located in 11 centres. As a rule counselling and referral agencies served their local community first. On the average 84.3 percent of their clientele came from within 20 miles, while the remainder (15.7 percent) came from smaller towns in the immediate vicinity. There were no significant provincial variations in this respect. Only one agency in Saskatchewan and four in Quebec reported there was a trend involving more women coming from other large centres.

When the profile of the women who were served by these agencies is seen from the perspective of the full range of their clients, a somewhat comparable trend emerges which is similar to the experience of the women in the national patient survey. Among the women who had contacted an agency in 1975, 63.8 percent were single and most were young women; 72.9 percent of the women seen by the agencies were under 25 years, and 1.2 percent were under 15 years. Two out of five (38.8 percent) were between 15 and 19 years; 32.9 percent, between 20 and 24 years; and 27.1 percent were 25 years and older.

Among the community referral agencies surveyed by the Committee, 45 agencies had referred a total of 4,700 women to Canadian hospitals in 1975. This group included some of the larger referral agencies which accounted for two-thirds of the abortion referrals to Canadian hospitals. These agencies may have made an estimated total of 7,500 referrals for abortion in 1975 to Canadian hospitals. Among the agencies which provided family planning information, 83.7 percent routinely referred women to hospitals in the communities where they were located. The level of contact between community agencies and local resources for abortion was the same across Canada, except in Quebec and Saskatchewan where the rates were slightly lower. In Quebec 62.5 percent of the agencies had contacts with local resources and among the agencies in Saskatchewan, 66.7 percent referred women to local hospitals. Among all of these agencies, 47.8 percent had no contact with hospitals in other areas, while 52.2 percent dealt occasionally with out-of-town physicians or hospitals.

Most of the community agencies (66.1 percent) at least occasionally referred women to out-of-country abortion facilities. Compared to the national average, fewer agencies in the western provinces, where the reported rates of therapeutic abortions were higher, followed this procedure. In comparison, community agencies in Ontario, Quebec and the Maritimes more often referred women to clinics in the United States. In British Columbia 55.5 percent of the agencies which were surveyed directed clients to clinics in the United States, and this was done by 40.0 percent of the agencies in Alberta, 37.5 percent of the agencies in Saskatchewan, and 40.0 percent of the agencies in Manitoba. In Ontario, 82.4 percent of the agencies referred women across the border, as did a similarly high proportion of all of the agencies in Quebec and the Maritimes.

Pathway three: Student health services

About 1 out of 5 Canadians between the ages of 18 and 24 years are students in post-secondary institutions and about 40.0 percent of this number are women who are studying at colleges or universities. The student health services of 211 post-secondary institutions (56 universities and 155 community colleges) were surveyed, with replies being received from 75.0 percent of the university health services and from 59.3 percent of the community colleges. While most academic institutions had standard health services, 12 of the colleges and universities in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario and Newfoundland had one or more additional clinical or counselling services for female students administered by students' councils.

The majority of the student health services (86.5 percent) operated during regular office hours. A few (11.6 percent) could be reached in the evening, and the remainder were available on a part-time basis. Their services included: 82.8 percent, pregnancy counselling; and 80.6 percent, abortion referral. Among the health services which were reported to be inadequate were: 44.4 percent, abortion facilities; 27.8 percent, pregnancy counselling; 22.2 percent, sexual and contraceptive information; and 5.5 percent, abortion counselling. The majority of the schools (76.4 percent) suggested that such services should be paid for by government. Approximately one-fifth (28.6 percent) felt that these services were best provided by trained volunteer counsellors in a family planning centre. Three out of four of the colleges and universities had made some abortion referrals during 1975. Most of these referrals were made by student health services in 26 large universities in British Columbia, Alberta, Ontario, and Quebec, and community colleges in two metropolitan centres. These schools accounted for 78.0 percent of all referrals for abortion in Canada reported by student health services. The results of the national patient survey found that a minority (7.4 percent) of the students who had an induced abortion in Canadian hospitals had gone to these health services and twice as many (16.7 percent) had contacted a community referral agency. The majority had directly contacted a physician.

Among the students who said they had seen a college or university counsellor about their pregnancy, the largest group was between 20 and 24 years (54.9 percent), followed by students between 18 and 19 years (37.3 percent). Students over age 25 were the group which least used these services (7.8 percent). The reluctance of students to use student health services for abortion counselling and referral stems from a concern to preserve their privacy and from fear that their academic standing may be affected. In particular, students attending small institutions may prefer to discuss their pregnancy elsewhere. For students attending larger institutions, the health services of these universities may be one of a number of sources of referral for abortion which are available.

> It is my impression that fewer students are using university resources in the last two years. In that time period, community resources have become more numerous and more visible.

> In 1975 I received approximately 15 requests for information about abortion facilities. I know and hear of many students who have taken action on their own. It is very difficult to assess the numbers of women at this university who have sought an abortion from just official reports.
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> My experience has been that a community referral agency in our city does an excellent job. I know that there are less reputable referral sources that the students use. I often hear about their experiences 6 or 8 months after the fact. That is why I believe it is extremely important that abortion be readily obtainable. One of the major difficulties I have with students is their concern over parental reactions. Because of this, they sometimes refuse to use a hospital in our province, because of fears with billing and therefore possible information to their parents.

The majority of the student health services (76.0 percent) handled requests for abortion on a local basis. The remainder (24.0 percent) directed requests to out-of-town hospitals or to abortion facilities in the United States. The proportion of institutions sending students outside of their communities for an induced abortion was lower than average in the western provinces and Ontario. It rose in Quebec and New Brunswick, where over half of the institutions surveyed used facilities which were not located in their own communities. A majority of the health services of colleges and universities knew of the activities of community referral agencies in their own communities or in their region. One out of ten (9.7 percent) referred students to such agencies for abortion counselling or referral.

Based on the findings of the national patient survey, many students who had contacted their health services felt they had been given practical information about abortion or they had been sent to a physician who would refer their request to a hospital with a therapeutic abortion committee (55.8 percent). For 16.2 percent of the students, arrangements had been made at a hospital by the student health services. Approximately 1 out of 7 of the students were referred to a community agency for counselling and referral.

Approximately 2 out of 3 academic health services (66.2 percent) mentioned the length of gestation and the requirements set by hospital therapeutic abortion committees as problems which they routinely encountered. Over half (58.1 percent) of the referring health services said there were financial problems for the students seeking an induced abortion. Two out of five of the institutions complained about the distribution of resources for abortion (41.8 percent) or their lack of availability (40.5 percent), although some of these universities were affiliated with teaching hospitals which did a sizeable proportion of all abortions which were performed each year. The need for consent from a husband or a parent ranked lowest in the listing of difficulties which were cited, with 39.4 percent of the academic institutions reporting it caused problems when abortion referrals were made.

Pathway four: To the United States

Two-thirds (66.1 percent) of the community agencies surveyed by the Committee had advised some of their clients to get an abortion in the United States. Community agencies recommended this course to women if: (1) they felt their pregnancy exceeded the gestation limits of local Canadian hospitals (77.8 percent); (2) their application had been refused by a therapeutic abortion committee (75.8 percent); and (3) they did not want to be identified by staff or other patients in a hospital (71.4 percent). Other reasons which were less often cited for these out-of-country referrals were: 67.6 percent, faster procedure and close to the United States; 53.3 percent, problems of consent; 53.1 percent, repeat abortion; 47.1 percent, difficulty in obtaining a medical appointment; 40.0 percent, financial difficulties; and 39.4 percent, no therapeutic abortion committee established at local hospitals.

Those women who go by referral from us do so because:

(a) they have already had an abortion and are afraid to apply again.

(b) they have enough money and prefer to avoid the time and inconvenience involved in seeing three doctors and awaiting a Committee decision.

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It is impossible for one hospital in a province to handle the total number of requests. A great number of women in our province are forced to seek abortions in the U.S. This is costly and excludes the women under a certain income.

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Women who choose not to submit to the humiliation and red tape, and who have funds, often opt for a clinic in the United States. Women who were turned down by the therapeutic abortion committee here and who could afford to do so travelled to the United States. Total cost for air fare, lodging and medical fees was over $300 and could amount to $1000 in the case of saline termination requiring hospital stay.

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Since _____ abortions are only $75, it often makes sense for women who will have to pay at least $50 in our city to go to the U.S. where it is done without waiting and red tape.

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It is much easier on the woman concerned to go to the States which is probably why the law exists the way it is anyway. Statistics don't look so bad for Canada that way. However, that discriminates against women who cannot afford an abortion outside of Canada.

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There are occasions when a patient cannot book an appointment for nearly a month because the nurse states that the doctor is too busy. Of course, the chances of the client receiving safe, early abortion then are practically zero,

> and our agency has no choice but to refer the woman to a clinic in the United States. We have been experiencing these kinds of difficulties for several years but the hospitals do not appear to have any particular desire to change their procedures to lessen the time for an abortion.
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> When a woman is too far advanced to go through the long process of having all the tests and filling in all the forms to be done here before she passes the time limit, we give her several referrals in the U.S. from which to choose.
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> One problem we face constantly is that almost all doctors in our city doing abortions overbill the woman anywhere from $50 to $200 cash on top of medical coverage. This delays abortions, takes time and causes more risk to the woman. We have only one doctor who does not participate in this extortion.

Although to a lesser extent than community referral agencies, the health services of colleges and universities also used out-of-country abortion facilities. The circumstances when student health services referred students to the United States included: 47.5 percent, non-approval for abortion by a therapeutic abortion committee; 46.2 percent, the preservation of anonymity; 43.6 percent, difficulty in obtaining a medical appointment; 40.7 percent, length of gestation; 40.0 percent, faster procedure and close to the United States; 29.1 percent, no local hospital with a therapeutic abortion committee; 24.5 percent, consent of parents; and 23.1 percent, repeat abortion.

A portrait of Canadian women who went to the United States to get an abortion was obtained from a small number of patients who were treated at eight clinics in five states. These 237 women came from seven provinces and the Northwest Territories. In comparison with patients who had abortions in Canadian hospitals there were fewer women who were younger (16.1 percent under 18 years) or older (8.9 percent over 35 years). Most of these women were single (68.8 percent), fewer were married (18.6 percent), and some were divorced, separated, and engaged to be married. The experience of these women with induced abortion provides an insight into why a substantial number of Canadians leave the country for this procedure. While they were only a handful of the several thousand women who went abroad for this purpose each year, the information which they gave the Committee concurred well with its general findings related to induced abortion. Like other Canadian women who had had induced abortions, most of these patients found it difficult to discuss openly their experience, and some were afraid their opinions and the fact they had left the country might become known.

Among a small group of women from whom information was obtained, most (85.8 percent) who went to the United States would have preferred to have had an abortion in Canada, if they had known or had been told this option was available. Going to the United States was expensive in terms of travel costs and the fees which they were charged for an abortion. Most of the patients (94.4 percent) paid for this operation themselves. Only a few indicated that they planned to seek reimbursement under national health insurance. In some

instances the trips involved several hundred miles, sometimes several thousand miles in the case of patients in the survey who lived in Newfoundland or the Northwest Territories who went to New York City. The main reason why these Canadian women went to the United States for an induced abortion was that they did not know how to obtain an abortion in Canada. The agencies or individuals whom they contacted either dissuaded them from trying to get an abortion in this country, told them it was too difficult or illegal, or inaccurately advised them on the procedures and practices involved in getting an abortion in Canada. From the perspective of patients who went to the United States to get an abortion, the counsel they got from physicians and agencies was a mixture of professional advice, moral values, and personal opinion.

Once they had made the decision to terminate their pregnancy, most of these women had turned to physicians for further counsel and for information as to how an abortion might be obtained. Three-quarters (75.2 percent) said they had a usual family doctor, but fewer than half (40.8 percent) had consulted these physicians whom they had already known. The remainder who had seen physicians consulted other family physicians or obstetrician-gynaecologists whom they had not known before, or went to clinics.

Most of these patients (74.4 percent) had seen one or more physicians in Canada about their pregnancy. Likewise, most of the patients had asked their doctors for assistance and advice in getting an abortion. Some of the patients had consulted more than one physician about their request, with 20.0 percent having seen two physicians, 5.1 percent three physicians, and 6.0 percent four or more physicians. The opinion of their physicians and the advice they gave was the single factor most responsible for the decision by most of these women to go to the United States for an abortion. A small number had found it difficult to get appointments for this purpose at hospital clinics, and 12.0 percent said that applications made on their behalf to hospital therapeutic abortion committees had not been approved.

The counsel given by physicians to these women included a gamut of different courses of action. A fifth of the patients (22.0 percent) going to the United States said it had been difficult to make an appointment with a physician. Many physicians gave more than one piece of advice. Taking all these reasons together, **over half (53.6 percent) of this small group of women who went to the United States to obtain an abortion said that their doctors felt they had little chance of getting an abortion in Canada, were morally opposed to assisting them, or were unwilling to refer them to a hospital where this procedure was done in this country.** The specific reasons included: physicians who would not refer patients to other doctors or to hospitals (13.4 percent); told by a physician that an abortion was illegal (22.6 percent); told an abortion could not be obtained at a Canadian hospital (41.5 percent); told pregnancy was too advanced (9.2 percent); no medical reasons (10.6 percent); abortion involved a risk to health (6.5 percent); told to go to term (14.7 percent); and told there were no doctors who would do the abortion procedure (8.8 percent). While most family doctors and obstetrician-gynaecologists referred patients to hospital committees, or if they were morally opposed to abortion, made patient referrals to other physicians, some physicians wanted no involvement at any

stage in the abortion procedure. Patients who turned to this small group of physicians, not knowing beforehand their views on abortion, either were given no assistance or in some instances were inaccurately counselled.

Pathway five: Childbirth

Child welfare agencies and maternity homes across Canada were contacted to obtain information about their experience with women seeking abortions and pregnant women who went to term for whom they provided services. Out of a total of 242 regional and local branches of child welfare agencies and 33 maternity homes (two additional homes which were contacted were closing) from whom information was requested, *complete* replies were received from 56 welfare units (23.1 percent) and 27 maternity homes (81.8 percent). In addition to providing information about the scope of their services, eight of the child welfare agencies and 24 of the maternity homes participated in a survey involving 203 women for whom they were providing assistance.

Private organizations in Manitoba, Ontario, and Nova Scotia operated child welfare services. The Manitoba Department of Health and Social Development operated 12 child welfare branches; services in that province were also provided by four Children's Aid societies and the Jewish Child and Family Service. All of the 53 child welfare agencies in Ontario were run on a voluntary basis, but worked within the framework of provincial legislation. The majority of these programs were non-sectarian (49); three were affiliated with the Catholic Church of Canada, and one was a Jewish welfare agency. While 5 out of 17 agencies in Nova Scotia were privately run, the provincial Department of Social Services supervised much of the scope of their programs.

In British Columbia, Alberta, Manitoba, and Quebec, child protection services were provided together with social welfare and health activities respectively by branches of the departments of Human Resources, Social Services and Community Health, Health and Social Development, and the Ministry of Social Affairs. Traditionally, these services had been directed toward adoption programs and the assistance of pregnant women. In recent years the scope of their services has been extended to provide for the needs of youth in general.

From the information which was given by the agencies which supplied statistics, there was a decrease between 1973 and 1975 in the volume of all individuals who were being assisted. If the number of women who were seen in 1973 is taken as an index equalling 100, then there was a 16 percent drop in the number of single pregnant women between 16 and 18 years who were seen over this three-year period and a 20 percent decline among women who were 19 years or older. The proportion of infants who were given for adoption compared to the number of babies who were brought up by their mothers during this three-year period decreased from 77.5 percent in 1973, 70.4 percent in 1974, to 60.0 percent in 1975. These trends based on incomplete information suggest what many physicians and health and welfare administrators told the

Committee, namely that fewer women were giving their infants for adoption than in the past.

About half of the pregnant women who contacted provincial child welfare agencies were in the third trimester of their pregnancies. These women had decided to carry their pregnancies to full term and had contacted these resources either to make arrangements for adoption or for their support during the last phase of their pregnancy and after childbirth had occurred. Some of the directors of these agencies commented on this aspect of their work.

> Abortion is raised as an alternative plan to consider, where appropriate. Counselling involves an examination of sexual activity, goals and possible referral to family planning clinics.
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> Since the most basic right of all human beings is the right to life, it is therefore incumbent upon us to uphold this right for all children: those already born as well as those about to be born. Our Society will not give permission to one of our wards to obtain an abortion, nor will we be involved in counselling a woman to have an abortion.
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> Currently, there is no policy regarding abortion. The practice has been to discuss the matter with anyone wishing to do so, make referral and provide information as requested, stressing that decision-making rests with the individual.
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> Difficult cases involving matters such as serious marital problems, abortion and sterilization, may be referred to the Moral Issues Advisory Committee for advice and direction. Referrals for abortion by staff may not be undertaken under any circumstances.
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> We have no written policy. Our procedure is to provide professional case-work services to assist clients in reaching their own decisions about family planning. Depending on the client's needs and wishes, this could include information giving and referrals to resources such as family planning clinics.
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> Responsible family planning within the framework of Catholic moral teaching is encouraged. Abortion is not considered to be an acceptable planning alternative but the adult client's right to self-determination is respected in this regard.
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> We have a policy. Social work staff is given authority to offer counselling to any client who wishes to discuss abortion and, if the client so desires, a consultation with senior staff provides support for the need to actively support a referral to our appropriate medical or hospital resource.
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> We have a committee developing a policy. Currently, we recommend abortion in cases where the mother's situation makes it unlikely that she will be able to care for her child for physical, emotional, or mental reasons.
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> No set policy exists. We attempt to work with each pregnant client on an individual basis in order to find the best solution to her particular problem considering her social and medical conditions.

Of the 27 maternity homes (out of a total of 33 identified across Canada) which provided information on their services, two were located in British Columbia, two in each of the Prairie provinces, 12 in Ontario, four in Quebec, and three in the Maritime provinces. The first maternity homes were established toward the end of the last century to aid young pregnant women. Through the years, the Salvation Army Corps has had a strong commitment to these services. Its work has gradually been joined by other denominations in providing services to unwed mothers. Of the maternity homes in the survey, three had been founded before 1900, 10 between 1900 and 1950, and the remainder since 1950. The impetus to open maternity homes rose following World War II. In 1976, the Salvation Army operated 14 maternity homes, seven were under the auspices of other Protestant denominations, and eight were managed by the Catholic Church.

As with the child welfare agencies, the traditional role of maternity homes has changed in recent years—from providing care for women wishing to relinquish their babies for adoption to providing residential services for many other young women. For these reasons many of the maternity homes which had been established in the past either have closed or re-aligned their policies to serve other needs. Based on the reports given by the directors of these maternity homes, the decline in the use of their services by pregnant women has accelerated since 1970. There were 1,852 residents served by the 27 maternity homes in 1975. Approximately half (48.1 percent) of the homes had 50 or fewer pregnant residents during that year, while the remainder accommodated between 60 to 180 women. The average length of stay in each home ranged from 1.5 to 4 months. Most of the homes (62.9 percent) accommodated residents for more than 2.5 months. Half (51.8 percent) of the institutions accommodated only single pregnant girls and overall, most of the residents in maternity homes were single, the remainder usually had only one or two married residents and about the same number of women who were divorced, separated, or widowed. In 1975 there were 32 married and previously married women who had stayed in these homes, a proportion which never exceeded 4 percent of the total number of residents.

Most of the residents were young women who were experiencing their first pregnancy. Over half (57.5 percent) were under 17 years old and 81.9 percent were below the age of 20 years. For 6 out of 7 of these women (86.4 percent) the conception had been their first pregnancy. Of the remainder, 4 out of 5 (82.1 percent) had carried one previous pregnancy to term and 17.9 percent had had two or more childbirths. A small number of these women (3.7 percent) had had an abortion.

According to several administrators of these maternity homes, the women who carried their pregnancies to term and had come to these homes had opted for this pathway because it was the only alternative available to them. Among the factors which were seen to influence their choice, in the opinion of the administrators, their opposition to abortion was the most important consideration. The second major reason for spending the last months of their pregnancy in a maternity home was that many of these women wanted to raise a child, but could not cope with their circumstances at home or at work. A third motivation for carrying a pregnancy to term in a maternity home was seen to result from strong pressure to do so which had been voiced by a woman's partner, her family, or her close friends. Problems associated with the availability of abortion services seldom were cited by maternity home directors as reasons why these women sought out this assistance.

Information was obtained directly from 203 pregnant women living in 24 maternity homes or who were being served by eight child welfare agencies. The majority of these women (82.3 percent) were under 20 years of age; the remainder (17.7 percent) were in their twenties. Over half of the women were 17 years or younger, with 18.8 percent under 16 years and 38.1 percent between 16 and 17 years. When birth occurred a majority of these young women would be single mothers as only 17.1 percent were married when conception occurred. These women in about equal numbers were Protestant (48.2 percent) or Catholic (42.7 percent.)

When they became pregnant, 2 out of 3 of these women (68.5 percent) had been living with their parents, while a few had their own homes (16.0 percent) or lived with a male partner (15.5 percent). In the interval between when conception occurred and when they took part in the survey, most of these women had made alternative living arrangements, with 3 out of 4 (71.7 percent) residing in maternity homes, 14.1 percent living with relatives, 7.8 percent working as "live-in" help for a family, and a few (6.4 percent) living in a boarding house. The proportion of these women who had been living with their parents when conception occurred declined with their age from 97.1 percent of females under 16 years to 47.2 percent of women who were over 20 years old. Prior to their pregnancy, 42.5 percent of these women had attended school, 35.8 percent had had jobs, and 1 out of 5 had been unemployed. At the time of the survey a majority of these women were attending school (52.2 percent), 1 out of 10 was working (10.3 percent), and the remainder were unemployed.

Although all of these women had decided to carry their pregnancy to term, half of them (50.2 percent) had initially considered the possibility of an induced abortion. For these women this option had been supported by some of their close friends (43.9 percent), their parents (25.3 percent), or their male partners (22.0 percent). About 1 out of 10 (8.8 percent) said that a physician had urged them to consider an induced abortion. The influence of their parents was greater among young teenagers, with 2 out of 5 (42.1 percent) who were 16 years or younger reporting that their families had advised them to obtain an abortion. The influence of a family in this respect declined among slightly older

women, with 1 out of 4 of these women (25.6 percent) saying that their parents had urged them to get an abortion.

Among a small group of women who were carrying their pregnancies to term 1 out of 4 (27.6 percent) had at one time considered having an induced abortion, but they had not taken this course because of a lack of accessible services for therapeutic abortion or because of delays which had been involved in applications submitted on their behalf to hospitals. Some of the factors which were involved were: 25.5 percent, physicians had told these women the length of their pregnancy went beyond the limits set for this procedure by hospitals; 30.4 percent, paying the additional costs was beyond their means; 8.9 percent, a physician had refused to refer them for this procedure; and 14.3 percent, did not know how to apply for an induced abortion. One out of five of these women thought that getting an induced abortion was illegal under any circumstances.

Among the women who had once considered having an abortion, 45.2 percent were Catholic, an equal number were Protestant, and the remainder either were members of other religious faiths or gave no affiliation. There were no trends by age among the women who had considered or not considered this alternative. There was a trend by age and the length of gestation, with more younger females, in particular those who were 16 years and younger (40.9 percent), having not sought an abortion on the grounds that their pregnancies were too advanced. Among the small group of married women who were living in maternity homes or who were assisted by child welfare agencies, 2 out of 3 (64.7 percent) had rejected the possibility of an abortion on moral grounds, 29.4 percent said that they had been unable to obtain an abortion, and 5.9 percent said they had reached this decision too late in their pregnancies to make an abortion feasible.

Two-thirds of the women who had considered having an abortion (69.9 percent) planned to give their babies for adoption, a proportion higher than the half of the women (46.9 percent) who had never considered that course. Among the women who had intended but had not had an induced abortion because their pregnancy was too far advanced to apply for one, 84.6 percent had planned an adoption. In contrast, among the women who were morally opposed to abortion, 72.2 percent planned to keep their children. Of the women who had had procedural difficulties involving the abortion procedure, 66.7 percent planned adoption. Among the women who had rejected an abortion following their partner's wish, 22.2 percent planned an adoption and 77.8 percent intended to raise their child. In reaching their decisions about adoption or retaining the custody of their newborn children, these women were influenced by their families and friends about what they decided to do. More of the women who had partners who supported their decisions, had made plans to keep their children. Among the women who had this type of support, half (52.0 percent) planned to keep their children, instead of considering an adoption. In comparison with married women more single women planned to give up their children for adoption. In each instance the decisions of these women might change after childbirth.

Family income and pregnancy experience

The relation between a person's level of income and how he works and lives has been extensively documented in Canada and elsewhere. It is on the basis of reducing these distinctions and ameliorating the situation that much of the intent of social policy hinges, and such national programs as hospital and medical care insurance were enacted. In the field of health care it has long been known that the rates of infant mortality, the distribution of certain diseases, and the accessibility to health services are not the same for all individuals, but vary directly by their social circumstances and on occasion by their level of income. As the economic standard of living has risen and as broad national programs of social security have been in operation for a period of time, a number of these disparities have been narrowed, in some cases, eliminated. Despite the extensive benefits provided by national and provincial programs, sharp social and economic disparities persist. While the social meaning of poverty and the types of services mounted to serve low-income individuals and families change and reflect the social purpose of each era, the culture of poverty remains entrenched. It molds a different way of life than that experienced by middle-income Canadians and in terms of the outcomes of pregnancy contributes to different social choices being taken between seeking an induced abortion or bringing to term an unwanted pregnancy.

As the economic standard of living of Canadians has risen in recent decades, making this nation one of the most affluent countries in the world, there has been a growing search for social indicators which, it has been hoped, would document more fully the essence and quality of how Canadians live, what they seek to do, and to further our understanding of disease which can be prevented, of the nature of social alienation, and the reduction of illegal behaviour. The quest for these new measures whose clarification is still on the horizon makes no less relevant the need to understand at present how an individual's economic lot affects his usual way of life. While there is no official national statement on the concept of poverty, a number of different measures have been developed which have sought to assess the extent and the social implications of poverty in Canada. In the past decade several reports on income indicators have been put forward by groups such as the Special Senate Committee on Poverty, the Social Development Council, Statistics Canada, and the Economic Council of Canada. Because of broad regional disparities in the lifestyles of Canadians, the divided nature of civic responsibilities, and the complexity of developing appropriate quantitative measures which are socially valid, there has been no agreement as yet about the utility of these indicators, how they may be used, or their social policy implications.

Statistics Canada has developed a measure of low income for individuals and families which takes into account the number of persons who are supported in a family and the size of the community where individuals live.[4] The 1975 revised low-income cut-off levels rose with the number of individuals in

[4] Statistics Canada, *Income Distribution by Size in Canada: Preliminary Estimates, 1974* (Ottawa, October 1975), pp. 6-7, 16-18. (This report deals with *family* size.)

families and were scaled to increase by the size of communities. Individuals or families whose annual income fell below these designated cut-off levels spent on an average 62 percent or more of their incomes on food, shelter, and clothing. For this reason they were considerd to live in straitened economic circumstances.

The low-income measure developed by Statistics Canada was used in the review of the family income levels of three groups of women who had been pregnant and two groups of single women. The three groups of *females who had children* from whom information was obtained in the national population survey were: (1) all married women who had children; (2) married women who had had induced abortions and the number of their children; and (3) single or unmarried mothers and the number of their children. In addition to the three categories of women who had had children, the two groups of *single* women who were considered were: (1) single women who had no children and who had not had an abortion; and (2) single women who had no children but who had had an abortion. In the analysis of the incomes of married women, the denominator which was used was the size of the family. The experience of all five groups of women was evaluated in terms of the low-income cut-off levels developed by Statistics Canada which take into account income levels by the size of the family and the size of the community where individuals lived.

TABLE 7.2

INCOME AND ABORTION EXPERIENCE OF FEMALES WITH CHILDREN

NATIONAL POPULATION SURVEY

Level of Income	Marital Status and Abortion Experience		
	Married Women: No Abortion	Married Women: Had an Abortion	Single Mothers No Abortion
	percent	percent	percent
—$ 4,000	8.7	7.7	15.6
$ 4,000— 5,999	8.0	0.0	3.1
$ 6,000— 7,999	8.3	7.7	12.5
$ 8,000— 9,999	9.3	19.2	25.0
$10,000— 12,999	17.9	17.3	12.5
$13,000— 14,999	13.3	21.2	6.3
$15,000— 19,999	16.4	9.6	6.3
$20,000+	18.1	17.3	18.7
Total	100.0	100.0	100.0
Proportion below Low-Income Levels*	18.6	15.4	25.0

* Based on size of family and size of community of residence, according to Low Income Lines used by Statistics Canada, 1975.

Among *married women* in the 1976 national population survey *who had had children but who had not had abortions*, a quarter (25.0 percent) had

family incomes of $8,000 or less; 27.2 percent had family incomes between $8,000 and $12,999, and almost half (47.8 percent) had family incomes which were above $13,000. The distribution of family income of married women with children in this survey undertaken by the Committee closely parallelled the 1974 proportional distribution of family incomes reported by Statistics Canada which was: 23.2 percent, $8,000 or less; 25.5 percent, $8,000 to $12,999; and 51.4 percent, $13,000 or above. The average family income in 1974 was $14,485. Different population sampling procedures may account for the observed differences as well as the fact that the information for the 1976 survey was calculated on a basis of families with children, thus excluding childless couples. The married women in the 1976 survey who had not had abortions had an average of 2.2 children, while those females who were widowed, separated, or divorced had on an average 2.3 children.

Based on the 1975 revised low-income cut-off levels developed by Statistics Canada, 18.6 percent of married women with children but who had not had abortions were below these income levels. What this means was that almost a fifth of these married women spent 62 percent or more of their family incomes on food, clothing, or shelter. In terms of the standard of living of the average Canadian family, these families were the poor of the nation.

In a number of reports which were submitted to the Committee and in some of the comments made by physicians in the national physician survey, the availability of the abortion procedure and income were linked together.

> It is unfortunate that frequently the factors which determine whether or not a patient gets a therapeutic abortion are economic or geographic. It is difficult for rural dwellers and for those in the lower income levels. The economic disparity in particular is great.
>
> • • •
>
> As long as Canadian women can go to New York State ... for abortions on demand (and all wealthy women have this option), it would appear discriminatory to reject reasonable indications in Canada and make them second-class citizens.
>
> • • •
>
> Penalizes the poor—especially in "holier than thou" areas.
>
> • • •
>
> There is nothing basically wrong with the present abortion committee set-up, except that such committees should be instructed to take a serious view of repeat therapeutic abortions, and cases in which there is evidence of improvidence, carelessness or irresponsibility. Such a serious or unsympathetic view towards abortion on demand requires a parallel development of facilities for the care of children from unsuitable parents or from women who are not likely to make good mothers. At the present time we probably do not know whether children born of such poor mothers will inevitably be a liability to the state, or an asset to the country. A thorough study of this question might help clarify the position. If the record of such children is no worse than the average, we should not be tempted (as we are at present) to grant an abortion to avoid

bringing into the world children who would be unwanted and the offspring of unsuitable mothers, who would become a liability rather than an asset to the country.

• • •

Abortion as it is practiced in Canada does not deserve the notation "therapeutic" because it cures nothing. Social ills cannot be cured by abortion on demand as has been proven in other countries ... Poverty cannot be cured by killing poor people. Undesired and unwanted pregnancies are a reflection of other problems and abortion should never take the place of contraception.

• • •

Therapeutic abortion should be performed outside of prepaid health care facilities. The economic cost should be borne by those requiring it. Everyone should bear a responsibility for their own health care, and in the light of today's knowledge, abortions should not be used as a method of contraception. Society as a whole should not be expected to pay for it. It will be argued that the poor will suffer—but it must be accepted that they should be just as responsible for their health care as anyone else. I am sure that relatively painless methods of payment can be devised.

• • •

The situation at present is a disaster. People in lower socio-economic groups are often at a disadvantage with respect to obtaining abortion, other people have a physician who will not give them the option of therapeutic abortion committee review.

Among *married women with children who had had abortions*, 15.4 percent had annual family incomes of $8,000 or less; 36.5 percent were between $8,000 and $12,999; and 48.1 percent had family incomes of $13,000 or more. Because there were few married women with no children who had had abortions, this group was excluded from this review. In contrast with married women with children who had not had abortions, 9.6 percent fewer married women who had had abortions had annual family incomes of $8,000 or less. More of these women than the former group were in the middle-income category of $8,000 to $12,999, and the proportions of both groups who had family incomes above $13,000 were comparable. When the family incomes of married women with children who had had abortions were calculated on the basis of Statistics Canada low-income cut-off levels, 15.4 percent of these families were below these minimum standards.

What this information indicates for the two groups of married women with children, a sample which represented a national cross-section of the population, is that while some married women who had abortions had low family incomes, as a group more of these women were from families in the middle-income levels. Slightly fewer of the married women who had abortions than other married women were economically poor. These findings contradict the belief which is sometimes held, that it is the poor more than the rich who turn to abortion to terminate unwanted pregnancies. The reverse situation is the case. It was the married women who were economically better off who tended to have abortions more often than the married women who were poor.

The definition of the family followed in this review of income and pregnancy experience used the guidelines of Statistics Canada which considered a family as "a group of individuals related by blood, marriage, or adoption, who shared a common dwelling unit at the time of the survey".[5] Included in this definition are families consisting of both parents and children, extended families which may have grandparents or relatives, and single-parent families involving women and men who either were once married (e.g., widowed, divorced, or separated) or who were never married and who had children living with them. It is the level of family income of single women who have had children, but who have not had abortions, which is compared here with the experience of all married women who have had children and married women with children who have had abortions.

Among all single women in the national population survey who had not had an induced abortion, 10.5 percent had had one or more children. In comparison among single women who had had an abortion, 23.1 percent had had one or more children. When the average family income of *the single women who had had children* is considered, more of these women had lower family incomes than all married women who had had children and married women with children who had had abortions. Double the number of single women who had had children (15.6 percent) than the other two groups of women had family incomes of $4,000 or less. Among the women in these three groups, 31.2 percent of single women who had children had incomes which were $8,400 or less; 15.4 percent of married women who had had abortions; and 25.0 percent of all married women who had had children were in this income group. In the highest bracket of average family incomes which were above $13,000, the proportional distribution was 31.3 percent of single-parent females, 48.1 percent of married women who had had abortions, and 47.8 percent of all married women who had children.

Based on the 1974 index of low incomes of Statistics Canada, 25.0 percent of single women who had had children were below these minimum cut-off levels. In comparison with the two other groups of women, the group of single women who had had children had lower incomes and more had poverty incomes.

There were comparable trends by level of income among the two groups of single females who had not had children. Almost a fifth of single women (19.5 percent) who had not had children had annual incomes of $6,000 or less. None of the single women who had had an abortion were in this income category. In contrast, over double the proportion (36.4 percent) of the single women who had had abortions had incomes between $6,000 and $9,999 than all single females (15.3 percent). The number of women in both groups who had incomes above $10,000 was comparable. As with married women with children, fewer single women who were poor had had abortions and there was a higher number among this group in the middle-income bracket.

When the annual incomes of *single women who had had abortions* and *single women with children who had not had an abortion* are compared, there was a sharp contrast in income levels. Almost a third (31.2

TABLE 7.3

INCOME AND ABORTION EXPERIENCE
OF SINGLE WOMEN WITHOUT CHILDREN

NATIONAL POPULATION SURVEY

Level of Income	Abortion Experience of Single Women	
	No Abortion	Had an Abortion
	percent	
– $4,000	14.2	0.0
$ 4,000- 5,999	5.3	0.0
$ 6,000- 7,999	8.2	18.2
$ 8,000- 9,999	7.1	18.2
$10,000-12,999	16.0	18.2
$13,000-14,999	12.1	18.2
$15,000-19,999	17.0	9.0
$20,000+	20.1	18.2
TOTAL	100.0	100.0

[5] Ibid., page 7.

percent) of single women with children had incomes of $8,000 or less. In contrast, 18.2 percent of single women who had had an abortion had this income level. Almost equal proportions of both groups (37.5 percent and 36.4 percent respectively) had incomes between $8,000 and $12,999. Among the highest income group of $13,000 or above, there were 31.3 percent of single women who had had children and 45.4 percent of single women who had had an abortion.

The opinions of women and men about abortion across the country varied by their level of income. While just about a third (32.3 percent) of the women with family incomes of $4,000 or less said it was legal to obtain a therapeutic abortion, almost half (47.0 percent) with family incomes of $20,000 or higher gave this reply. Somewhat fewer rich women (43.5 percent) than poor women (52.0 percent) had no comment on how accessible treatment services were for abortion, while the proportion who felt it was too difficult in each income bracket was comparable (18.1 percent and 16.4 percent).

Both women and men who had higher incomes knew more women who had had an abortion than individuals with lower incomes. Slightly over a quarter (28.8 percent) of women with family incomes of $4,000 or less knew someone who had had an abortion, while somewhat less than half (44.6 percent) of women with incomes of $20,000 or more were familiar with such individuals. The proportions for men in similar income categories were 22.3 percent and 35.8 percent respectively.

Slightly fewer men than women felt the current abortion legislation was too liberal or "about right". More men than women (36.5 percent versus 26.5 percent) said this law was too restrictive. Overall, 16.2 percent of women and 12.7 percent of men said the law was too liberal and 24.9 percent and 23.0 percent respectively endorsed the status quo. The remainder of women and

men (32.4 percent and 27.7 percent) had no opinion on this point. There was little difference among women by their level of family income in the proportion who felt the law was too liberal or who endorsed the present legislation. The proportion of women who were undecided on this issue dropped substantially as family income rose from 40.0 percent of women who had incomes of $4,000 or less to 16.5 percent of women whose family incomes were $20,000 or higher. Counterbalancing this trend, twice as many women (34.0 percent versus 17.3 percent) who were rich compared to individuals who were poor said the law was too restrictive.

What these findings on the knowledge and opinion of the Abortion Law indicate is that there were consistent trends in these replies by the level of income of women and men. In each instance individuals with higher incomes, whether the basis of their knowledge was accurate or not, held more definite views on the abortion issue. More women and men with higher incomes than individuals with lower incomes said the abortion legislation was restrictive, knew someone who had had an abortion, and said it was legal to obtain an induced abortion.

The use of health services involves a number of related factors. These components include whether health personnel and facilities are available, the type of disease an individual has and the extent to which the symptoms of an illness are known or recognized, and a knowledge of how to go about using treatment services. It is in this last respect, the knowledge of the law and of other women who have had abortions, that the poor or individuals with lower incomes had less information about abortion and the treatment services than women who had higher family incomes. This difference in knowledge about abortion and the availability of treatment services represents a much broader trend involving people with different incomes in their knowledge and their use of health services.

Women as a whole in different social and economic circumstances made different choices about the outcome of pregnancy. The information requires replication; it is but a step toward the documentation of a fuller understanding of how and why these choices are made. Among married and single women in the national survey, fewer females who were poor obtained induced abortions than middle-income and rich women. It is not known how many of the single and poor women who became pregnant were married immediately before or just after childbirth. What is known from the national population survey is that **a substantially higher proportion of single women who had had children were poor. Fewer poor women who were single or married had had abortions. In contrast, more middle-income women had had abortions and fewer of these women and those females with still higher incomes were unmarried mothers.** These broad and distinctive social choices, when the trends are considered in aggregate, represent fundamentally different ways of life and of reacting to a pregnancy. In the context of the "rich-poor" issue, these social choices have profound social and ethical implications which go well beyond the scope of this inquiry.

Alternative choices

A fuller understanding of the several options which pregnant women take would require an extensive review over a longer period of time than was available to the Committee. These options include wanted and unwanted childbirth occurring within marriage. The Committee did not deal with the effects of unwanted births on children or their parents. Little is known about the childrearing of unwanted children, their emotional capabilities, the state of their physical health, what constitutes child abuse and the extent to which it occurs, or what the life chances are of these children. The potential consequences of this course when an unwanted conception occurs are a matter for a separate inquiry. Little is also known about the emotional well-being or the physical health of women who give their infants up for adoption.

When a woman has an unwanted pregnancy, she must reach a decision about one of two alternatives. Either she must go to term, or obtain an induced abortion. From the information obtained by the Committee dealing with the experience of a small group of women who were carrying their pregnancies to term and from the results of the more comprehensive national population survey, a substantial number of single mothers who had unwanted pregnancies had low incomes and many lived in poverty. Because they were less well educated and less familiar with the workings of health services, a number of these women would have preferred to have had an abortion if they had known how to proceed. In contrast to these women, a significantly higher proportion of women who had higher incomes had induced abortions when unwanted pregnancies occurred.

In taking the alternative of obtaining an abortion, women may select one of several courses. Based upon the fragmentary information obtained by the Committee, little can be concluded about women who obtain illegal abortions in Canada. The evidence which is available from the national population survey, the personal accounts of women, reports given by physicians and the prevalence of complications resulting from illegal operations indicate that in the past several years there has been a substantial decline in the volume of illegal abortions. As the occurrence of therapeutic abortions has risen coupled with a still extensive use by Canadian women of abortion facilities in the United States, fewer women now than before take this option. Because there is more public awareness of the risks involved, women if they decide upon an abortion, are now more likely to obtain this operation in a Canadian hospital or to go abroad. In the opinion of a number of senior physicians who were consulted by the Committee, most of the relatively few illegal abortions which are now done are performed during the earliest phases of a pregnancy by means of menstrual extraction in physicians' offices. This is a step about which both the patients and the physicians involved are secretive, with this procedure in many instances being done under the guise of a minor curettage. There appear to be few guidelines governing the purchase or the importing of the required medical equipment which is readily available.

The idea of gatekeepers to health care cuts across the experience of women who by various means obtain induced abortions. While the decision to

take one course or another is always a difficult and intensely personal choice, who these pregnant women turned to and what type of counsel they received profoundly affected the steps which they subsequently took. Among the sizeable number of women who obtained abortions in Canadian hospitals, the main factor which served to lenghten their pregnancies was the amount of time taken after a woman had initially contacted a physician. Many of the women who went to the United States for an abortion either had been given no assistance or had been given inaccurate information by the physicians whom they had consulted. The findings indicate that most patients and most physicians tried to resolve the difficult issue of abortion. But where this was not the case, the timing of the abortion operation was delayed or women by-passed their local physicians and went elsewhere. These delays and the advice which was given resulted in some women going to term who should have preferred to have had an abortion.

About 1 out of 5 women turned to one of a number of community agencies for assistance. The aid given by these agencies involved counsel and the expediting function of making arrangements where abortions might be obtained. Essentially, these agencies were used by women seeking abortions who did not know how to go about getting this information themselves. These agencies often knew little about each other's work. It was the exception, not the rule, when spokesmen for one or another of these programs endorsed the work of other agencies. There was little effective coordination between the efforts of these agencies, hospitals, physicians, or public health units. Each of these groups tended to establish their own domain of services and to regard the work of other agencies as an intrusion. This duplication of effort often resulted in much bitterness and hostility whose side effects meant that the women who turned to these resources were not always well served. In some instances they were given misleading advice about the accessibility of health care services for therapeutic abortion in the community or the province where they lived. For their part, local public health units by ignoring this situation did little to redress what was happening or to move toward the coordination of pregnancy and abortion counselling and referral services.

Chapter 8

Personal Experiences

In its work the Committee was aware that the information which it received from several thousand persons—patients, the public, and the health professions—in each instance represented the difficult-to-summarize views and the diverse personal experiences of women and men. This fact was true for the decisions which were made by physicians as they considered the personal and ethical implications of their work with abortion patients. This point was equally true for the women who had had an unexpected and unwanted pregnancy. National surveys are useful to assess broad trends, but they do not easily capture the deeply felt concerns or the personal anguish which women may feel in approaching this decision.

The Committee received a number of written statements from women across the country who had had induced abortions. To ensure that these personal accounts were valid, only those reports which had been written and submitted directly by women themselves and were signed were considered to be valid. Many of these statements were accompanied by sworn affidavits. In presenting excerpts from some of these personal statements, the only alterations which have been made were to ensure the absolute confidentiality of the women who provided details about their personal experiences with abortion. For the same reasons the names of physicians, other individuals, hospitals, addresses, and provincial identification have been deleted.

In their own words the personal accounts of these women "tell it like it is". These personal experiences illustrate the broader trends which emerged from the findings of the national population survey and the national patient survey. The personal accounts which have been excerpted come from women in all provinces. They are representative of the other reports which were received but which were not included. These statements are divided into five categories: (1) consideration of abortion; (2) illegal abortion before 1969; (3) illegal abortion after 1969 which includes two transcripts from court records; (4) out-of-country abortions; and (5) legal abortions after 1969.

Consideration of abortion

Personal Account 1

At the age of 38 I found myself pregnant. I had been using the diaphragm. I had two previous children, the youngest was fifteen. I was upset at the results of the positive pregnancy test and told my doctor so, vaguely hinting at abortion. He treated the matter very lightly, almost jokingly. My second child had to have a blood transfusion after birth as I am RH negative and this added to my worry about the third pregnancy. By the fifth month the antibodies had reached a high level and I was sent to _____ for pre-natal fetal blood replacement. I made three trips in all and a fourth for the delivery of the baby, which was induced six weeks early. The whole experience of this pregnancy was one of expense, pain, and anger that I had no choice (that I knew of at the time) and of being forced into motherhood. This child, now five is healthy, loved and part of our lives. However, I feel my husband and I should have had a choice of whether we wished to be parents again, and been told of the risks involved. We probably would have chosen not to have this last child.

Personal Account 2

In 1961, I got pregnant for the third time. I did not want to go through with it. I had a boy and a girl and was a career woman. I had taken every precaution for birth control but somehow it failed. I tried the potassium permanganate douche and it didn't work.

I finally had the baby. I still regret it. It may be my attitude toward her, but she was not, nor is, a wanted child. It sounds terrible for a mother, but I so resented the authorities that *forced* me into that birth that I am still bitter. The child is backward in school, whereas the other two are bright and intelligent. I have a guilty feeling because I tried to abort her and failed, and blame myself for her slightly retarded brain.

Personal Account 3

I wanted an abortion because my husband was irresponsible and didn't have any intention of working steady. How I hunted for a doctor to do an abortion! I couldn't find one—I was scared to try too much for fear of killing myself. I ended up with two unwanted children. After my second contraceptive failure, they put an IUD in me, which has worked for me. My "ex" finally got tired and left. Now I sit on welfare, bitter at being trapped and in poverty.

Personal Account 4

My story is nearly 12 years old. It is especially difficult to tell it because the fetus that I wished to abort, wasn't, and today is 11 years old, an intelligent, energetic child who I feel very close to and love very dearly. At a time when there was nowhere to turn but to quacks and charlatans, I was 22 years old, unmarried, in a semi-professional job and a year out of university. By the time I became pregnant it was apparent the relationship could not sustain itself, let alone a child. My first instinct was to terminate the pregnancy.

The sheer terror of the situation is indescribable. The ultimate shame of an illegitimate pregnancy, the loss of face, the disruption of a just-beginning working life, the pain of having to face it all alone, no matter what happened,

led me to seek out someone to abort me. My scanty knowledge of methods told me that a D&C was very dangerous, if improperly done. The child's father had home remedies for me to take—quinine, and castor oil only caused ringing in my ears and diarrhea. The next step was to have a douche—supposedly safe, sure and $150.00. A woman gave it to me in a friend's house. Then we waited. Nothing happened—not a cramp, not a drop of blood, nothing. I got back half my money with help from my "friend's friend". Then he washed his hands of me. I was on my own.

It wasn't easy to find an abortionist, but I did. This time it was a man from _____ who agreed to fly to _____ and "help" me for $200.00. I met him at the airport, drove to my friend's empty house and after a lengthy talk while he "psyched me out" he gave me a douche after giving me my first pelvic examination to determine how "far along" I was. Then he called a cab, took my money, and left me alone. Again, nothing happened.

By this time I was over two months pregnant, absolutely desperate, going through the days like a robot, almost paralyzed with fear. About two weeks later I took a friend into my confidence and told him my situation. He offered to take me to _____ to see this man again if I was determined that there was no other course I could take. I called up _____ and after a lot of difficulty got through to him and convinced him that he had to see me again because what he had done had not worked.

We drove to _____ over night because our work situation didn't allow a lot of time away. We got a room in a motel and slept the rest of the night there. In the morning I called _____ and told him where I was. He picked me up in a dirty car with a lot of paper litter inside it. It was in sharp contrast to his person—he was a very clean well-groomed man.

He took me to a basement apartment that was untidy and dirty. I remember feeling I had really reached the bottom of the barrel. He said he had to give me some pills to make me relax and then he gave me two tiny capsules to take. The feeling I recall having was a kind of giving up—of just having no choice anymore, and a terrible sense of worthlessness. Here I was in a dirty, cluttered basement apartment in a city I'd only visited, on a street I didn't even know the name of, with a sly con man who was telling me that if I wanted to end my pregnancy I must take drugs I had no way of identifying. He then told me that the time during which a woman's cervix opened up the most was during sexual arousal. The best way to succeed with the douche was to "warm up". He then told me to get on the bed with my pants off, and he proceeded to "arouse me". He removed his own pants but kept on his shirt and tie, still done up at the neck. Between the drugs and the sense of giving up, I did get a little aroused. I remember feeling I must be some kind of slut.

Suddenly he jumped off the bed, ran and got his "equipment". He came back all business. He very painfully twisted my breast to extract some colostrum. Then he said almost angrily, "you see, you're at least three months!" He then did something to me—douched or seemed to "pop" something inside me, then showed me the white enamel pan he used—with an inch or more of dark blood in it. I got dressed. He drove me back to the motel with another $100 in his pocket.

My friend drove me back to where we had come from. The next day I realized that I was still firmly pregnant. The next day I called my family doctor. I told

him why. Then I drove 90 miles alone to his office where he confirmed my pregnancy, told me I had a very mild vaginal infection, and was damn lucky to be alive. The fetus had refused to budge. I had to succumb to the inevitable.

I left my job, hid out at home, and then lived for two months in an unwed mothers' home, giving birth alone and frightened in _____ hospital. I fed and held my beautiful son until that terrible last day when I was to go home and he was to be put into the care of _____ for adoption. I will never forget sitting up in bed on a grey February morning at 6:00 a.m., holding in my arms the most beautiful person I had ever known and telling him that I would always love him and need him but had to give him to someone else to care for because I couldn't.

After seven weeks, during which time I had seen my son twice in his foster home, I drove one day to the _____ where I signed a paper that said my son was no longer mine. I was releasing him for adoption. Then I died inside.

My story takes a sudden happy turn 10 days later. My friend who had driven me to _____ asked me—no, us—to marry him. After more soul-searching I said yes. I called up the social worker and told her I wanted my baby back. She said "you can't do that". I said I could because the three week "escape clause" on the paper I had signed was not up. And I was right. We got him back and brought him home when he was two and a half months old. We married two months later. We had two more sons.

Our oldest son knows that he had a different "man who helped mummy make him". He has only one father. He knows he was loved and very much wanted when he was finally here.

It was eight years before I was able to separate my wish not to have a baby, from the baby that I had. Then I knew forever, that no woman should have to go through what I did, or the far worse experiences of other women.

Illegal abortion before 1969

Personal Account 5

Many years before 1969 I had two illegal abortions. Three other members of my family, to my knowledge, also had an abortion at various times, only one legal. All of us also had children who were planned and wanted. None of us had any regret over the abortion itself, only over the accidental factor that caused the pregnancy to occur.

At 66, I am long past child-bearing age. I have four children and seven grandchildren. At 18, I "had to get married", left two families in a devastated state, went to _____ to hide the disgrace, and then, when living in a rather ramshackle cottage in rural _____ with an income of $100 per month and a ten-month baby, found I was pregnant again—the contraceptive didn't work. Another baby meant plain disaster. A good friend had a brother who was a medical student at _____ and he found out the name of a doctor who did abortions in his house. His uncle, a well-known gynaecologist, told him.

I went to see this Dr. _____ . He told me to come back a week later and bring $150 in cash. No cash, no abortion. My young husband and I didn't even know

anyone who could lend us that kind of money. Desperation was relieved by the unexpected over-night visit of my uncle who was a physician. He understood the situation and made no effort to change my decision, merely to help me avoid a nervous breakdown, his chief concern being how competent Dr. _____ was. He gave me $100.

I was so frightened that I took a friend with me to Dr. _____ 's office. The pleasant man of the week before had become a raging bull. By the time my friend had left and I had persuaded him to go ahead with the operation (the near-hysterical crying and begging having persuaded him that neither my friend nor I was from the police) I was so distraught that I fell on the stairs following a nurse down to his basement set-up. He had my money and all he wanted was to get it over.

I was taken to one of a number of curtained beds around the sides of one big room—there were of course no windows. I undressed and put on a gown. At that time I knew no one who had had an abortion and hadn't the least idea what would happen to me. A nurse led me out and I got on an operating table at the end of the room.

The operation was a dilatation and curettage done with no anaesthetic and as fast as possible, which meant the cervix was stretched as though it were made of elastic. I would not wish such pain on the vilest criminal. I just hung on tight, not daring to make a sound for fear of making the doctor angrier than he already was. When he finished the job, he picked me up, carried me back to my bed and dropped me from shoulder height. He left, and the nurse drew the curtains and left too. All I remember doing was crying. A couple of hours later, the nurse said I was ready to go. I hailed a taxi in the street and went to my friend's apartment. I stayed there two days, my husband dropping in after work and then going home to _____ where another friend was minding the baby.

About a week after I was home I haemorrhaged. Lying in bed with bath towels wasn't enough to stop blood from soaking the bed. I went and sat on the toilet. I thought I might bleed to death. There was no hospital in the area. I knew no doctor. The nearest phone was three blocks away. My young husband was too scared to do more than mind the baby. I had had an "illegal operation" which meant I had committed a criminal offense . . . the feeling of my insides draining out of me was unforgettable.

The bleeding stopped. I never did find out what caused it. Two years later I had a planned pregnancy. The doctor didn't seem to notice anything abnormal in my condition.

Seven years after the first abortion I had another due again to the failure of birth control. This time one of our top gynaecologists told me to go to Dr. _____ , which I did. He looked like a prize-fighter but presented no problems except $250 cash in advance, which in the depression was an awful lot of money. Instead of using his basement he used his second floor, and I had a small bedroom. I again had a D & C but this time with a general anaesthetic. In a couple of hours after sitting up for some coffee, the nurse said I could leave when I wished but if I wanted a taxi would I please go across to the drugstore and order it from there. Instead, I walked the eight blocks home. The contrast from the sheer terror and brutality of the first abortion combined with a lovely July day made me feel so relieved, it was wonderful.

My husband had not come with me because he was looking after the children. He'd been going through as much strain as I had when he saw me jauntily walking down the street instead of being carried in on a stretcher or crawling out of a taxi, he had a very pleasant shock. But I was taking my kids to my parents and had to pack. So, the second day after the operation I blew a fever, It got worse. Here I was on an isolated island convinced I could be dying of peritonitis. I took one person into my confidence and she backed me up on a story to justify me leaving the children and going back to _____ the following day. I was now running a temperature of 103 degrees. I met my husband in the lobby of the Medical Arts (he looked pale green) and went to see my gynaecologist. Verdict? "If you'd had peritonitis you'd be dead by now." Operation? "Clean as a whistle. You? Sheer devastating strain and exhaustion—go home and let your husband do everything for you for three days." It was a wonderful three days.

Personal Account 6

I, _____ of _____ in the province of _____ do solemnly declare that: "I am 56 years of age. I had an abortion approximately October 1940 at which time I was about three months pregnant. I visited the office of a physician where reams of gauze were packed into my womb. I was awake during this procedure. The next day he visited my home and removed the packing and the foetus was removed. I was supposed to return to his office but did not do so. I went to live with my parents in _____. One morning I awakened and found I was bleeding profusely and called out for my parents as I could not move for fear of drenching the bed. A physician was summoned immediately. I think he removed the afterbirth. The bleeding stopped.

The second abortion occurred during the winter of 1943 to the best of my memory. I was between four and five months pregnant. No other means being available I effected it myself. This was done by inserting a solution of castile soap, cream (dairy) and lysol into my womb with a syringe. I became very weak and took to my bed. I became delirious and a physician was summoned. He pressed on my abdomen and the foetus was expelled. My pulse was very low and I was sent in an ambulance to the _____ Hospital. It was during the war and due to overcrowding I was placed, on a portable bed for moving patients, in the hallway. To the best of my memory I laid there from early afternoon until the next morning when the doctor attended me and I received intravenous and blood transfusions.

My third abortion occurred in _____ about December 1945. Two women met me at a friend's house. They inserted something in my womb twice. The first insertion was very painful and probably would have been sufficient. I don't know what it was but the extreme pain commenced immediately. I think a couple of days later the foetus was expelled. I was about three months pregnant. I was about a week in the _____ Hospital afterwards. I believe damage was done to my bladder and took physiotherapy treatments at the hospital—deep heat applied to my abdomen sometime later. I came to _____ in the winter of 1949 and visited Dr. _____, a gynaecologist. He sent me to _____ Hospital for about a week. I am all right now except that my bladder is a little weak sometimes.

Personal Account 7

I am a woman of 56 years. I am happily married. My husband and I have had two children, a girl and a boy. We have practiced birth control under

supervision of our doctor. I had my pregnancies before oral contraceptives were available. At eleven months of age my second child was diagnosed as a "severe" hemophiliac. Throughout his infancy, youth, adolescence, and manhood, he has been transfused at least twice every month and he has been hospitalized countlessly. At least five times he has been on the critical list.

In spite of my diligent use of the diaphragm (the preferred method of the time) I became pregnant again. It is very difficult to have a healthy family with one hemophiliac. My husband and I knew we could not keep our family in good mental and physical health if we had a third child—hemophiliac or carrier. I knew that we could not manage another child. We also knew that there would be a chance that this foetus could be a hemophiliac son or a carrier daughter.

At that time my daughter was a little over two years of age and my hemophiliac son was a year old. My son was hospitalized repeatedly. My husband had colitis at that time and unable to work, I was forced to get a position to support the family. . . and I was pregnant.

I appealed to my physician, to the physician attending my husband, and to the geneticist at _____ Hospital—all to no avail. No one would give me a therapeutic abortion. I persisted and was interviewed by the chairman of the medical committee set up to review the cases of women who were pregnant with special circumstances. The chairman would not forward my case for consideration because he said that he would not be 100 percent sure that the foetus, if carried to term, would be hemophilic. You see, there was a 50 percent chance that the foetus would be carrying the defective gene.

I had no alternative but to turn to a woman who provided abortions for fifty dollars. She was a distant relative of mine. She did not have any medical training or experience. What could I do? I was desperate. She used a combination of a syringe of warm soapy water and Lysol and of Exlax. After a lot of hard work, scrubbing floors, pushing furniture around and stretching, I induced an abortion. However, I bled excessively and had to go to the _____ Hospital for a D&C.

We continued to scrupulously use birth control. The second and third times I became pregnant, the situation hadn't changed. Again I had to risk the well-being of my family and my life, by self induced abortions. Both times I had to be hospitalized at the _____ Hospital for medical attention. The second time I was admitted due to excessive bleeding (the foetus had not been eliminated) and I developed an infection.

About 1966 I found a gynaecologist, Dr. _____, who was sympathetic to my situation. He did not like to recommend taking the pill because of the possible severe side effects for me. I wanted him to sterilize me but he felt I was too close to the menopause. However, he did promise to sterilize me if I became pregnant. In 1968, I was 48 years old and I became pregnant. Dr. _____ performed an abortion and sterilized me at the _____ Hospital.

Personal Account 8

In the late 1950's I faced a pregnancy which I did not wish to continue. In those days one couldn't, and didn't, talk about it. I'd never come across anyone in the same boat. I lived in _____ . I asked our family doctor if he knew where I could obtain an abortion and recall well that he replied he made a

particular point of not having such information. He said though he didn't dare interfere surgically, he'd do what he could medically. He prescribed the necessary doses to induce menstruation. Though he didn't say so, I suspect he'd done the same for other of his patients. It worked.

I've never forgotten the ghastly misery of the whole business of realizing that I was pregnant. When I knew it was all over, my emotions were those of overwhelming relief. I have never had the slightest sense of guilt whatsoever, only thankfulness coupled with a deep anger that the whole thing couldn't have been done quickly, quietly, safely, and legally.

Personal Account 9

I, _____, do solemnly declare that I know the following to be true:

At the age of 24 I became pregnant because I felt that an unmarried woman was promiscuous if she planned to have sexual intercourse. I left my home city to have the child and gave it up for adoption. The doctor who had diagnosed my pregnancy subsequently prescribed birth control pills. He also gave me long, guilt-producing lectures on self-control.

As a result of confused emotions about my sexuality, I stopped taking the pill and again became pregnant in 1968. After trying to get medical help I resorted to an illegal abortionist who used a soapy douche to induce labour. The first attempt was unsuccessful and two weeks later I had to return to the abortionist, who accused me of becoming pregnant again. She then agreed to repeat the abortion attempt for the same $300 fee. I finally aborted while at work. After several days, when the bleeding had not stopped, I went to a hospital and was given a dilatation and curettage. To this day, I don't know whether I could conceive and bear a child if I chose to.

Personal Account 10

People like me who desperately require termination of a pregnancy will do anything to terminate it. I was aware of the risks involved—unwed and from a respected family. The thought of death occurred to me but I was so upset emotionally that I did not care. As far as I was and still am concerned that "quack" did me a favour. His method was unorthodox—no anaesthetic, no reassurance, an instrument was passed into my vagina, into the cervix. Possibly fluid was introduced. Immediately my bladder filled indicating that the uterus was punctured. What happened after that I don't recall, until I was being slapped on the face to consciousness and told to pay my $400.00 and "get out". Infection and emotional strain and guilt followed, but I was grateful to be alive.

Personal Account 11

In 1963, as a student I found myself pregnant. I wished to finish my training and was in no way ready for marriage or the responsibility of parenthood. My boyfriend at the time was willing and able to marry me and support the family. He was 21 at the time; I was 20. I became pregnant in the summer (July). Since I did not wish it to be known or to tell my parents, I waited until my Christmas holidays before I had the abortion. During the fall, through a friend, I found the name of a woman in _____ who was a waitress and who would perform the abortion for $150. I went to her home on December 19 with two friends who waited in the car.

It was a pleasant, clean, expensive home in a new subdivision. I was taken into the bathroom and instructed to lie down on the floor on the bathmat with my pants off and legs apart. She inserted a hard rubber catheter into my vagina and through my cervix. She then injected a solution of lye, soap, quinine, and oil which she had boiled on the stove. There was a fair amount of cramping and a feeling of fullness but no real pain. I was told I would abort in about 24 hours. No other instructions were given. I gave her the money—cash—and was driven to a party where we spent a couple of hours, then went back to a friend's apartment.

Exactly 24 hours later—about 7.00 p.m. the next evening—I started experiencing bad cramps, nausea and backache. I was alone in the apartment and the contractions became more and more severe over the next three hours. By this time I was bleeding and vomiting. I aborted the foetus finally and panicked, pulled on the cord and probably tore the placenta, retaining a piece in the uterus.

Over the next two weeks I bled off and on, finally ending up in hospital. The gynaecologist who examined me was very angry and punitive. When he heard what I had done, he removed the tissue from my uterus in the hospital treatment room with a sponge stick—and no anaesthesia. *That* was the worst part of the whole experience plus the attitude of the hospital staff when it—inevitably—became common knowledge that I had had an illegal abortion. I had two units of blood, was placed on birth control pills and sent home after three days in hospital.

I have—luckily—been well since, suffered no ill effects physically and although I have not had children subsequently, it is only because I have chosen not to until now. I have never regretted the action I took—only that I took a grave risk with my health and fertility. I certainly suffered no great emotional trauma and then, as now, I was only greatly relieved that a pregnancy was not going to force me into a situation I was in no way prepared or ready for. It really only forced me into being more responsible for my sexual behaviour—and admitting to myself that I was sexually active and not relying on "chance" and the occasional condom.

Personal Account 12

I became pregnant in January 1965 when I was 26. I had been brought up with sex being a taboo word; nothing was therefore ever explained to me. I knew nothing about the hazards, ways of protection—the pill was very new—thus I was quite completely at the mercy of my male partner even at that age, and with a B.A. My menstrual periods had always been irregular (sometimes none for months) so that I was three months pregnant when I found out. Being healthy, and a relative newcomer to the country, I knew of no doctor who could help, or who would know me enough to trust me. The doctors I did speak to, refused to do anything. Only one suggested, that if I did get an abortion somewhere I should come right after, to make sure everything was alright.

Through a friend of my friend a nurse tried to abort me three times with soap solution—cost $100 but no result; I was four months pregnant by then. Through another friend of my friend a man from the U.S. came to that friend's place; he also tried the soap solution method; this time it did work—cost $500 and another $100 to that friend for use of his place.

I did not know the implications of an abortion and went to work the next day. Labor started at noon; I barely made it home; 24 agonizing hours followed.

Luckily my mother was on holidays. My younger brother never figured it out. My father had died in 1963. My friend's friend assisted me during the night.

I spent the next morning in bed and the afternoon washing sheets and towels and all other traces of the abortion. Next day (36 hours after the abortion was induced) I went back to work although I almost fainted on the way; the following week the Dr. said I was all right.

Today, I am enjoying the eighth year of a happy partnership with my spouse and the seventh month with a wonderful, healthy, lively and very much wanted and planned son.

Personal Account 13

Because abortions were not legal in Canada, I was taken to Japan where they were. Although I went willingly, I was rather naive. This option had not even occurred to me. I suffered mental and physical pain.

Because of the language problem, I didn't know what was happening or going to happen to me. I believe there was a balloon inserted into the womb and filled with air to simulate a larger fetus. This balloon was tied to a rope and hung out of my body. An iron weight pulled on the rope and balloon, in hopes miscarriage would begin spontaneously. When it didn't injections were given and labor induced.

Although the staff was very kind, my surroundings were unsanitary. There was bleeding, but I didn't get a change of gown. During the three days or so I spent there my sheets weren't changed.

I was going to college. I had to borrow a substantial amount for the trip. Financially, this experience set me back for a year and more.

"Abortion" was not mentioned in those days. I suffered great anxiety for years afterwards that others would find out, although I personally did not feel I had committed a moral crime. One understanding parent took me to Japan, the other threatened to kill me. Before deciding on abortion, I had almost dropped out of college so I could have the baby in another large city and give it up for adoption. I also considered suicide.

Illegal abortion after 1969

Personal Account 14

In the fall of 1974 I had an illegal abortion. Not something that I'm particularly proud of, but nothing that I'm overly ashamed of either.

When I discovered that I was pregnant I didn't delve too seriously into the possibilities of getting a legal abortion. I was mentally and physically healthy, in a fairly good income bracket and living with the father of the child. When I decided that motherhood wasn't for me, I asked my family physician how I could go about solving this problem. The only solution he could offer was for me to go to _____ for $200.00.

I decided to stay in _____ and pay a bit more if necessary than face the long bus ride before and after the operation. Through one contact and another I

was directed to a respectable doctor who would perform the abortion at the same price ($200.00), with supervised medical attention should it prove necessary. The operation was performed in his office with a nurse standing by to hold my hand. The whole thing took about 20 minutes, and then I was sent home with instructions to call at any time if there was any undue bleeding, or if an infection occurred. Fortunately only one of these happened, and when I called with a fever of 102, the instructions given were complete and proper; and the infection rapidly abated. The whole recovery period, mentally and physically, was about a month.

Don't ask me for the name of the doctor. I have honestly tried to remember it, but have drawn a complete blank. I simply blotted his name out of my mind. I did a heck of a good job—if I were to find myself in the same position that I was in in 1974, I wouldn't know who or where to turn.

Personal Account 15

I was 20 years old when I became pregnant (because of a faulty condom) in late 1969, about to enter graduate school and still financially dependent on my family. The father and I agreed that in order to continue with our education we had to put off beginning a family. We felt that at our age and with our financial situation as it was, a child would surely suffer. Our only recourse was to find a way to terminate the pregnancy. As I knew of no counselling or referral services in _____, abortion was to be found through the grapevine.

I made numerous phone calls, meeting with both rudeness and fear. Perhaps I was lucky that none of the people I contacted were "in business" any more. Through a medical student, I found a man who had European medical papers but who could not practise medicine in Canada.

This man had a fairly complete medical unit in his basement; he was clean, kind and expensive. $350 put quite a hole in a student-sized bank account.

The experience was expensive in terms of emotional costs, too. Everything was shrouded in fear and secrecy. But, I was lucky—my doctor was clean and safe.

Personal Account 16

I live at _____ with my husband and my three children. I had my last period of menstruation in January 1971 and in February when I missed my period I knew I was pregnant and became very worried. We already had three children and my husband did not make very much money. I made some enquiries about an abortion and found that we could not make the $300 to $400 payment that was required in _____ where abortions are legal.

One Saturday in February 1971 I went to _____ who is my hairdresser and I told her about my problem and she called her aunt _____ who said she could help me. I went back home to my husband. _____ came over to my place and we talked about the abortion. She told my husband that she needed $50 now to buy the medicine and my husband went over to the drug store to cash his cheque and he came back and paid Mrs. _____ $50 and she left. She said she would return on Sunday morning.

On Sunday Mrs. _____ returned to my apartment and she told my husband to take the children for a walk for about a half an hour which he did. She then pulled out a bottle of lysol and a bar of soap and asked me to give her a pot. She put soapy water in the pot and poured the lysol into it and then she took a

knife and shaved the soap into the pot. She then gave me two pills to take while she boiled up the solution on my stove. She then told me to lie down on the floor in the bedroom and she took a floor mat and put it under me. She then took a douche and put the nozzle into my vagina and forced the solution from the pot into me. She did this several times then she put all the stuff into a bag and left the rest of the solution in the pot. I put the pot with the remaining solution on the shelf in my bedroom closet. Mrs. _____ wanted another $125, but I told her we didn't have the money.

Mrs. _____ then left our place and I showed my husband the pot of solution. He took it and poured it into a ginger ale bottle. That night I became very sick and the following day my husband took me to the _____ Hospital where I was admitted and Dr. _____ looked after me. On Wednesday, February 24, they let me go home and on Friday I was still getting pains. On Saturday Mrs. _____ came in. We had an argument about the abortion. I told her that she tried to kill me, and my husband suggested that she tried to poison me. Mrs. _____ said she would do the job again but she wanted her $125 and she told me not to go to the hospital again and that I would be alright. After some more arguments she left.

My husband then took me back to the hospital and I stayed there until March 2, 1971. I was still pregnant.

Personal Account 17

I was 18 years old and lived at home with my parents. I had left school and had a job. Through this job I met a man whom I dated for about four months. I was intimate with this man starting about three months before July 20, 1970.

My regular menstrual period should have occurred on July 20 and when it did not happen I became worried that I might be pregnant. I went to my doctor just after that. He assured me I was not pregnant but I was doubtful and went to _____ and had a pregnancy test done. This was negative.

On August 4, 1970 I again went to my doctor and this time I was told I was pregnant. I called my boyfriend and he was unsympathetic but through him and others I got the name of _____ and the telephone number.

On August 28, 1970 I called this number in the evening. The woman who answered said she was _____ but seemed reluctant to speak on the phone. I added that I was a friend of _____ and this seemed to reassure her. She asked how advanced my pregnancy was and other information about myself. She said an abortion would cost $300 and that I should call her back on the Tuesday following to complete arrangements. I did not have the money that day so did not call till the Tuesday after that, which would be September 1, 1970. I said I had the $300, which I had borrowed and saved.

After some conversation she suggested I should see her on Friday, September 4, 1970. I wanted to go in the evening but she said it would be better at 1.00 p.m. She then told me how to get to her address at _____ and that after entering I should go to the third floor where she would look after me.

I had brought some sanitary pads with me at Mrs. _____ suggestion and when I saw that the door to this apartment was open I put the bag inside the door then went outside again after knocking. I heard a voice call from below saying that the caller would be up right away. A woman came up the stairs still speaking and I recognised her voice as the one I had talked to on the telephone.

I paid her $300. She went into the kitchen, turned towards the stove, and then called me into the kitchen. She explained she was heating liquid on the stove to put into me; that it always worked; that she was doing about two abortions each day; and that the girls were sent to her by a gynaecologist because she was so good.

She cleared off the kitchen table. From under the kitchen sink she took a white cloth, with a plastic covering on one side and cotton on the other. She also brought out some disposable diapers, some newspapers, and other things. She instructed me to remove my panties and lie down on the table. I did this. The white plastic cloth was under me, next to the table, then on top of that was the newspapers, then directly below me were the disposable diapers.

She then poured some liquid from the pan on the stove into a syringe. She inserted the syringe into my vagina and used about a pint of the fluid. About then I lost track of things and became sick and began to vomit. The woman fetched a pail and started to clean the articles she had used. I sat up then, feeling better.

She took me into the living room where my two friends were seated. She went back into the kitchen. She brought me a small vial of blue and white capsules that were the same as those in a large jar in the kitchen. She said there were twelve pills in the vial; that she used them for migraine; that I should take one every four hours, and to take two pills if the pain got really bad. She said she had got the pills in large quantities from her doctor for her aches after her hysterectomy operation some years before. I then went to the front door and left.

During the night the pains and cramps started. At about 4 a.m. I passed something solid and started to bleed badly. I called a girl friend and asked her to call an ambulance, which arrived shortly afterwards and took me to the _____ Hospital.

Out of country abortion

Personal Account 18

In 1970 I became pregnant. My husband and I decided together, early in my pregnancy that, because this was an unwanted child, an abortion was imperative. At that time we were living in _____ .Since we were both in therapy with a psychiatrist at that time, we approached him for assistance as he knew only too well the tenuous situation under which we were functioning.

Dealing with a judgmental physician, we were doomed. We had asked that he take our case to the abortion committee at the _____ Hospital. We were refused. We searched around _____ desperately trying to grasp the loose ends of the elusive "red tape" in order to get our case heard somewhere.

With time running out we were forced to go to _____ for we knew of nowhere closer to go for help. Having made a very personal and private decision, we were put in the position of having to expose ourselves to friends and family in an appeal for a lot of money—very quickly. We travelled to _____ where I found a doctor who would perform my abortion for $500. I was then placed in a hospital and complications ensued making it necessary for me to be

hospitalized for three days. The latter cost me an additional $500. Provincial Medicare refused to reimburse me for any of the expenses.

Personal Account 19

I was very much impressed with the kindness and respect with which I was recently treated by a doctor in _____ and his entire staff. Unable to find assistance in _____ , and unable to make a quick appointment in my home province of _____ , I was fortunate to make a very prompt appointment over the phone and acquire a therapeutic operation within one week, at the doctor's office in _____ . I received far more understanding and attention from this office, even over the telephone, than I did in my own country. Without their help, I might still be in trouble today, and I feel deeply indebted to them.

Personal Account 20

In the summer of 1972 I went to my obstetrician (of six and a half years) to seek sterilization advice. I was 32 and a half years old and had two children. Although when I went to my physician about sterilization, I was mainly interested in my husband's obtaining a vasectomy, the doctor proceeded to recommend instead his own technique of vaginal tubal ligation. I had this operation in July 1972.

On October 29, 1974, a G.P. after a lab test confirmed that I was pregnant. A phone call to my obstetrician informed me that he was not so surprised, as he'd been having poorer luck with his technique than he'd expected, and had since improved it.

I was a very stunned, trapped, human being. I felt betrayed by my physician, but worse still, I felt myself in an absolutely impossible situation, that I had done my best to avoid. Previous methods of birth control I had always treated with care and what I felt was intelligence; and they had been effective. The decision for sterilization had been one that had been made with a great deal of thought, discussion and baring of souls—but we had made a decision "for life". I had not thought that I was being careless to let my obstetrician be the judge of the most effective method of sterilization.

Although I went through the motions (in the next couple of days) of preparing myself and my family for the inevitable, it wasn't long before I realized that there wasn't one part of me that wanted another baby. In fact I was very afraid, for my own physical and psychological health, and the effects on my sons and my husband.

My neighbour sent me to _____ where my husband and I received an interview. They agreed to help me. About three days later we met again with the counsellor, who informed us that the _____ doctors working with them were willing to take on my case, but because of the great number of applications going before the Committee at the _____ Hospital, relative to the few abortions that were actually done (the committee meets only once a week), that it would be three or four weeks before I could expect an abortion in _____ . At this point I was now about eight weeks pregnant.

I realized that I would have to take the only alternate route—to _____ . I was lucky in that we could afford it. The bus fare for my husband and I (round trip) was $100; the operation was $150. A phone call from our counsellor to _____ , let the clinic know they could expect us the next morning. We left the children with neighbours and took a 9 p.m. bus to _____ , and at midnight boarded a bus to _____ .

At around 7 or 8 a.m. we arrived in the city and made our way by cab to the clinic. The clinic was clean, efficient, but busy. My husband estimated that at least 30 women were treated during the time we were there. I was asked for a brief medical history, given a tranquilizer (which in my case had little effect), and given pills for afterwards and instructions for taking them. I was also given a blood test. We waited—a not very cheerful group. Finally, around 11 a.m. I was called. My husband could not come. I went into a room with an examining table, a piece of equipment (the vacuum aspirator) and a large empty bottle which had not been rinsed clean. I was told to remove my slacks and underpants and put them on a chair. I climbed onto the examining table and put my feet in the stirrups. I do not recall a gown but rather a sheet over me. A nurse and a doctor were present—both pleasant but rushed. I assume I was given a local anaesthetic.

What I do recall is the shame, the sorrow and the bitterness that I felt. I felt like a second class citizen. In spite of the obvious cleanliness and good medical care, the personal dignity that one expects with any operation, especially one so emotional, was just not there. Because of people like myself coming from out of town and crowding clinics such as these, everything was run like an assembly line. It was sad that I should feel so degraded, simply because I wanted desperately to remain reasonably sane myself, and to be able to raise well-adjusted children. But that is what I felt—degraded, ashamed, and bitter.

I will never forget the feeling of the vaccum machine on my uterus. I was scared. I begged for a few more moments to lie there. I was given a pad and led to an adjoining room. My clothes were laid at the foot of my cot, and I was left along with about 5 other patients. For the most part we were quiet, except to reassure each other about the feelings we were experiencing physically and emotionally. We were given 10-20 minutes to rest, then we got dressed and went through the waiting room. My husband joined us at this point and we went into a sitting room where coffee, tea and a few cookies had been left.

My husband went with four of us to a neighbouring restaurant where we ate lunch and tried desperately to bolster each other's feelings. Two of the girls went to the airport but the other had been in a state of shock since the operation, so we decided to stay with her and take our time and catch the night bus back.

This was in November, 1974. I cried most of the way home. I wanted to die—not for what I had done, but for what I had had to do.

Two weeks later my husband had a vasectomy by a surgeon who has done thousands of such operations with no failures.

Legal abortion after 1969

Personal Account 21

I had an abortion in December 1975. I was pregnant as a result of pill failure; I had been on the "mini-pill". I am married. Both my husband and I feel very strongly about the responsibility involved in having a child, as we are both products of very unhappy families. We periodically discuss whether or not to have children, now or ever. We were very lucky in having done this, as we did

not then have to make a decision under emotional strain and the pressure of time when I became pregnant, we had only to re-examine our criteria. We both feel that no one has the right to have a child unless they are prepared to accept full responsibility for that child's happiness and to do the very best they can for it. Our decision not to have children at this time was based on financial, emotional and career factors.

We were lucky. I have a very good physician who realized that it would be wrong for me to have a child at this time. We were also lucky in living in a large urban centre, where an abortion is more readily available. The whole process took less than a month. All three doctors I was in contact with, the psychiatrist, the physician and the gynaecologist were very competent, and once they were sure that I was sure, very helpful. The hospital staff was very considerate. At no time was I subjected to any disapproval or criticism. My only criticism, in turn, is that I was not informed of the procedure I would be going through. Physically, I had no idea of what to expect.

Personal Account 22

On my first visit to Dr. _____ I was very concerned to have a doctor with whom I could talk. I was pregnant and in an uncertain position. On my return from a one year trip I was three months pregnant with a child not my husband's. I was vaguely contemplating an abortion, but mostly I wanted to carry the baby to term and in that time decide if I would keep the baby or give it up for adoption depending on my situation with or without my husband. I went into the doctor's office wanting to be quite honest about my circumstances. From the first he made me uncomfortable asking questions but not even listening to my answers, sometimes repeating questions twice. He seemed extremely interested in my sexual life implying that since the child was not my husband's, I must have spent my life sleeping around. He asked questions like how many men and how often after I had already told him what had happened.

During the pelvic exam I asked questions about the position of my uterus because I had had previous problems earlier on in pregnancy with my cervix putting pressure on the urethra making it impossible for me to urinate. He gave me little satisfaction never answering a question directly. He told me to come back in two weeks and I left feeling uneasy.

I returned in two weeks hoping things would go better though I was already asking around about different doctors. The experience was even worse. It was as if I hadn't been in to see him just two weeks before. He asked all the same questions over again—even questions such as when I had conceived. Somewhere along the line he asked if I did much drinking. I said no but I occasionally smoked marijuana. This opened another topic of conversation. He started asking questions. I became very nervous as he asked if when I smoked with my friends we had orgies and seemed surprised when I said no. I am not normally upset about questions about my sexual life, or the smoking of marijuana, especially with a doctor. But this man gave me the impression that he was a voyeur looking in on my life and considering me as scum, an "easy lay". My feeling of unease and nervousness was absolutely confirmed with the humiliation of that doctor rubbing my clitoris with his thumb as he was doing the pelvic exam. I've had many pelvic exams and no doctor has come close to touching my clitoris. The doctor I went to see after this doctor told me a second pelvic exam, 2 weeks after the first was not necessary, if not detrimental.

Personal Account 23

I found it expedient through undergoing mental anguish and great physical discomfort to decide against carrying my fourth pregnancy to term. This decision had been a difficult one, arrived at eventually by a consensus of opinion, in that my husband and I talked exhaustively about our decision, then took the matter to our three children for their views. Because we lived at that time in _____, we were able, with little difficulty, to obtain an abortion and we have none of us regretted that decision since.

Ours is a warm happy and loving family environment. My pregnancy was the result of an IUD failure. We could have stretched our finances to absorb yet another family member, but we felt we were unable to stretch our emotional and physical resources, enough to welcome another child.

I come from a background where my mother found herself pregnant with her first child (me) at a most inconvenient time. My mother was an immigrant as was my father and both struggled to make ends meet in an often hostile environment. The home I was raised in was never a happy one. It was an emotionally deprived situation. I am of the firm opinion that some women are not meant to be mothers. They do actual harm to society in raising children. My mother may well have been one of those women for all her children are alienated individuals in one way or another. While I give thanks to my parents for bringing me into the world, for I hold it most dear, I do believe my mother should have been given the choice to have, or not to have children.

Personal Account 24

I am writing to you about my experience with having an abortion in _____ in July 1975. I am thirty years old, single, and a university graduate. I have conscientiously practiced birth control and have subjected myself, over the past ten years to such unpleasant and perhaps dangerous methods as the pill, two different IUDs, foam, and finally a diaphragm and jelly (which I was using when I became pregnant). When on the pill I tried several different brands and they all produced in me a bloated uncomfortable body, mood swings, depression, and a general feeling of not being myself. I persevered for several years, going off occasionally.

I realized that it was certainly not conducive to leading a productive, positive life and I refused to subject myself to that again. However, I know that the pill is the safest form of birth control, but for me the price is just too high. I doubt that many men would be prepared to subject their bodies to that kind of abuse.

Next I tried an IUD (the safety coil) which I kept for four months but couldn't tolerate. It was too big, I was told by another gynaecologist, and I have a small uterus. So he removed it and inserted a Dalkon shield. The cramps and bleeding were not much better, but I reasoned that after all some people live with the pain of arthritis and so I could survive with this. I lasted eight months this time. I had the Dalkon removed when the scare of infection and several deaths in the U.S. from women pregnant with the device in place.

At the time I realized that I was pregnant I was working for the summer in a community about 150 miles from _____, and could appreciate how difficult it must be for women who live long distances from big centres and have to come down twice, once for the initial assessment and then again several weeks later. My own gynaecologist was unable to help me because he was on the

Committee at _____ Hospital and apparently that eliminated him as a doctor to administer treatment to his patients in this area. He gave me the name of several other gynaecologists at that hospital whom I called. Two of them were on holiday, one was no longer performing abortions and one had his quota filled for the following week's committee meeting. I was floored!

My faith was shattered, and when it was suggested in my search to find a doctor that I go to _____ , I was tempted to pay the $200 and go. But now it became a matter of principle. I pay my premiums, I rarely use the services I am supposed to be insured for and now I had a real need and I was being advised to go to the States, pay out of my pocket, and act like a criminal, sneaking over the border.

I must have made fifteen phone calls that afternoon to different doctors and none of them would help me. They either didn't do abortions, they were on vacation or I would have to wait two weeks. The staff at _____ Hospital told me that since I was so early (six weeks), it would be about three to four weeks before I could have the abortion because they were bogged down with cases that were 11 and 12 weeks pregnant and they too had a quota. I was shocked and deeply angered. This was forcing me to wait three to four weeks.

I finally found a doctor who practiced at _____ Hospital, who said he would do it, but I would have to wait two weeks because their committee wasn't meeting the next week because again the bloody doctors were on holidays. I decided to take it. He informed me, after an internal examination that confirmed my positive pregnancy test, that I would be required to see a social worker at the hospital, and I would be examined by another gynaecologist on staff at their hospital. As I sat in his office and he spoke to the social worker on the phone, he assured her that I had been using birth control. He repeated this several times, and seemed to be trying to convince her to see me. He said that it was important that I stress to this social worker how depressed I was and to tell her that I had been using the diaphragm when I got pregnant because her report was very important.

I swallowed my anger, saw the social worker, visited the other doctor who stuck his professional fingers inside me and nodded sagely that I was about six weeks along. This whole process wasted the time of all the people I had talked to on the phone trying to find a doctor. It wasted the time and services of a social worker and a doctor who performed an unnecessary examination on me. And it wasted my time and energy, and humiliated me unnecessarily. I had done nothing I was ashamed of and I refused to feel guilty or like a criminal. I was given no supportive counselling and the only person who spoke in an understanding, kind way was the nurse of one of the doctors at _____ Hospital, who gave me some advice and expressed concern with my situation. God bless her.

The final humiliation came two weeks later when I again returned to _____ after a nauseating bus trip and was admitted to the hospital. I was told that I would have to stay for 24 hours after the operation, which I had no intention of doing, and come in the night before. At 10 p.m. a nurse (who was also very kind) came in with a large soapsuds enema and a shave prep tray. I was to have an enema and shave prep for a first trimester abortion! I refused. The woman in the next bed was not so lucky. She was vomiting as a result of hers, and was sharing my fate the following day. But she didn't know that it wasn't necessary, and thought it was part of the procedure. When I awoke in the

recovery room with an intravenous Pitocin drip interstitially infusing into my hand, I removed it. I refused another IV and was given an injection of Pitocin IM and returned to my room which I left four hours later, against the protests of a head nurse.

Personal Account 25

Through an IUD failure, I became pregnant in January 1972. I was a student in ——— at the time, and unmarried. To undertake the role of motherhood was impossible for me at the time and I was most upset and nervous. But I was fortunate. I lived in a large metropolitan area and had relatively easy access to hospitals with therapeutic abortion committees. I had an understanding general physician who knew that I could not carry that pregnancy to term and who referred me to a gynaecologist who in turn submitted a recommendation for a therapeutic abortion to the ——— Hospital. I had a most anxious two-week waiting period before I learned that I had been accepted. I woke up in the recovery room feeling nothing but gratitude that I did not have to be forced into the role of motherhood prematurely. Today, three years later, I have graduated, have a promising career, and have married.

Personal Account 26

In mid-December 1974 I learned on a visit to my doctor that I was one month pregnant. I decided to have an abortion. Irrespective of my age, financial and marital status, I simply and very strongly did not wish to have a child at that time, nor, I quickly realized, by the man with whom I had conceived. Carrying the child for nine months and allowing it to be born seemed much more unnatural than aborting a foetus I hated. I felt that my whole body was in revolt against me; not only was there an unwanted thing in my stomach, but I was constantly nauseous, aching, and extremely tired.

My doctor composed the necessary letter to the gynaecologist who would do the abortion, should permission be granted. Although nothing in the letter was exactly a lie, much of it was slanted. The facts were true; I was 25, single, unemployed, and had split apart from the man by whom I had conceived.

During my initial interview with and examination by the gynaecologist he only once actually looked me in the face. The rest of the time I was treated as an object to be examined or a piece of meat to be prodded and probed. Had I been in a position to change doctors, I certainly would have, for he made me feel like an insignificant piece of dirt.

Dr. ——— and his committee agreed to the abortion. It was performed in mid-January, a month after my pregnancy had been confirmed, and two months after conception. I was placed in the maternity wing of the hospital. I am not so insensitive as to feel no regret, no sense of loss for the child I didn't have. Someday I should like very much to have a child, but not now, and certainly not then. My decision to abort was not made lightly. The one consolation was that the nurses on this ward were extremely kind and friendly, providing the sort of warmth and understanding that neither my own doctor nor the gynaecologist were able to (or cared) to give.

I consider that I got off very easily—I was referred promptly to a specialist; got permission to have the abortion; had my costs covered by ——— ; and suffered no complications at all. What I do object to is having to wait a month; having to agree to a letter that bordered on defamation; having to be the

patient of a doctor who was cold and insensitive in the extreme; having to be granted permission by an unseen committee for an operation I regarded as essential. I felt powerless and abused throughout the whole experience.

Personal Account 27

It was in 1972, and I was 17 years old at the time. My boyfriend and I were using contraceptives, a condom, which broke during intercourse. Perhaps he wasn't wearing it properly, perhaps it was old, I don't know. When it was confirmed I was pregnant, my doctor (a G.P.) was very helpful. She contacted another doctor for me who could perform the abortion. This was the start of the countless excuses I had to make to get time off work. The only people who knew of my pregnancy were my doctor, my boyfriend, and a very close friend. My doctor had written a very good covering letter explaining everything. Of course this doctor didn't believe a word of it and quite frankly told me so. By then I was even more humiliated. He announced that because of my age (not yet 18 he could not do the operation without parental consent. The whole purpose of the covering letter and my seeing him was so that I would not need to get my parents involved.

I had graduated from school at the age of 16 and that same year had found a very reputable job. My parents were, at that time, going through a marriage crisis and were drinking quite heavily. My older sister had moved out some two years before, and my other sister and I were having a hard time at home. We decided to leave and share an apartment together, feeling that my parents' marriage would be saved somewhat, which, incidentally, it has. I had started my job in June, we left home in October. It was December when I found I was pregnant. Our parents still were not speaking to us—it was four months before they realized the reasons for our move. I had a lot on my mind then, and could not bear to have my parents involved.

My doctor searched and finally found another doctor for me to see. He agreed to do the abortion, but his attitude was even worse than the former doctor. He admitted "I have 4 kids. I bring babies into this world, I don't like having to do abortions." I was charged $150 and had to travel out to a rather dingy hospital. I could not even tell my sister for fear of her upset. So I fabricated some story about the need for a D&C and asked her to tell my coworkers that I had the flu. At this point I was about three months pregnant. I went and returned from the hospital alone. During my stay they found that the father of the child had a positive blood type and I had a negative, resulting in numerous tests, injections and worries. The nurses in the ward knew what we were in the hospital for and treated us accordingly. One woman in my room (there were five of us crammed together) had to come from _____ and another sobbed her heart out the whole time. There was no type of counselling.

I only took three days off work, since I was a bit paranoid and thought any more time off would arouse suspicion. I really didn't think I needed more time. I was only back a week and a half when I started to hemorrhage violently at work and had to be shipped back to the hospital for another D&C to get rid of blood clots. It was at that time that my boyfriend took off, never to be seen again. It's been so long since I've spouted this story. I'd forgotten how alone and empty I'd felt. It's good to talk about it. Too bad I couldn't do this three years ago.

Personal Account 28

When I was seventeen in 1972, I had an abortion at the _____ Hospital. The only way I found out about how to go about getting one was through a

girlfriend of mine. Half a year before she had had one. I was lucky she could help me as I had never read any information about legal abortions in any doctor's office, or for that matter at school.

When she took me down to the clinic she told me I'd better act pretty desperate and young or else they might not let me have the operation. So I told them the truth: I *was* desperate. I did not think of the thing inside me as a child but as a problem I wanted to get rid of. I also told them I wanted the whole thing absolutely confidential. Since I was over 16 years old this was done.

I was given a rough, cold internal examination in a lineup of other girls who had similar problems. During my two night, two day stay at the hospital I was treated fairly. I don't know what kind of operational procedure was practiced on me. The abortion was not discussed with me at all, by nurse or doctor, before or after the abortion. I was however given a birth control prescription afterwards, and was told how to look after myself for the following two months.

Personal Account 29

My medical background as it affects the abortion:

August 1974—gave birth to my second son.

September 1974—coaxed my husband into having a vasectomy.

June 1975—had a "stripping operation" done (varicose veins) to the tune of 37 scars on my legs.

December 1975—I discovered I was pregnant. Hubby had *never* had his sperm count checked. He was fertile!

I told my doctor that I wanted an abortion. No questions were asked as his office made arrangements for me to go to Dr. _____ . I had to make three trips to _____ —all in the few days before Christmas: (1) Appointment—general examination by Dr. _____ and my only chance to give my "story" (I was told that it had to be a good one or the abortion committee at _____ Hospital would not accept it.) With the story of my husband's vasectomy and my leg operation, I was OK'd. (2) Appointment the day before the abortion (Dec. 22)—to insert an apparatus that causes the cervix to dilate. (3) _____ Hospital: Admitted 8.30 a.m.; out by 4.30 p.m. After I came out of the recovery room, I spent the rest of the day in a large room with about 10 women who had also undergone abortions that day. It was a depressing environment, believe me. I had semi-private hospital coverage but this was not used.

I was told the bleeding after the abortion would stop within five days. Mine stopped three weeks later. I finally began my first menstrual period after the abortion on Feb. 4, 1976. Unfortunately, it never stopped. In fact, it got heavier. Yesterday (Feb. 20), I had to have a D&C performed. Today, I'm recuperating, and hoping that things will start to "get right again" with my body. Was the abortion performed correctly? If so, why so much subsequent bleeding and the D&C?

Personal Account 30

In the summer of 1972 I had a Dalkon Shield inserted by my obstetrician-gynaecologist. I had no problems with it, but in November of that year I

discovered that I could no longer feel the string and went to my doctor to see if it had been expelled unnoticed. A pregnancy test came back positive. At that time I was single and unemployed and financially dependent upon the man I was living with. I asked my doctor to help. He suggested going out of town, but I felt that I should be able to have the abortion locally, and we submitted an application to the _____ Hospital. I wrote a letter outlining the various reasons I desired the abortion and also consulted a psychiatrist upon the recommendation of my doctor. My application was turned down, and my doctor remarked that one committee member had asked whether I was a "test case". A referral was made to Dr. _____ of _____ Hospital in _____ . I saw him six days after my refusal in _____ and had the abortion performed under local anesthesia three days later on December 21.

Personal Account 31

Appointment was made with Dr. _____ for one week after the pregnancy had been confirmed in _____ . Arrived in _____ . First saw the gynaecologist who referred me to a psychiatrist in the same building. Before seeing the psychiatrist I was asked to complete several forms; one was a fill-in-the-blank questionnaire and some of the questions were:

I feel _____ Mothers _____ what annoys me most _____ I wish _____ Sports _____ Most feared thing _____ Dancing _____ I hate _____ I dislike _____ People _____ I like _____ this place _____ Men _____ Reading _____ .

Then I went into the psychiatrist's office and we talked for about half an hour. He asked me several questions: Have I ever had V.D.? What would my parents think if they knew? How many men have I slept with? Why do I want an abortion? How much money do I have in the bank? How much do I earn monthly? How old is my boyfriend? Will I ever get married? Was I using birth control? Why not? What would I do if I didn't get the abortion? If I had the baby, would I keep it or give it up? Had I ever taken drugs? Did I ever try to commit suicide?

I then saw the gynaecologist. He examined me and I was finished. They said the committee would meet Friday and I'd be called. The operation was scheduled for 11.30 Tuesday. I was given my first needle at 11:00 and got to the operating room at 12:00 or 12:30. Another needle—out stone cold. Back to my room by 1:30. I slept all day. I was given intravenous immediately after my operation which lasted for about six hours. For the next few hours I was extremely tired and wanted to sleep. I was in an overflow ward with other women who were having gynaecological surgery. By Wednesday morning I was restless and more than glad to be discharged. The nurses and doctors were all nice to me. I felt no hostility or coldness from them at all.

Personal Account 32

A couple of years ago I had to give up taking the pill and due to some misinformation I became pregnant. My husband and I were in a position where we would have run into great financial difficulties had I gone through with the pregnancy and I decided to seek an abortion . . . I was put in the care of a very qualified doctor and subsequently had the operation in a _____ hospital under the proper conditions.

Personal Account 33

At 38 years of age, I had an abortion last year. Not having any particular reason for not having another child, such as poor health, financial, emotional,

family insecurity, I was very upset thinking of going through another pregnancy.

My doctor insisted there would be no problem, referred me to a gynaecologist who after a very pleasant examination, told me of my appointment in one week at the _____ Hospital where in a pleasant one night stay (sterilization included) I was relieved of all my anxiety. I have never had *one* twinge of guilt or misgiving since I am a devoted mother of two, very happy with her lot who knows there are enough (too many) children in the world.

Personal Account 34

In the Spring of 1973 I had been fitted with an intra-uterine device, the Dalkon Shield, by Dr. _____ . He had recommended the IUD as a method of birth control, following the development of side effects (severe headaches and chest cramps) on the pill, which I had used for approximately five years. I did not regard myself as being in either a financial or an emotional position to adequately maintain a child. The IUD was still implanted in my womb somewhere, and I was concerned about its potential damage to the fetus. Finally, I was pregnant *despite* having followed medical advice.

In the late summer of 1973 I had separated from my husband. During October 1973 I began to think I was pregnant. My regular doctor was away at that time and I was examined by another doctor who was unable to confirm a pregnancy. Following a two or three week delay, such a confirmation was made. Since I have a low income I requested a referral to a doctor with whom I could discuss a therapeutic abortion. An appointment was made with Dr. _____ for the second week in December. I was informed that this was the earliest possible date.

During the pre-examination interview, Dr. _____ conducted a very cursory review of my personal situation and my reasons for desiring an abortion. He attempted to discourage me from undertaking that action, arguing that economics were not a barrier to raising a healthy child and that childbearing was a beautiful and most fulfilling experience. He suggested that children could "bring together" a previously unhappy marriage. I could bear the child and put it up for adoption. Dr. _____ went to great length to describe the medical "dangers" of the therapeutic abortion procedure, such as future child-bearing difficulties and possible sterility.

A nurse was not present during the examination. The conversation escalated to a diatribic monologue. Dr. _____ claimed that doctors such as himself were being "forced" to perform therapeutic abortions by the actions of the "damn stupid" government which had relaxed the regulations surrounding this procedure. I suggested that if the procedure bothered him so much he should refer me to another doctor. He stated his opinion was the unanimous position of all doctors, so that a referral was unnecessary. He claimed this was the reason for all the gynaecologists "getting together" and setting a standard fee, which was higher than the government rate for the procedure and was directly charged to the patient. That action was the only option available to doctors to "counter" the government and to control what had become, in his opinion, an "abortion on demand" situation. Dr. _____ became quite emotional and excited, repeating many of his arguments and claims. At one point he accused me of "looking at him as though he were stupid". I assured him that I was not, but that I did not agree with many of his thoughts or opinions. All of this occurred

while I was undressed and on the examining table, and lasted for approximately 20 to 30 minutes.

After the examination, Dr. _____ agreed to perform an abortion. He said I would be required to pay the fee prior to the operation. It was, to the best of my recollection, either $120 or $160. At no time did he describe what was actually involved from a medical standpoint.

I had one examination in late January 1974 with Dr. _____ following the abortion. The latter was conducted on either December 22 or 23, 1973, and was completely straightforward, with no complications. At the time of the examination I complained of a discharge. Dr. _____ declared it to be quite normal, and declared me healthy. For approximately a month and a half I ignored the discharge, until it became quite painful. Subsequently, another doctor diagnosed it as symptomatic of extensive cervical infection. He referred me to still another doctor who performed a cervical cauterization later that spring, after a period of drug therapy.

The personal side of care

Regardless of how their pregnancies were terminated, all of the women who gave personal accounts had in common a deeply held concern about the choice which they had to make. Once they had made their decision, they had a sense of urgency to get it over, that they wanted to get the induced abortion done promptly. As the number of illegal abortions has declined and there has been a shift toward more patients obtaining this operation in Canadian hospitals, these personal accounts show that there have been changes in the outlook of women about the type of care which they expected to receive. Unlike the frightened women who got illegal abortions, often under hazardous circumstances and at considerable cost, many of the personal accounts about abortions which had been done since 1970 show that these women expected, but had not always in their judgment received, compassionate treatment from doctors and nurses.

These women felt they were entitled as patients to a degree of respect and a sensitive understanding of their situation, qualities which for a number of women had been missing when they obtained their abortions. While the technical quality of the care which they got may have been excellent, and in terms of what is known about the low rate of short-term complications associated with therapeutic abortions this seems to have been so, these women in some instances felt they had been treated with discourtesy and had been humiliated or degraded as persons.

At its nub the effectiveness of the doctor-patient relationship rests on a sense of mutual trust and respect. For those conditions which require a personal knowledge by a physician of the social circumstances of a patient, particularly when these matters involve social ethics and stigma, the give-and-take in obtaining information under these circumstances requires time, much perception, and a sense of personal tolerance by patients and physicians. Because of the important service provided by the medical profession, patients

often have a feeling of personal gratitude for the treatment and the special concern which they have received from their physicians. Patients may see their physicians as wise and understanding counsellors who are to be trusted as few others are in society with the intimate details of personal experience.

But just as there can be discrepancies between what is ideal and what is actual, there are also two sides to the treatment which is given to induced abortion patients. For many of these patients and their physicians, the customary doctor-patient relationship had broken down. In many instances mistrust had replaced trust. There was much mutual bitterness and a not always shielded antagonism. For some patients and some physicians, these situations led to strained and emotional encounters.

From the perspective of the women who had induced abortions, the personal accounts give some graphic details about how they saw their medical treatment and how they felt about it. Many of these women were angry that despite having previously visited physicians and having taken contraceptive precautions, they were seen to have been sexually irresponsible or promiscuous. They were often angry about the difficulties which had been involved and the complex manoeuvring which was required in the processing of their requests for an abortion through professional and administrative networks. They saw many doctors as roadblocks, rather than as facilitators. In their eyes some of the physicians whom they had consulted had failed the test of personal decency by insulting them, making light of what was being done, providing indifferent and impersonal care, or on occasion, giving rough physical examinations.

In some instances the pelvic examinations of these women by their physicians had not been done in the presence of a nurse or another attendant. A few patients in this situation felt that the professional care which they had received bordered on being impertinent and in one instance, lewd. The extent to which this happens is unknown. Because of the intense personal nature of this aspect of the doctor-patient relationship, which in some cases were already strained, these allegations are difficult to prove. It should be observed, however, that where the widely endorsed but not always adhered to practice was followed of having another attendant such as a nurse or an aide present during a gynaecological examination, no concern was voiced by these patients about professional improprieties. Some of the women who gave their personal accounts were upset because they had been financially gouged for a service to which they felt they were entitled under national health insurance. Constrained by the stigma associated with this operation from making formal complaints about their extra-billings, some of these women felt their physicians had taken an unfair advantage of them.

The views of the physicians who did abortion operations were on occasion in sharp contrast with those of their patients. Half of the obstetrician-gynaecologists in eight provinces did not perform this operation. Among the members of this medical specialty who did, many did so out of a sense of professional obligation. Almost without exception these specialists and many family doctors made the point that they had been primarily trained to provide therapy and to save lives, not to terminate life. With little or no formal training in the social and psychological management of the special circumstances

involving the women who were seeking abortions, these physicians had much ambivalence about their work. Adhering to the ethics of their profession, many of these physicians gave exemplary care. But the personal dislike which some doctors had about induced abortion was not always professionally shielded in their treatment of these patients. Their opinions of induced abortion such as in some of the replies which were given in the national physician survey were readily apparent to their patients.

> The women who do not take the trouble to try to prevent pregnancies are the majority of abortion cases.
>
> • • •
>
> I have seen many women who repeatedly come demanding abortions for unwanted pregnancies, but yet despite family planning counselling they "cannot be bothered" to take contraceptive measures.
>
> • • •
>
> ...someone who's doing sex liberally, without morals, not bothering (about) contraception. Having no responsibility, not willing to obey parents or school disciplines, alcoholics, school drop-outs, and welfare cheaters.
>
> • • •
>
> An easy solution to an illegitimate affair or a morning after the night before.
>
> • • •
>
> Many of us feel our practices can be ruined by the constant barrage of young irresponsible girls seeking a therapeutic abortion without a whim of regret and like it's our responsibility to perform it. I do it. But I dislike it. Our beds are filled with these patients, while others wait months for elective, needed surgery.
>
> • • •
>
> Love and sexual companionship are rights to be preserved and cherished, not treated as an offhand form of excitement as part of the day's entertainment.
>
> • • •
>
> Too liberal and readily available...the increasing number of repeaters with an increasing decline in morals leading to degradation and degeneracy.
>
> • • •
>
> Abortions are sought by women as a "back-up" to contraception and women have become careless about contraception.

Ridiculous: After 25 years of active practice—this problem did not exist 15 years ago.

What the sharp differences in the perspectives of some patients and some doctors about induced abortion highlight is that personal convictions can be, and on occasion are, intermingled with what patients may expect of physicians, and in turn, be involved in the professional judgment of physicians. Changes in legislation do not immediately alter long-held values, particularly when the medical condition poses difficult choices involving personal morals, professional ethics, and much social stigma. Unlike the practice of some other branches of medicine, there was little that was felt to be satisfying either by patients or physicians about the induced abortion operation. Both wanted to be done with it as quickly as possible. From the personal accounts given by women and the surveys done by the Committee, **an appraisal of how the optimal professional care of women who obtain induced abortions can be provided is indicated, an appraisal which takes into account their views, and the concerns of the doctors and nurses who serve them.**

Chapter 9

Medical Practice

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

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

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

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

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

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

Profile of physicians

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

[2] Among the physicians returning questionnaires, no information was given by 4.2 percent about their sex; 3.6 percent, their age; 3.7 percent, martial status; 3.9 percent, religious affiliation; and 9.2 percent, the province where they lived.

Definition of health

Physicians were asked what was included in their definition of health in the context of therapeutic abortion. The five major components which were listed were: physical health; mental health; social and family health; eugenic health; and ethical health.

TABLE 9.1

COMPONENTS OF CONCEPT OF HEALTH IN CONTEXT OF THERAPEUTIC ABORTION BY SELECTED CHARACTERISTICS OF PHYSICIANS

NATIONAL PHYSICIAN SURVEY

Characteristicis of Physicians	Concept of Health					Row Totals (N)	
	Physical	Mental	Social	Eugenic	Ethical		
AGE							
25-34 years	99.2	84.6	60.0	77.7	77.5	884	(28.3)
35-44 years	95.5	81.5	60.5	75.4	76.9	840	(26.8)
45-54 years	92.9	79.6	55.0	71.8	74.2	798	(25.5)
55-64 years	91.4	75.8	50.3	68.1	70.3	360	(11.5)
65 years & over	90.3	69.4	38.1	64.9	70.1	134	(4.3)
RELIGION							
Catholic	88.5	62.0	36.7	58.1	55.8	960	(30.7)
Jewish	98.1	94.9	80.8	83.2	88.8	214	(6.8)
Protestant	97.4	91.1	63.2	80.7	84.6	1,412	(45.1)
Other	94.6	88.8	68.9	78.2	79.8	312	(10.0)
None	97.3	82.0	63.1	78.4	80.2	111	(3.5)
REGION							
Maritimes	93.9	83.8	58.1	72.2	71.7	198	(6.3)
Quebec	92.5	70.9	46.7	70.0	66.0	724	(23.1)
Ontario	95.7	85.9	62.7	75.7	80.0	1,082	(34.6)
Prairies	95.7	80.4	53.2	72.6	75.9	419	(13.4)
British Columbia, Yukon and Northwest Territories	94.3	84.9	62.2	76.3	80.6	418	(13.4)
SEX							
Female	95.5	83.5	59.4	78.4	79.0	310	(9.9)
Male	94.4	80.4	56.4	73.1	74.8	2,689	(85.9)
SPECIALTY							
General Practitioner	93.5	80.7	55.9	71.8	74.6	2,207	(70.5)
Obstetrics-Gynaecology	93.5	77.7	55.6	74.8	73.9	922	(29.5)
Column Totals (N)	2,925 (93.5%)	2,498 (79.8%)	1,746 (55.8%)	2,274 (72.7%)	2,328 (74.4%)	3,129	(100.0)

Physical Health. There was general agreement among physicians that the physical health of patients was central in their definition of health with

93.5 percent citing this reason. There was a broad consensus among physicians of different ages in the two specialties although there was a slight trend which increased with the age of the respondents. There were only minor differences in how this concept was seen by the sex of physicians or where they lived in the country. There were also small differences in this respect by their religious affiliation with 97.4 percent of the Protestants mentioning physical health in their definition of health as it applied to therapeutic abortion, 98.1 percent of the Jewish respondents, and 88.5 percent of the Catholic physicians.

Mental Health. Most physicians said that mental health was a valid part of the definition of health (79.8 percent) in the context of therapeutic abortion. Opinions on this point varied directly with the age of physicians with 84.6 percent between 25 and 34 years citing this factor, while the distribution among other age groups was: 81.5 percent, 35 to 44 years; 79.6 percent, 45 to 54 years old; 75.8 percent, 55 to 64 year group; and 69.4 percent, 65 years and older. Women mentioned mental health slightly more often than men as this concept applied to therapeutic abortion.

More substantial differences occurred by a physician's religious affiliation, a personal attribute which was partly linked to where physicians practiced. Mental health as it related to therapeutic abortion in the general concept of health which was held by physicians was endorsed by: 91.1 percent, Protestants; 94.9 percent, Jews; 88.8 percent and 82.0 percent by respondents of other or no stated religious affiliation; and 62.0 percent by Catholic physicians. With the exception of Quebec, the regional differences were not great. Among the regions, 83.8 percent of physicians in the Maritimes, 85.9 percent in Ontario, 80.4 percent in the Prairies, and 84.9 percent in British Columbia cited mental health in this context, while 70.9 percent of the physicians in Quebec endorsed this point. More, though not many more, family practitioners than obstetrician-gynaecologists recognized mental health in their definition of health as it applied to therapeutic abortion.

Social and Family Health. Over half of the physicians (55.8 percent) said that a patient's social circumstances and the implications of her well-being to her family were an integral part of health which should be considered in the context of therapeutic abortion. Younger physicians were more likely than their older colleagues to adopt this view. Among physicians who were between 25 and 34 years, 3 out of 5 (60.0 percent) gave this reply. The proportion of physicians holding this view dropped substantially among older physicians. This perspective was endorsed by 55.0 percent, 45 to 54 years; 50.3 percent, 55 to 64 years; and less than half (38.1 percent) among physicians who were 65 years and older. Slightly more women than men regarded social health as a component of health in the context of therapeutic abortion. There was no difference in the proportions of family practitioners and obstetrician-gynaecologists who accepted this indication.

There were broader differences between the views of Catholic and non-Catholic physicians regarding the validity of social health in the context of therapeutic abortion. Jewish physicians most often endorsed this view (80.8 percent), Protestants and those with no stated religion held it somewhat less

often (63.2 and 68.9 percent respectively), while most (2 out of 3) Catholic physicians did not accept this interpretation (36.7 percent endorsed this point). There was less regional variation in these replies. The distribution of physicians who accepted social health in the context of therapeutic abortion was: 58.1 percent, the Maritimes; 46.7 percent, Quebec; 62.7 percent, Ontario; 53.2 percent, the Prairies; and 62.2 percent, British Columbia.

Eugenic Health. While the phrase "eugenic health" can have many meanings, it is generally seen to involve genetic factors which may be associated with an individual's health. Three-quarters of the physicians (72.7 percent) included this consideration in their definition of health in the context of therapeutic abortion with a trend toward younger physicians emphasizing this component somewhat more than older physicians. This position was taken by 77.7 percent of physicians who were between 25 and 34 years; 75.4 percent, 35 and 44 years; 71.8 percent, 45 and 54 years; 68.1 percent, 55 and 64 years; and 64.9 percent who were 65 years and older. Slightly more female physicians than male physicians held this view. There was little difference by where they lived, or whether they were trained in obstetrics-gynaecology or family medicine. There were, however, more marked differences in terms of their religious affiliation. More Protestant and Jewish physicians (80.7 and 83.2 percent respectively) included the eugenic principle in their concept of health in the context of therapeutic abortion than did Catholic physicians (58.1 percent).

Ethical Health. The idea of ethical health involves events affecting a person's health status which may result from activities considered to be illegal or immoral. Some of these considerations may be clear-cut such as injuries resulting from assault, others may be somewhat more ambiguous such as venereal disease, while some issues such as induced abortion and euthanasia are deeply rooted in moral principles. Three out of four physicians (74.4 percent) believed that ethical considerations should be included in the concept of health when it involved therapeutic abortion. There was a trend, but one which was less marked than for some of the other components involved in the general concept of health, for younger physicians to hold this view more often than older practitioners. There were few differences on this point by the sex of the physicians, but there were more marked regional differences. More physicians who practiced in British Columbia (80.6 percent) and Ontario (80.0 percent) held this view than the proportion of physicians who lived in the Prairies (75.9 percent), the Maritimes (71.7 percent) or Quebec (66.0 percent). As was the case in how the social and eugenic factors associated with the general definition of health were seen by physicians, there were differences which occurred by their religious affiliation how the ethical aspects of health were seen in the context of therapeutic abortion. Considerably more Protestant (84.6 percent) and Jewish physicians (88.8 percent) than Catholic physicians (55.8 percent) endorsed this principle.

Overview of Definition of Health. Physical health considerations in the context of therapeutic abortion were endorsed by virtually all physicians. In contrast, there was less unanimity and several consistent differences as to how the other four components of the definition of health were seen. About 3 out of 4 physicians endorsed mental health, eugenic and ethical considerations. While

the idea of social health was less often cited, over half of the physicians in the national physician survey held this perspective. The most marked differences among the physicians endorsing these ideas were by their age and religious affiliation. Consistently, younger physicians and more practitioners who were Protestant and Jewish considered these four ideas to be central to their concept of health in the context of therapeutic abortion. Conversely, fewer older physicians and Catholic physicians endorsed these principles.

Medical indications for abortion

Physicians were asked what health indications they would consider to be valid in the support of an application for an induced abortion. A distinction was made between a request for an abortion that occurred during the earlier stages of a pregnancy (first trimester) and one that was above this length of gestation (second and third trimesters).

Indications for Supporting an Application for Therapeutic Abortion	First Trimester	Second Trimester	General Definition of Health in the Context of Therapeutic Abortion*
	percent	percent	percent
Physical Health	91.7	67.7	93.5
Mental Health	81.8	47.3	79.8
Family Health	54.0	23.1	55.8
Eugenic Health	81.6	57.0	72.7
Ethical Health	85.5	52.3	74.4

*From Table 9.1.

There was considerable similarity in how the indications for an induced abortion during the first trimester were seen by physicians and in their ranking of the components of how they defined health more broadly in the context of therapeutic abortion. The level of endorsement was slightly higher for three indications (mental, eugenic and ethical) for a first-trimester abortion than the extent of their support cited in the general concept of health. For each of the five broad categories of indications, there was an across-the-board substantial drop between support of indications which were felt to be appropriate during the earlier weeks of a pregnancy than during its later stages. These differences did not reflect a different concept of health held by physicians, but represented the widely held medical judgment that induced abortions, if they were to be performed, should be done during the first trimester.

A regression analysis was done to determine if the personal characteristics of physicians and their experience with therapeutic abortion were related to the various indications upon which they would base their support of a woman's request for a therapeutic abortion.[3] Neither this general analysis nor the

[3] See Appendix 1, *Statistical Notes and Tables*, Note 2.

analysis of each specific indication showed any consistent trends which accounted for how most of these decisions were reached by physicians. In no instance could more than a fifth of the accumulative variance be accounted for in these analyses. **Among the physicians in the national physician survey such factors as their age, their sex, their religion, their primary language, their type of specialty training or where they worked in Canada, when these personal attributes were considered together, were not related to the range of indications upon which they would support a woman's request for a therapeutic abortion. Much like the attitudes which were held by Canadians in the national population survey, the issue of therapeutic abortion for these physicians was one which cut across all social backgrounds and types of medical practice experience.**

There was a broad diversity of views about the indications supported by physicians in their review of requests for therapeutic abortion. There was little consistency or uniformity with some physicians supporting all such requests, others never doing so, while the majority followed guidelines which varied according to their perception of health. In these circumstances for the woman who was involved, the choice of her physician was a crucial decision, one which might result in her request being referred immediately for review to a hospital therapeutic abortion committee, result in considerable delay, or be turned down completely.

Interpretation of mental health

A majority of the physicians (79.8 percent) included mental health in their broader concept of health in the context of therapeutic abortion and an almost equal number (81.8 percent) would support a request for an abortion during the first trimester if this were indicated based on their assessment of a patient's mental health status. In its work the Committee found that in practice both abortion patients and their physicians held divergent views about the concept of mental health. Their ideas on this point ranged from transitory anxiety, fear, and unsettled social circumstances to major chronic neuroses and psychoses. All of these conditions are included in the broad definitions and the codification of mental disorders in the *International Classification of Disease.*

A majority of the diagnoses associated with therapeutic abortion reported by Statistics Canada were for reasons of mental health, mostly listed as reactive depression. Few physical indications were reported in these national statistics. What these findings may indicate is that in terms of their physical health, most women who had abortions in Canadian hospitals were considered by their physicians to be in good physical health, but as a result of their unwanted pregnancy, some aspect of their mental health had been affected. The extensive diagnostic classification involving the mental health status of women obtaining therapeutic abortions masks to a considerable extent what their actual state of mental health may be. The reason why this information must be considered to be unreliable is that many physicians gave their abortion patients

these diagnostic labels to facilitate their applications for therapeutic abortion. Many physicians whom the Committee met on its visits to hospitals across Canada openly acknowledged that their diagnoses for mental health were given for purposes of expediency and they could not be considered as a valid assessment of an abortion patient's state of mental health.

Physicians in the national physician survey were asked whether, in their judgment, mental health as an indication for therapeutic abortion was being interpreted too liberally, correctly, or too restrictively. Their replies indicated a sharp division of opinion on this question.

Interpretation of Mental Health As Indication for Therapeutic Abortion	Percent
Too liberal	43.9
About right	37.5
Too restrictive	14.9
No reply, don't know	3.7
	100.0

How this issue was seen by physicians varied directly with their age, their religious affiliation, and their type of work. Substantially more younger physicians than older physicians felt that the condition of mental health was being interpreted too restrictively in the context of therapeutic abortion. The attitudes on this point did not vary sharply among the physicians who practiced in different regions. Male physicians somewhat more often than female physicians felt that the mental health of abortion patients was being interpreted too liberally. Three out of five Catholic physicians replied that the interpretation of mental health was too liberal (60.1 percent); Jewish physicians more often endorsed the current situation, with fewer of them (24.5 percent) saying the interpretation of mental health was too liberal. Somewhat more Protestants, Jews, and physicians of other religious affiliations endorsed the current interpretation as being appropriate (45.6 percent, 45.2 percent, and 45.6 percent respectively).

The largest single proportion of family practitioners and obstetrician-gynaecologists felt the interpretation of mental health was too liberal. Among the remainder, rather more members of these two groups of physicians thought the interpretation to be appropriate (39.3 percent of the family practitioners and 37.4 percent of the obstetrician-gynaecologists) than the number who found it to be too restrictive (17.7 percent and 10.0 percent respectively). Among the physicians who said the current interpretation of the indication of mental health was too liberal (43.9 percent), a number stated that the abortion operation might endanger a woman's health or her ability to carry a normal pregnancy in the future.

> . . . Psychiatrists dishonestly vouch for patients' depression to make abortions *legal*.
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> Anyone who demands one (an abortion), I think, remains psychologically marked.

... I have seen much mental and physical anguish later from patients who have gone through with therapeutic (so-called) abortions.

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Young people in particular have not been adequately educated about the risks of abortion *especially* in respect of future fertility (i.e., the abortion pregnancy may be their last).

• • •

Women who have had one or more "therapeutic" abortions have a higher incidence of premature deliveries in future, pregnancies with consequent cerebral palsy and mentally retarded babies.

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To obtain a therapeutic abortion legally, it is necessary for the doctors concerned to state that the pregnancy is a danger to the patient's physical and mental health ... In the majority of cases this is nonsense as there is no real threat to the patient's health if the pregnancy goes on.

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I believe that few pregnancies endanger the health of the mother and that each time I do one I could be breaking the laws of the land.

In contrast with these views, those physicians who felt that approval of therapeutic abortion was justified on the grounds of mental health said that this procedure had helped to avert other types of complications which their patients might experience.

... (Abortion Committee members) interpret the guidelines of the law in their own way, i.e., single girl, 27, working to support her immigrant sister, got pregnant after a party ... Reviewed by Committee members and refused on grounds of "no apparent mental health hazard". This patient, if forced to continue her pregnancy will *surely* become a psychiatric patient.

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Disagree with the fact that the medical profession has to find a medical excuse for a patient to have an abortion which is done on a social basis.

• • •

Social aspects should be involved in indications—these are closely linked with emotional problems and in turn with mental health.

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In 10 years of general practice I have had at least a dozen women who had given up unwanted babies, return for treatment of guilt and depression, some returning as long as a year or two later. The more liberal interpretation of the Abortion Law over the past four or five years has resulted in the fact that I have had no patients in that time who have carried through unwanted pregnancies and given up babies. I have, however, seen a fairly large number of patients who have had therapeutic abortions instead, and have not had one return seeking treatment for guilt and depression resulting from the fact that they had decided on, and carried through with abortion.

There is *much* long-standing emotional trauma to "give a child up for adoption" though valiant it may be!

• • •

I have found much less psychic trauma following a therapeutic abortion than completing an unwanted pregnancy and giving the baby up for adoption.

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Contrary to all sorts of silly reports, I have seen nothing post-abortion but relief—no guilt complexes, no recriminations, no depression—just joyful relief.

While there may be a general definition of the mental health status of patients, as this indication applied to women obtaining therapeutic abortions, its interpretation was affected not just by medical considerations but as well by the nature of a physician's personal circumstances. More younger physicians, female physicians, and those doctors whose religious faith was Protestant or Jewish said that mental health was justified as an indication in their assessment of requests for induced abortions.

The Committee's Terms of Reference stipulated: "To what extent is the danger to mental health being interpreted too liberally or in an overly-restrictive manner ... ?" Based on the findings of the national physician survey, **the medical profession was deeply divided on this question. Considering the intensity with which different views were held, the basic principles at stake were unlikely to be easily or soon accommodated. Overall, 43.9 percent of the physicians said that mental health as an indication for induced abortion was being interpreted too liberally, 37.5 percent endorsed the present situation, and 14.9 percent felt that mental health in this context was interpreted too restrictively.**

Length of gestation

While the Abortion Law sets no limits when an induced abortion may be done involving the length of gestation, most physicians in the national physician survey agreed with what they felt the law said on this point. Less than 1 out of 10 physicians said the law set no time limit, (7.6 percent), 3.9 per cent did not know or did not reply, and **9 out of 10 (88.5 percent) physicians reported the number of weeks which they said the Abortion Law stipulated about the length of a pregnancy when an induced abortion could be performed.** On the basis of this misinformation (the law sets no time limits), about a fifth (17.0 percent) of the physicians thought that the law was too liberal while a handful (3.7 percent) said it was too restrictive in terms of the time which they felt it set. The majority said the Abortion Law set specific time limits and agreed with what they thought these requirements were (68.3 percent).

There was some ambiguity in the replies of physicians who said they would never support a request by a woman for a therapeutic abortion. When

the physicians were asked for instance if they "under no circumstances would support an application for a therapeutic abortion", 203 physicians out of a total of 3,129, or 6.5 percent, agreed with this statement. However, when physicians were asked "Beyond what length of time in weeks do you think a therapeutic abortion should not be carried out?", 519 physicians, or 16.6 percent, listed either no time, or said that therapeutic abortions should never be done.

One out of five (20.5 percent) of the 3,129 physicians said they would support an application for an induced abortion anytime a woman requested it up to 14 weeks of gestation and half of this group (10.5 percent of all physicians) were prepared to provide such approval beyond 14 weeks, whenever a request was made. **The majority of physicians held views which were in between the 1 out of 6 doctors who would never support an abortion request and the 1 out of 5 who would always support such requests up to 14 weeks of gestation.**

The personal views of physicians about whether they felt therapeutic abortions should never be done or performed whenever a request was made were distinct from the medical judgment of beyond what cut-off point they felt induced abortions should not be done. Out of the 3,129 physicians a handful (1.2 percent) did not reply to this question and 1 out of 6 (16.6 percent) said abortions should never be done. Four out of five physicians (80.8 percent) said that abortions could be carried out up to and including 12 weeks of gestation. As the length of a pregnancy increased, fewer physicians felt that induced abortions could then be done with safety for their patients.

Length of Gestation Beyond which Therapeutic Abortions could be done	Percent
No reply	1.2
Never	16.6
Under 11 weeks	82.2
12 weeks	80.8
13-15 weeks	70.4
16 weeks	59.3
17-19 weeks	47.6
20 weeks	40.2
Above 20 weeks	10.6

In contrast with younger physicians, fewer older physicians endorsed a longer cut-off limit. While a fifth of the physicians (22.2 percent) who were 65 years or older listed an upper limit of 20 weeks, a third (34.8 percent) of the younger physicians cited this 20 week period. There was little variation in the length of gestation which was given by a physician's sex or where he or she lived. About a third of the physicians in each region set 20 weeks as the point beyond which therapeutic abortions should not be done. There were more marked differences by the religious affiliation of physicians. The 20 week cut-off point was cited by 36.2 percent of Protestant physicians; 52.9 percent, Jewish physicians; and 21.8 percent, Catholic physicians. Family practitioners

set an earlier time limit than obstetrician-gynaecologists. Among the former, 28.3 percent set 20 weeks as a maximum, while 40.6 percent of the obstetrician-gynaecologists listed 20 weeks.

Physicians gave many reasons why induced abortions should not be done during the middle or later stages of a pregnancy. These reasons included: their concern for the safety of the patient; beyond 20 weeks the procedure was a stillbirth and the foetus approached viability; or their distaste for doing the procedure intensified as the length of gestation increased.

> Women should have unrestricted access to safe, effective, and humane therapeutic abortion facilities for pregnancies up to 20 weeks gestation.
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> In the second trimester up to 20 weeks gestation, the patient and the doctor of her choice should have access to public facilities for the more sophisticated management required at this stage.
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> Should be considered the same as any other form of elective surgery with the only restriction in most cases relative to gestational age because after 20 weeks the foetus may survive with all the attendant physical deficiencies possible to the resultant individual, along with the social phenomenal costs to the community as a whole.
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> The law could read: "The decision for abortion up to the 24th week is up to the patient and her physician as long as provisions and programs are made for sexual education and family planning . . ."

Many physicians felt that the increase in the number of therapeutic abortions in recent years had substantially reduced the occurrence of illegal abortions and the extent of its associated complications.

> . . . illegitimate childbirth and adoption are now a rarity but then so is *septic* criminal abortion and maternal morbidity and *death*.
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> I genuinely feel that more liberal abortions have saved lives. Septic abortions are almost a thing of the past here.
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> A woman who does not want to keep her pregnancy will find a way to obtain an abortion regardless of the existing law. I treated 3 to 4 patients on an average per month for septic abortions before the availability of abortions in the U.S.A. and in some liberal Canadian hospitals. I see about 2 septic cases per year at the present time.
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> Years ago I would see 2 to 3 septic abortions in the hospital each month and many *died*; others were sterile. I have not seen *one* in the past 2 years. That alone is a big improvement.

The physicians were asked to estimate the average length of time which elapsed between when patients initially consulted them and when the therapeutic abortions for these patients were done in Canadian hospitals. Most of the obstetrician-gynaecologists in the survey had at one time performed therapeutic abortions and most family physicians had been approached by women requesting their support for an abortion application. On this basis **4 out of 5 physicians (82.2 percent) found that this was a question which they preferred not to answer.** Of the 3,129 physicians, 4.4 percent said they did not know how much time elapsed between when abortion patients initially consulted a physician and when the operation was done, and 77.8 percent did not answer this item. Of the 1 out of 5 (17.8 percent) of the physicians who replied, most listed an interval that was less than two weeks.

Physicians' Opinions of Time Interval Between Patients' Initial Medical Consultation and Therapeutic Abortion Operation	Percent
Under 7 days	9.2
7-14 days	6.4
15-21 days	1.1
22-28 days	0.6
29 days and over	0.5
Don't know	4.4
No reply	77.8
	100.0

Among the small group of physicians who answered this question, those doctors who more often gave the time interval as being under seven days were: 80.0 percent, physicians 65 years and over; 65.4 percent, Catholic physicians; 63.5 percent, physicians in Quebec; 43.2 percent, family physicians; 33.1 percent obstetrician-gynaecologists. In contrast, among the 1 out of 5 physicians who gave a time interval, more younger physicians (42.5 percent) and male physicians (41.8 percent) cited a period of above a week.

The replies of these physicians and the decision by most physicians to report no time interval contrasts sharply with the actual experience of the 4,754 women in the national patient survey who had therapeutic abortions in Canadian hospitals during the first six months of 1976. On an average these patients had their abortion operation done 8.0 weeks after they had initially consulted a physician. **Less than 1 out of 200 physicians in the national physician survey (0.5 percent) accurately knew or reported the actual length of time (8.0 weeks) between when a woman had initially consulted a physician and when the operation was performed.** Among the physicians who replied to this question, most extensively under-estimated this time interval. Physicians, it would appear, either chose not to know how much time was taken in the processing of abortion applications or were optimistic on this point.

In general, physicians who set a lower cut-off time limit were more likely to report that less time was spent between a patient's initial consultation with a physician and when the operation was done. Fewer of these physicians were

directly involved in the abortion procedure. More of these physicians either were opposed to induced abortion on principle, or felt that if it were done, the medical decision should be based on demonstrable physical and mental health indications. The length of time involved between the initial medical contact and the timing of the operation cited by these physicians did not accord well with the length of time which patients actually experienced.

At the other end of the scale some physicians who consistently felt that the interval was longer between when a patient contacted a physician and when the operation was done, also gave estimates which did not closely match the experience in this respect of patients in the national patient survey. Only 1 out of 10 physicians between 25 and 34 years for instance had done this operation. What these findings suggest is that among some physicians who had little direct involvement in the therapeutic abortion procedure, their strong personal views—either those who were opposed to abortion or those who endorsed the view that it was a human right—may have affected their estimates of the actual time which was involved. In each instance, neither group of physicians had done many abortion operations.

There was no ambiguity, however, in the judgment of physicians within what time limits the abortion operation should be performed, if it were to be done. **A majority of physicians (80.8 percent) saw the abortion operation being performed with safety prior to 12 weeks of gestation. As the amount of time over this time limit increased, either due to a delay in the initial contacts made by patients in consulting physicians or due to the time which was taken in the medical review of applications, a larger number of physicians became apprehensive about the risks involved. Three out of five physicians (59.3 percent) set the upper limit at 16 weeks.**

Abortion and the value of life

In addition to their general views on the definition of health, indications for abortion, and their interpretation of mental health in connection with therapeutic abortion, the views of the physicians in the national physician survey were obtained on three broad related issues. These questions dealt with whether in their judgment therapeutic abortion was a human right, whether this procedure lowered the value of life, and its comparison with an illegitimate birth or an unwanted child. Their replies were:

Physicians' Attitudes About Induced Abortion	Agree	Disagree	No Reply or Undecided
		Percent	
Abortion is a human right	54.8	42.3	2.9
Abortion lowers the value of life	50.5	47.7	1.8
Abortion is preferable to an unwanted child	58.4	37.1	4.5

The replies to these three questions were consistent with the answers which physicians gave concerning indications for abortion. As a whole more physicians agreed with these views than disagreed with them. Few were undecided or gave no reply to these points.

Therapeutic abortion should be freely available to any woman requesting it.

• • •

I would no more go for abortion on demand than I would go for amputating a woman's right arm because it offended her.

• • •

An abortion should be the right of all females.

• • •

Therapeutic abortion should have no place in Canada, no place in Medicine.

• • •

Therapeutic abortion should be readily available to people all over the country, i.e., as available as they are in _____ .

• • •

I do not feel it is an unqualified right.

• • •

I feel strongly that a woman should have an abortion if she requests it.

• • •

There is no place for therapeutic abortion.

The same general trends by the social background of physicians were reflected in their views about whether induced abortion lowered the general value of life. Their replies were almost equally divided on this point. Physicians residing in the various regions were fairly evenly split as to whether they affirmed or rejected the view that abortion lowered the value of human life. The greatest agreement came from physicians in the Prairies (55.8 percent), the greatest disagreement from Ontario (51.2 percent), and among Quebec physicians there were substantially more who agreed or disagreed than in any other province.

I think legislators are paying too little attention to the value of human life, especially foetal life. This attitude is rapidly eroding the moral fibre of our society and leaving us with a decadent nation.

• • •

Clearly, if we accept "general" therapeutic abortion we will not be long in accepting euthanasia—easy death for those "unwanted" and useless in our society: the old, the senile, the retarded, the incurables.

The matter is getting out of hand: the case of obtaining an abortion is markedly contributing to the moral laxity and breakdown of family life which we are witnessing today.

• • •

When we lose our reverence for human life, we lose the hallmarks of a civilized nation.

• • •

A symptom of our general moral decay.

• • •

Abortion is only part of the answer but if there were not so many broken marriages then the family as a unit will become stronger and the sexual permissiveness decrease.

• • •

Most of the general public give their opinions solely on an emotional basis . . . they do not see the young people locked into poor marriages because "society" still pressures them into ill-timed and premature marriages.

• • •

With skyrocketing mental and nervous disorder, illegitimate children and cost of looking after unwed mothers and their children, it could be argued that easier abortions could alleviate a great many social problems.

• • •

Easy access to therapeutic abortion must *raise* the value of human life—because since fewer are born more value is placed upon them.

With the exception of physicians who were 65 years or older, 3 out of 5 (58.4 percent) said that it was preferable for a woman to have an induced abortion than to bear an unwanted child. More female physicians than male physicians held this opinion, one which also varied by the type of work which physicians did.

We must, above all, guard against making a single girl have a baby as a punishment for being careless. Above all every physician who refuses an abortion may be taking responsibility for yet another unhappy alienated individual arriving into the world (and there are plenty already).

• • •

I cannot feel deep concern for those who have not survived the experience of birth. We ought to concentrate on relieving the misery of the born before drawing up codes of rights of embryos.

• • •

To coerce young women who have become pregnant contrary to their wish and intent, to deliver babies for the purpose of supplying sterile couples with children, would be synonymous with forcing them into a "stud farm pool" . . .

• • •

Progress is yet to be made to clearly establish the individual right of a woman to decide as to whether or not she is mentally or physically capable, or desirous of bringing a person into existence, with all of the attendant responsiblity and change in her personal *modus vivendi*, and to do so with the necessary affection and care so as to facilitate the development of an adequate, responsible, and well adjusted member of society. The state of motherhood is hardly a state of being cared for by a man, with relatively simple duties, but rather constitutes a profession of considerable importance. From the time of birth, a woman will likely spend 60 to 80 percent of her time taking care of the physical and emotional needs of the child for about the next six years, and then gradually decreasing time as the child, in the natural course of events, grows to independence over approximately the next twelve years.

I can only arrive at the conclusion that it would be extremely presumptuous and arrogantly naive for me, on the basis of an interview, however detailed, to coerce a patient into making a decision to commit herself in such magnitude for the next decade and longer. The community is a continuum of ever-developing children, hence it is obviously in the interests of the community that the children develop in an environment of being wanted, adequately cared for, and well educated. Unwanted or maltreated children who have, however inadvertently, been conditioned into values contrary to the interests of the community, contribute to the number producing the ever-expanding crime rate, etc., and the ever-expanding need for emotional and mental health care facilities.

• • •

If a patient presents requesting an abortion, following a frivolous or other sexual encounter, the antithesis of which intent was procreation, it can readily be assumed that the impending potential child is unwanted. The omnipresent argument that the obliteration of potential human life represents devaluation of human life, is philosophical and without definite resolution, and is not practicably applicable to our society's present situation.

• • •

The unwanted child is certainly deserving of our consideration. This child should be transferred with expedience to parents who do want the child . . . There are thousands of responsible parents still seeking children to adopt and raise.

• • •

(Abortion) should be restricted until all adoption seeking couples are saturated. This will raise more native Canadians. The guidelines can then be adjusted on a 2 year basis . . .

• • •

Subsidize the pregnant girl to carry on with her pregnancy. We have too few babies up for adoption.

• • •

There are no unwanted children; there is always somebody who is longing for a child.

Appointment to therapeutic abortion committee

The majority of physicians surveyed had never served on a therapeutic abortion committee (77.9 percent) while 1 in 5 (20.2 percent) had. (The remainder did not give this information). Regardless of their age most physicians had not served on a therapeutic abortion committee. The largest percentage of those who had (27.7 percent) were between 55 and 64 years with the smallest proportion being between 25 and 34 years (12.0 percent). In about equal proportions, female and male physicians had served on these committees (20.4 percent and 20.9 percent respectively).

More Protestant physicians (30.1 percent) than Catholic physicians (7.9 percent) had served on therapeutic abortion committees. Proportionately more physicians from British Columbia (33.4 percent) had been members of these committees than physicians who lived in other provinces. Physicians residing in Quebec were the least likely to have been involved (10.2 percent). A larger percentage of obstetrician-gynaecologists had been committee members (29.1 percent) than had family practitioners (17.0 percent).

Physicians were asked if they would be willing to serve as a member of such a committee. **Over one-third (39.2 percent) of the 3,129 physicians said they would be prepared to accept an appointment to serve as a member of the hospital therapeutic abortion committee, an almost equal number said they would not (34.6 percent), and the remainder (26.2 percent) gave no reply.** The proportion of physicians who were willing to accept this committee responsibility declined among older physicians, was about the same for physicians of all religious faiths, was slightly higher among female than male physicians and was fairly uniform in all regions of the country. Almost equal proportions of family physicians and obstetrician-gynaecologists said that if they were asked to serve, they were prepared to be a member of a therapeutic abortion committee.

The physicians in the survey made a number of comments about how therapeutic abortion committees functioned at the hospitals in the communities where they practiced.

> In this province there is but *one* active abortion committee—in a province where *all* hospitals are government supported.
>
> • • •
>
> In _____ —as much as anywhere—with large religious overtones throughout the hospital—there is no chance of getting an abortion committee—never mind an abortion—off the ground.
>
> • • •
>
> In this community there are two hospitals—one has a (therapeutic abortion) committee. The other hospital would only consider medical moral committee with one doctor and three moralists. It was dropped when doctors realized they were never going to be allowed to win an argument.

The main problem centres around small towns and small cities where hospitals have refused to set up a committee.

• • •

In our hospital the abortion committee has not met since July 23, 1973.

• • •

After 3 years on an abortion committee I feel that committees of this type serve absolutely *no* useful purpose and should be disbanded.

• • •

Our local problem is that the committee here blows hot and cold depending on the composition of the committee. Nevertheless, it has not been decided whether abortion is good or bad and it would seem to me that a committee will sway from right to left and (advance) one opinion more than another, depending upon the times. This would seem to reflect general opinions and therefore is not bad.

A wide variety of reasons were cited by the physicians who said they were unwilling to serve on therapeutic abortion committees. Some of the reasons were related to the nature of their affiliation with a hospital and whether a hospital where they had admitting privileges had established or had not established a therapeutic abortion committee. **Among the physicians in the national physician survey, two-thirds (66.1 percent) held appointments at hospitals which had established therapeutic abortion committees, almost a quarter (23.5 percent) worked at hospitals which did not have these committees and the remainder gave no information on this point (10.4 percent).** A small group of physicians (3.9 percent) said they could not be a member of a therapeutic abortion committee because they performed the abortion procedure. Among the physicians who said why they were unwilling to serve on these committees, their opposition on personal and professional grounds to induced abortion was the single factor which was most frequently cited (38.3 percent). Only 2 out of 3,129 physicians mentioned legal reasons, saying that they would not serve on such committees because they felt they would have insufficient legal protection.

In addition to a physician's willingness or unwillingness to serve on a therapeutic abortion committee, a second factor which was involved if a hospital had established such a committee, was how medical staff appointments to committees were made by a hospital administration. On its site visits the Committee was frequently told by hospital administrators, medical directors, and chiefs of medical services of the considerable care which was usually taken in the selection of committee members. In many instances it was known that some physicians who were members of the medical staff of a hospital would be willing to serve on these committees, but it was felt by those individuals who were responsible for the nomination of committee members that their views were not in accord with hospital policy. Where there was an acknowledged and well-known position, physicians holding contrary views seldom challenged a medical staff executive or a hospital board. This accommodation occurred in hospitals regardless of the number of abortions which

were done. Among some hospitals with committees where the views of the medical staff were divided on the abortion issue, it was more unusual for physicians known to hold strong views to be asked to serve on these committees. More often what happened in these situations was that the work of the committee fell to physicians whose views matched the hospital's policy. In this respect the requirements and guidelines of therapeutic abortion committees generally reflected the views of the majority of physicians on a particular hospital's medical staff.

Based on the findings of the survey of physicians and from its hospital site visits, the Committee concluded that: **for most hospitals which met other requirements, there was a sufficient number of physicians who were prepared to serve on therapeutic abortion committees. But for the slightly over a third of the physicians who were prepared to do so, there was a sifting process in the nomination of committee members which substantially reduced the actual number who were likely to be asked to serve on these committees.**

Among the physicians who said they would be willing to serve on therapeutic abortion committees, 70.9 percent were affiliated with hospitals which had established committees and 29.1 percent were members of the medical staff of hospitals which did not have committees. There was a somewhat similar distribution among physicians who said they were unwilling to be members of such committees, with 63.2 percent being affiliated with hospitals with committees while the remainder (36.8 percent) worked at hospitals without committees. Looked at somewhat differently, **almost half (46.3 percent) of the physicians for whom information was available who worked in hospitals without therapeutic abortion committees said they were prepared to serve on these committees, if they were established at their hospitals.**

From its site visits to hospitals across Canada and based on other reports which it received, the Committee found that in general several broad patterns of accommodation had emerged among the medical staff of hospitals about the abortion issue. These patterns were: (1) the self-selection by physicians of the hospitals where they held appointments; (2) the sifting process involved at hospitals in the nomination of physicians to therapeutic abortion (and other) committees; (3) an accommodation when there were strongly held and divergent views about abortion held by the medical staff; and (4) more rarely, an open conflict over the issue among members of the medical staff.

No direct survey of medical interns or residents was done for this inquiry. On its site visits to hospitals the Committee obtained information about the usual practices which were followed. It was reported that in the past obstetrical-gynaecological residents at a few hospitals had been required to perform the abortion procedure. In these instances those physicians-in-training who were not prepared to do this were not accepted in the training programs of some hospitals. While the extent to which this may have occurred is unknown, the Committee received several reports from physicians about their experiences in this respect.

> This is to certify that as a resident in training at _____ on two occasions in the past year my views on abortion have caused me to be replaced in proposed

training positions. The first incident occurred in mid-March 1974. I had been verbally informed of my appointment. The appointment was made in December 1973 and I was to commence work in July 1974. In March 1974 I received a phone call from the programme coordinator, stating that unless I would perform abortions, I could not have the position as previously arranged. The second incident occurred in February 1975. At that time I was interviewed by _____ in regard to my proposed appointment at _____ . At this interview I was told that I should not be required to induce abortions, but that I would be expected to deliver dead foetuses after saline induction. I was also informed that because of my views on abortion I should never become Chief Resident at that hospital as had been originally anticipated. On each occasion, I had to find suitable training posts where abortion was not a mandatory requirement of residents.

• • •

I saw Dr. _____ along with Dr. _____ today with respect to taking a residency here and the abortion activity in our clinics.

First of all let me explain our current situation. We book 20 patients per week in our clinic. A staff man attends every clinic and a staff man also does an abortion list by himself without resident participation in order to cut the load down on the trainees. About 60 percent of our entire abortion activity is with the clinic group of patients, with the minority being private abortions. Residents rarely participate in private abortions.

I explained to Dr. _____ our position in the matter, which is unchanged since the issue came to a head with Dr. _____ . It is as follows:

1. We would not expect Dr. _____ to attend abortion clinic or recommend abortion.

2. We would not expect Dr. _____ to perform abortions.

3. We would, however, expect Dr. _____ to give medical care to individuals with abortion complications and to assist in the management of a saline abortion at the time of delivery of the dead foetus or any time significant expertise was required subsequent to the actual act of intervention.

Dr. _____ 's position is that Dr. _____ would render care to this group if they were in trouble. Here is the stumbling block—in that the feeling of my staff and myself is that these patients should be treated with the same degree of skill, attention and understanding that Dr. _____ would bring to bear on any other patient once the act of producing the abortion had been done whether they are "in trouble" or not. Dr. _____ feels that this is participating in the abortion process; we feel that it is discriminating against a patient who has been aborted by someone else. With our rotation situation, he would be the senior on call and could not delegate to another senior at nights or weekends.

There is no resolving this difference in viewpoint since both parties hold their position firmly and I am sure, sincerely.

Our feeling is that hospitals are free to define their position in the abortion scene and to decide if the service is to be provided or not, to what segment of the population it will be aimed, how it will be provided and so on. Once this position is defined, however, it should be provided at a high level of care. If it

is to be altered it should be altered as the result of a considered position by permament staff, and cannot be altered by the opinion of trainees who are on the scene for a limited time. Nor should the quality of the care vary with the circumstances of house staff appointments.

I am sorry this is not going to work out with Dr. _____ and even more significantly when Dr. _____ reaches Chief Resident level there is no way he could function in terms of overall supervision of the quality of work on that service and exclude the abortion activity.

This position of ours is not new, and is quite consistent. We do not expect individuals to recommend or to do abortions if they feel this is wrong. However, we do expect the best level of care they can bring to bear on all patients who are aborting or have aborted whether or not this was spontaneous, self-induced or therapeutically induced.

• • •

It has been my experience that there are problems in undertaking training in the University of _____ in obstetrics unless one agrees to undertake pregnancy terminations. At _____ , where I undertook two years of post-graduate resident training in obstetrics and gynaecology, the situation is such that one teaching hospital will not train physicians who do not perform pregnancy terminations. However, the interpretation of "involvement" in pregnancy termination sometimes becomes confusing. I feel that an example is probably required to clarify this situation. If a pregnancy is terminated by injecting saline into the mother's uterus to kill the foetus and thereby induce labour, then the act of delivering the dead feotus is considered by some to have no bearing on the therapeutic abortion procedure. It is my feeling that to deliver these killed human foetuses is to become involved in the pregnancy termination procedure and I will therefore not perform this procedure. The feeling of one senior obstetrician in this city is the reverse of this and he insists that if a trainee physician will not perform delivery of the dead foetus then he will not train him in his obstetric unit.

• • •

Applied to Dr. _____ (Coordinator of post-grad. training for obstetrics and gynaecology) to have the next six months of training, which would normally have been in internal medicine, changed to general paediatrics as allowed by Royal College.

Offered six months gynaecology at _____ . Agreed as long as ok with Royal College.

Phone call—told six months residency at _____ approved—told would have one half day a week in the O.R.—told written confirmation would follow. _____ phoned Dr. _____ to ask why no letter—told letter typed and awaiting signature—should be in mail within 48 hours.

Few days later—Dr. _____ phoned _____ and reported that Dr. _____ had mentioned that she had been told _____ did not do abortions. Verified that this was correct. Dr. _____ then announced that since Dr. _____ was head of department and considered abortions essential to the service, Dr. _____ was not eligible for the appointment. It was cancelled.

All general paediatric appointments had been made and a general medicine appointment was available at _____ which Dr. _____ took.

The Committee found that the policies which were usually followed at most hospitals were:

—Residents did no abortions. They were all performed by staff physicians.

—Residents were not required to assist with the procedure, but they were required to provide post-abortion medical care.

—Residents were not required to participate, if it was against their personal beliefs.

—Residents did only a certain number of abortions, with the remainder performed by staff doctors.

These policies were not mutually exclusive. The majority of the hospitals respected the personal decisions of residents and interns if they did not wish to take part in the abortion procedure. The process of physicians selecting hospitals and of hospitals selecting physicians also occurs, an example of which was given by an obstetrician-gynaecologist.

> Since July 1970, I have had admitting privileges as an obstetrician and gynaecologist at _____ Hospital. In 1971, while resident in _____, I wished to transfer my practice to the same area, and therefore I applied for an appointment to the obstetrics and gynaecology staff of the _____ Hospital. I was interviewed by Dr. _____. Among other questions, I was asked whether or not I would perform abortions. I replied that I would never agree to destroying innocent human life for social convenience. I added that I am a Roman Catholic, I consider induction of abortion a moral issue, and therefore even if the Roman Catholic Church changed its views about abortion, I would not change my views. I stated that I was willing to perform sterilizations. I also agreed to do my share of running the "free clinic" that Dr. _____ discussed during the interview.
>
> My application for the staff appointment was refused. I would like to bring to your attention the fact that I am a member of the Royal College of Surgeons of Canada—there is no higher qualification obtainable in Canada.

At several of the hospitals which were visited by the Committee, difficulties had occurred in the scheduling of abortion operations because anaesthetists on the medical staff were reluctant to assist in this procedure. At one hospital the reluctance of these specialists had resulted in limiting the abortion procedure to those operations which could be done under a local anaesthetic. At several hospitals visited by the Committee, no abortion operations were scheduled on days when anaesthetists who were opposed to this procedure were "on call". At larger hospitals there was usually a sufficient number of anaesthetists on the staff so that alternate arrangements were made. In no instance known to the Committee was an anaesthetist forced to participate in the abortion procedure against his will.

Among the physicians who had appointments at hospitals which had therapeutic abortion committees, 3 out of 5 (58.5 percent) of these physicians agreed with their committee's guidelines, a quarter (23.3 percent) did not, and the remainder did not know the committee's guidelines. More doctors of all age groups approved of their hospital's guidelines than did not. The highest percentage of agreement was among doctors between 35 and 44 years (60.6

percent), while the lowest proportion (46.5 percent) was among physicians between 25 and 34 years. Proportionately more men than women concurred with the guidelines of their hospitals.

About a third of Catholic physicians were employed in hospitals which had no therapeutic abortion committees (35.9 percent). Of the remainder, approximately a half (45.7 percent) agreed, and less than a half (41.8 percent) disagreed with the committee's guidelines. Three out of four (75.8 percent) of the Protestant physicians endorsed the guidelines of their hospital committees. The regional distribution of the proportion of physicians who approved of the guidelines of the therapeutic abortion committees of their hospitals varied widely with the proportions being: 59.3 percent, Maritimes; 40.6 percent, Quebec; 65.9 percent, Ontario; 61.2 percent, Prairies; and 63.6 percent, British Columbia, the Yukon and Northwest Territories. Among obstetrician-gynaecologists who worked in hospitals with committees 70.6 percent agreed with the guidelines of these committees, 28.4 percent disagreed, and the remainder gave no reply.

Physicians were asked who should make the decision about an induced abortion. Like the results of the national population survey, no strong consensus emerged. The three choices which were listed most frequently were that the decision about a therapeutic abortion should be made by: (1) the woman and her physician; (2) the woman, her partner, and the physician; and (3) the hospital committee. **About a quarter (23.0 percent) of all physicians said the decision should be made by a hospital committee. Almost that number (21.7 percent) thought that the decision should be left to the woman, her partner and her doctor, and a third (30.7 percent) said the decision should be reached between a woman and her physician. Less than 1 out of 10 (8.3 percent) believed the decision should be the woman's alone.** The replies of the remainder were: 1.5 percent, a woman and two physicians; 8.5 percent, a mix of options; 2.9 percent, abortions should never be done; and 3.4 percent, no reply.

> I would favour continuing with the therapeutic abortion committee ...
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> • • •
>
> I favour a hospital committee to judge the patient's request for abortion, (but) I wish to qualify that by adding, "only if that committee sticks to the letter and the spirit of the law".
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> • • •
>
> I feel it is a decision between patient, her partner, and the physician.
>
> • • •
>
> The best people to do this (are) the patient, her consort, and the patient's trusted personal physician.
>
> • • •
>
> The decision should be between physician and patient and this would enable early suction of the uterine cavity in the doctor's office for a missed period of a few days with quite a saving in hospital costs and medical costs and anguish to all concerned.
>
> • • •

> I would like to submit my considered opinion, asserting that only one person can decide whether or not to carry through a pregnancy, regardless of the circumstances under which it occurred, and that person can only be the patient herself.

Different age groups favoured different solutions. Physicians between 25 and 34 years more often felt the decision should be made by a woman, her partner and her physician (25.1 percent) or by a woman and her physician (20.7 percent). More of their older colleagues endorsed the continuation of the therapeutic abortion committee. While few physicians felt the decision should be made by a woman alone, more younger physicians held this viewpoint (10.5 percent). One-quarter of the male physicians favoured the therapeutic abortion committee (24.2 percent) in comparison with one-fifth (20.4 percent) of the female physicians. Both men and women preferred to have the decision made by the woman, her partner, and her physician, or by the woman and her physician to other options. Catholic physicians endorsed the committee method (38.3 percent) more than physicians of other faiths. One-third of Jewish physicians thought that the decision should be made by the woman and her physician (33.5 percent) or said it should be decided by the woman, her partner, and her physician (31.1 percent). Protestant physicians specified a woman and her physician (26.5 percent), the woman, her partner, and her physician (22.0 percent), or the hospital committee (20.5 percent) as the decision makers.

The highest percentage of physicians from British Columbia, Ontario and the Maritimes felt that the decision to have an induced abortion should be made by the woman and her physician. In the Prairies and Quebec, the majority of physicians considered the hospital committee as the appropriate means of reaching this decision. In each instance almost one-quarter of the family practitioners thought that the decision for an induced abortion should be made by the woman in consultation with her partner and her physician (23.9 percent) or by a hospital committee (23.4 percent). Obstetrician-gynaecologists favoured that the decision be made by the woman and her physician (29.1 percent) or a hospital committee (25.5 percent).

Reflecting the social mosaic of the country and its medical profession, the options endorsed by physicians were numerous and diverse. Their perspective in this respect is in the tradition of how health services have been organized and provided to Canadians which have allowed for a great variety of choices. For these reasons it is not unexpected that several options on how decisions should be reached about therapeutic abortions were endorsed by physicians. **What these several choices mean is that no single course of action was widely supported by the medical profession. While there was no consensus about the utility of the present committee arrangement in reviewing abortion applications, the more prevalent mood among the physicians in the national physician survey was toward a structurally simpler means. Few physicians were totally against the principle of permitting induced abortions under any circumstances and a minority were for this choice being made by a woman herself. There was much broader support for the idea that this decision should be reached between a woman and one or two physicians.**

Part of the dislike that most physicians had about the committee arrangement went beyond the fact of abortion. It is accounted for by two facts which were often cited on visits made by the Committee to the 140 hospitals across Canada. While most physicians participated in provincial health insurance programs, the stance of many members of the medical profession was one of skepticism, often a staunch distrust of the role of government in what were considered to be professional medical decisions. This broader outlook was interwoven in the abortion issue with a consensus moving toward the perspective that the decision about abortion should be a matter between a woman and her physician. There was also a deep-rooted dislike of documenting for a potential audit, the decisions which were reached. This dislike did not appear to be affected by concern for any protection which such documentation might afford physicians, but went beyond the issue of abortion and involved the requisite paperwork that pertained to many facets of medical practice. It raises the unresolved issue of how much and what type of accountability there should be when decisions affecting the law or the public purse are involved. **The mood of many physicians about therapeutic abortion** as epitomized in their replies **was that the medical profession should retain its autonomy in this matter, that it was competent and should be trusted to do so. Government, most felt, should have no direct involvement in this matter.**

A second factor which was involved in the criticism by some physicians of the therapeutic abortion committee arrangement stemmed from a different and more practical concern. In their medical practice most physicians work as independent, fee-paid professionals. While their role in the hospital is indispensible, they neither own these public institutions, nor are they legally responsible for their administration. This authority is vested in hospital boards, or some comparable arrangement. As part of their medical staff duties at hospitals, physicians in return for certain "hospital privileges" of admitting patients for treatment are expected to serve, when requested, on various hospital committees. These responsibilities, usually well discharged, take time away from direct contacts with patients, and to the extent that they may involve more rather than less time, directly affect a physician's financial earnings. On its site visits to hospitals the Committee found in some instances a resentment that government by its imposition of the committee system in the review of abortion applications wanted to "get something for nothing" as physicians were not reimbursed for doing this work and the time which was spent in doing these duties meant a direct loss of income. Their acceptance of this direct loss of income was made none the easier by the overriding fact that most physicians regarded induced abortion with considerable distaste and would have preferred not to have been involved in this procedure. Another commonly cited reason why committees were disliked was that many physicians felt they were put in the awkward position of "second-guessing" the judgment of their medical colleagues who had submitted abortion applications. Without first-hand knowledge of a patient's situation, physicians in this position often felt they were not only making a decision about a patient, but as well about the competence of a medical colleague.

Contraception and sterilization

While most of the physicians in the survey (69.2 percent) as far as consent for an abortion was concerned considered a woman to be a minor until she was between 16 and 19 years of age, they were more willing to start contraceptive counselling at an earlier age. Many of the physicians were prepared to start birth control counselling by age 16 or younger (64.7 percent, obstetrician-gynaecologists, 70.5 percent, family physicians). Younger physicians (25 to 34 years) were somewhat more prepared to begin the contraceptive counselling of their patients prior to puberty. Their older colleagues (55 to 64 years) were the least likely to start such counselling for very young females. More Catholic physicians (62.7 percent) than physicians of other faiths were prepared to begin contraceptive counselling for patients who were between 14 and 16 years, and fewer Jewish physicians said they would take this step (50.5 percent). The latter were more apt to say they would consider a patient's situation rather than her age (27.3 percent). More physicians from British Columbia (10.2 percent) were prepared to begin contraceptive counselling of their patients prior to puberty, while physicians in Quebec were the least likely to start this type of counselling at this age (6.4 percent). The highest proportion of physicians who started counselling between 14 and 16 years lived in Quebec (61.6 percent), while under half of the physicians in British Columbia began such counselling for patients of this age group (49.0 percent).

There was a widespread feeling among the physicians that more extensive knowledge of the means of birth control would decrease the need for induced abortions.

> I feel more adequate and thorough sex education including attitudes as well as physical facts for early adolescents would cut down on the incidence of abortions.

Much concern was expressed about the obtaining of adequate information by adolescents, especially when they were sexually active.

> I see girls 15 to 18 years old in my office who haven't used (birth control) methods and do not know about them.
>
> • • •
>
> It would be helpful if the law was changed to allow (doctors) to prescribe oral contraceptives for 14 year old patients without parental consent and without fear of litigation.
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> • • •
>
> As far as contraceptive counselling to teenagers, I feel that when a patient is at risk, irrespective of age, contraceptive advice should be given. If a 14 or 15 year old is referred for advice, specifically for this or is inherited as a result of termination, contraceptive advice is given freely almost invariably with the knowledge of the parents.
>
> • • •
>
> If it appears intercourse is likely or has occurred, I counsel at *any* age with or without parental knowledge.

The physicians in the national physician survey were asked under what circumstances they would recommend the sterilization of patients seeking abortion. The categories listed were if such a patient: (1) had borne two or more illegitimate children; (2) had two or more abortions; (3) was 40 years or older and had the desired number of children; or (4) would never recommend a sterilization associated with an abortion.

> I believe the state has a right to expect no woman will need more than *one* therapeutic abortion in her lifetime, *if* she has access to adequate counselling and sterilization.
>
> • • •
>
> Birth control information should be more easily available and sterilization for older couples more widely promoted.
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> • • •
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> Any woman having a second therapeutic abortion should be offered an operation for surgical sterilization and if she refuses she should only be given the privilege of having a further therapeutic abortion if there is a threat to her physical health or a chance of her baby being deformed.
>
> • • •
>
> Sterilization must never become a condition even if a woman is seeking abortion more than one time. ***But*** it should be again a medical and social decision by the doctor and the woman.
>
> • • •
>
> The abortion committees should perform far more abortions and sterilizations on parasitic and inadequate families and make the well-to-do pay well for their too easy access to securing what they want whereas many poor cannot secure the help they need.
>
> • • •
>
> In the recent past sterilization has been recommended as a condition of abortion in some cases but this has not occurred since complaints from the Status of Women Council.

About a third (34.8 percent) of the physicians said they would recommend sterilization for a woman who had two or more illegitimate children. Half (48.9 percent) would do the same for a woman who had had two or more abortions. The majority (81.5 percent) were prepared to suggest sterilization for a woman who was 40 years or older who had completed her family. Only 1 out of 10 (9.6 percent) said they would never recommend sterilization at the time of an abortion.

Younger physicians (25 to 34 years) were more prepared to recommend sterilization for women 40 years or older who felt they had completed their families, while older physicians (65 or over) were the least likely to make such recommendations. One-quarter of the physicians aged 65 years or over would never recommend sterilization at this time. Physicians of both sexes were in close agreement when they would recommend sterilization. Almost half of the

Protestant physicians were prepared to recommend sterilization if a woman had two or more illegitimate children. Jewish physicians less often held this view. More of the Protestant physicians were willing to advise the sterilization of women who had had two or more abortions, while fewer of the Jewish physicians endorsed this course. Most of the Protestant physicians favoured the sterilization of a woman 40 years or over who had completed her family, while Catholic physicians were somewhat less apt to make this decision. More Catholic physicians than physicians of other faiths said they would never recommend sterilization at the time of an abortion (16.9 percent).

Half of the physicians in British Columbia (48.1 percent) would recommend the sterilization of women who had had two or more out-of-wedlock children. This recommendation would be made by a third (31.9 percent) of physicians in Quebec who were in the survey. The highest proportion of physicians recommending sterilization for women who had had two or more abortions was among physicians in the Prairies (60.1 percent) and was the lowest among Quebec physicians (46.1 percent). Physicians living in the Prairies were the most likely to advise a sterilization for a woman 40 years or older who had completed her family. Obstetrician-gynaecologists were a little more likely to recommend sterilization for women with two or more illegitimate children (43.1 percent versus 38.9 percent) and for women 40 years or over who had completed their families (89.1 percent versus 86.6 percent) than were family practitioners. Both groups of physicians held the same views about advising the sterilization of women who had had two or more abortions (55.7 percent and 54.2 percent). Family practitioners were somewhat less willing to advise sterilization at the time of the abortion operation than obstetrician-gynaecologists (13.3 percent and 7.9 percent).

From the information which is available, it is apparent that the sterilization of women and men has become more extensive at present than in the past. This decision involves at least two parties—a patient and a physician, and often as well the decision of a spouse or a partner. **The implications in the findings from the national physician survey suggest that more physicians in the future than at present may be prepared to advise patients to have the sterilization operation. This trend may be indicated by the higher proportion of young physicians who were prepared to advise their patients along these lines.** How these decisions were reached, as indicated in the national patient survey, did not uniformly affect all abortion patients. Because sterilization represents a permanent form of contraception, the emerging trends have profound implications for the future growth of the Canadian population and the selective patterns of growth for some groups and some regions of the country.

Opinions of the abortion law

In obtaining more detailed information about the views and experience of physicians with induced abortion, several general questions were asked in the national physician survey about their opinions of the current legislation. **Over**

half of the physicians (56.2 percent) wanted therapeutic abortion to be removed from the Criminal Code, 35.5 percent favoured the present arrangement, and the remainder either gave no reply or said they had no opinion on this issue. Perhaps more than any other item in the national physician survey, this question resulted in strongly voiced comments.

> Abortion is a medical issue and the only applicable laws should be those regarding malpractice and incompetence. Otherwise the law should not interfere.
>
> • • •
>
> Remove it from the Criminal Code (it is a medical decision) and treat it as any other medical problem, College of Physicians and Surgeons and Ethics, etc . . .
>
> • • •
>
> . . . I would strongly recommend that the procedures for therapeutic abortion be removed from the Canadian Criminal Code or from any area where such a matter can be tampered with, depending on the political winds of the time.
>
> • • •
>
> If therapeutic abortion (is) taken out of the Criminal Code, I feel it leaves it open to individual interpretation, and money-making abuses.
>
> • • •
>
> The government must concern itself with the welfare of the foetus. The issue must not be removed from the Canadian Criminal Code.

Opinions on this issue varied most by the age and religion of physicians. Two out of three (63.4 percent) of the younger physicians (25 to 34 years) wanted abortion to be removed from the law, while this view was expressed by about half (52.4 percent) of physicians who were 65 years or older. A majority of Jewish physicians (84.1 percent), about two-thirds of Protestant physicians (65.4 percent), and less than half of the Catholic physicians (44.5 percent) held this view.

About a fifth (21.2 percent) of the physicians said the present law was too liberal in its terms, 39.0 percent said it was too restrictive, and 30.4 percent endorsed the present arrangement. The remainder were undecided or they did not reply. While the exact proportions varied, these opinions varied by the age, religious affiliation, and the type of work which was done. **While 3 out of 5 physicians (60.2 percent) were dissatisfied with the current legislation, there was no unanimity on this point.**

> The laws are too liberal both in law and practice.
>
> • • •
>
> The law disregards the value of human life in utero.
>
> • • •
>
> The law as it stands is reasonable, but its interpretation appears to vary.

I think the system in Canada is sufficiently flexible to allow all of us to satisfy our conscience and at the same time enable those women who really need abortion to have one.

• • •

The law pertaining to abortion as it stands seems to work well.

• • •

The issue as it now stands is restrictive . . .

• • •

. . . I think the present abortion laws in Canada are too restrictive and that liberalization is urgently required.

• • •

I stand for the liberalization of legislation on therapeutic abortion . . .

• • •

In my opinion the laws are too restrictive.

When they were asked where first-trimester abortions should be performed, two-thirds (63.5 percent) of the physicians endorsed a hospital day-surgery unit, followed by in-hospital patient service (51.6 percent). A fifth (21.0 percent) said this procedure could be effectively handled in a community clinic, and less than 1 out of 10 (8.0 percent) said this operation should be done in a physician's office.[4]

The law stipulates abortions in the first-trimester must be done in hospital. In many hospitals this means general anaesthesia. Nosocomial (hospital acquired) infections occur in 2 to 13 percent of patients. The complication rate for general anaesthesia is around 5 percent. As a result, the complication rate reported for first-trimester abortions is in the neighborhood of 7 to 10 percent. In contrast, the complication rate for first-trimester abortions done in an office setting is less than 1 percent with newer techniques utilizing local anaesthesia. This phenomenon has been documented in the U.S. by the Joint Program for the Study of Abortion receiving reports from 66 institutions. It has also been considered by the U.S. Supreme Court in their historic decision to make abortion a matter only between patient and doctor in the first three months. Our law, therefore, is bad when it decrees that first-trimester abortions must be done under less safe conditions than would be the case if office abortions were allowed.

• • •

We should remove (therapeutic abortion) from the active treatment hospitals to some special abortion clinics in the community that have a broader interest than abortion, i.e., that are active in contraceptive and sexual counselling.

• • •

Abortion is one area of medical practice where a central community clinic with appropriate paramedical counsellors and sessionally paid qualified doctors doing the procedure would be an advance over the present system of private practice and doing procedures in hospitals.

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[4] Replies non-accumulative as more than one response could be given.

> . . . I feel full hospital facilities should be available including possible blood transfusion.
>
> • • •
>
> Making abortions possible outside of hospitals would be a very retrogressive step.
>
> • • •
>
> I would urge more readily available facilities in the present general hospitals. I feel only doctors (who) are capable of handling any complications that might arise, e.g., perforation of uterus, should do the procedure.

On its site visits to hospitals across Canada, the Committee found broad support for the options endorsed in the national physician survey and, in particular, for designated day-care specialty units based at hospitals for first-trimester abortions. To maintain a standard of excellence, it was felt that this procedure required hospital-type services and facilities, and when these were available, the procedure should be done on a day-care basis. The option of doing this procedure in a physician's office was widely rejected on the basis that there would be an insufficient professional review of the type and the quality of medical care provided, and in the event of unforeseen complications, the required services would be less readily available.

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

[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.

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Among the hospital administrators and the senior medical staff who were met in this region, the Committee was consistently told that there was little justification for women seeking an induced abortion to go to the United States for this purpose. It was felt that a sufficient number of hospitals, often unknown to each other in the extent to which the abortion procedure was done, were performing a sufficient number of induced abortions to preclude the need for women to leave the region for this purpose. When this happened, it was suggested, it was because these women wished to have the operation done promptly without the "hassle" of a committee review or they sought to retain their anonymity.

Based on the information obtained in the surveys done by the Committee and its site visits to other hospitals in the region, these reasons were not a sufficient

explanation. In many parts of the region hospitals either did not have committees, or in some instances established hospital committees required extensive documentation of physical and mental health indications. At one of these hospitals the policy of the committee changed completely with the appointment of a new chairman in early 1976. Prior to this appointment, all applications had been approved, while under the reconstituted committee only specific physical and mental health indications were considered as valid reasons for the approval of first abortions and no applications for second abortions were approved. At another hospital which had had an established committee for several years, no applications had been approved since the departure of two staff physicians in 1973 who at that time were performing induced abortions.

Disposition of patients' charts

One concern frequently voiced by women seeking an induced abortion and by physicians who in one way or another were involved in the procedure was how to preserve the confidential nature of what was being done. This concern reflects the widely held sense of stigma which is often associated with this procedure and the curiosity which many individuals may have about its details. At some of the hospitals which were visited by the Committee, special steps were taken to hide the identity of abortion patients either by not listing this procedure or substituting another diagnostic category on the list of surgery which was posted daily. The procedure followed at one hospital for instance, if it was requested by a woman, was that the patient became an official "non-person". No indication was given to visitors that these abortion patients had been admitted to the hospital, they were not listed in the directory of patients which was kept at the hospital's reception desk, no telephone calls were taken on their behalf, and their mail was returned stamped as "address unknown".

Particularly in smaller hospitals and in centres where there was only one hospital in the locality, there was a heightened sense of concern among patients and physicians about retaining their anonymity. It was for this reason that a number of women living in smaller communities chose to by-pass their local hospitals in favour of going to larger centres or to the United States to obtain this operation. It was also partly for this reason that some physicians recommended to their patients that they take these steps, which while serving to maintain the anonymity of their patients also reduced their own involvement in the abortion procedure.

Because induced abortion is an issue which evokes more than a passing interest among some medical and hospital staff who are not directly involved in this procedure, some hospitals made special arrangements for the filing of committee decisions, the storage of patient charts, and established guidelines for the accessibility of these records for medical and hospital staff. These steps which were taken were a tacit recognition that there was often an open accessibility to patients' charts by a wide range of hospital personnel. In the type of the special precautions which were taken by hospitals with therapeutic

abortion committees, the concerns and the interests of physicians were more recognized than those of abortion patients.

TABLE 11.6

DISPOSITION OF CHARTS OF THERAPEUTIC ABORTION PATIENTS BY REGION

NATIONAL HOSPITAL SURVEY

Region of Country	Disposition of Patient Charts			
	Special Storage Arrangements	Special Files for Committee Decisions	Guidelines for Research Accessibility	Guidelines for Accessibility by Hospital/ Medical Staff
	percent			
Maritimes	37.5	87.5	40.0	40.0
Quebec	47.1	93.8	52.9	33.3
Ontario	32.0	77.3	45.8	37.7
Prairies	27.3	56.3	32.3	34.4
British Columbia	32.4	71.4	41.2	37.1
CANADA	33.0	74.3	42.4	36.5

Note: Non-accumulative as each committee could make several arrangements for the disposition of patient charts.

Among hospitals with committees from which information was obtained, 3 out of 4 of these hospitals (74.3 percent) made special arrangements and kept separate files of the decisions which were reached by committee members in their review of abortion applications. Representing a more heightened concern with this matter, these arrangements were more often made in the Maritimes (87.5 percent) and Quebec (93.8 percent) than in the Prairies (56.3 percent) or British Columbia (71.4 percent).

These special arrangements for the handling of the records of therapeutic abortion committees took many forms. In one hospital in the Maritimes visited by the Committee, only the executive secretary to the hospital administrator handled these records which were stored in the administrator's personal files. Only these two individuals had keys to the files which contained the lists through the years of physicians who had served on the therapeutic abortion committee and the decisions which had been taken in the review of abortion applications. At another hospital in the Prairies much the same arrangements were followed, with the executive secretary to the administrator attending all committee meetings, taking minutes, maintaining records, and preparing the statistical reports which were subsequently sent to Statistics Canada. In this instance the abortion records were directly accessible only to the administrator, the executive secretary, and the chairman of the therapeutic abortion committee. They were kept in locked files in an alcove of the executive secretary's office.

By taking these unusual steps these hospitals recognized the socially sensitive nature of the abortion procedure. These precautions were intended to

safeguard the reputations of the physicians who were involved. But similar steps were less often taken to protect the privacy and the interests of patients who had induced abortions. **In comparison with the special arrangements made by 74.3 percent of the hospitals for the records and minutes of therapeutic abortion committees, 33.0 percent of these hospitals took comparable precautions involving the handling and the storage of the charts of induced abortion patients.** There was little variation in this respect across the country. After the abortion operation had been done in two-thirds of the hospitals, these charts devoid of the therapeutic abortion committee's decision were stored along with all other hospital records. In this respect these records were accessible on a basis which was comparable for all other charts of patients to all medical and hospital staff.

Few hospitals with therapeutic abortion committees had established either special guidelines governing the accessibility to the charts of induced abortion patients by staff (36.5 percent) or for their use for research purposes (42.4 percent). This matter touches upon the much broader issue of ethical research standards involving the accessibility and the use of patient records. In the Committee's review of the few research studies which have been done in Canada dealing with abortion, it was not always clear whether the consent of patients had been obtained for these research purposes. This issue may pose an ethical dilemma particularly in hospitals (which are not affiliated with universities) where a stipulation of consent for teaching and research is not necessarily signed when patients are admitted to hospital. Many of the studies which have been done do not appear to comply well in these respects with acceptable ethical research standards governing the informed consent of patients, their personal identification, or the disposition of research records. These studies usually drew upon an accumulation of available hospital charts of induced abortion patients and presented a mixture of statistical findings and on occasion detailed clinical case studies. **Dual standards obtain in this regard, for comparable access is unknown to the Committee to have been given for research involving the review of the work of therapeutic abortion committees or for the analysis of the decisions reached by these committees on abortion applications.**

Interpretation of abortion law

Most of the larger hospitals which did a sizeable number of the abortions accepted physical health, mental health, and social indications as the basis for their decisions. It was more often the case that hospitals located in smaller cities and towns limited their criteria to physical and mental health indications. The meaning attributed to the diagnosis of mental health was varied and diffuse. No clearcut distinction could be made by the Committee between instances where this classification was valid, or was used to represent social indications. The classification of mental disorders given in the *International Classification of Diseases*, Eighth Revision, a classification system which is used across Canada, lists disorders whose etiology is both physical, mental, and social, or a combination of these in their origins. In the introduction to this

classification, no specific definition is given, with the categories listed being subsumed "where the main interest is in the mental state of the patient". The various mental disorders which are listed can assume any degree of gravity for a particular patient whose usual state of mental health may be affected.

The Committee was asked to determine "to what extent is the condition of danger to mental health being interpreted too liberally or in an overly restrictive manner?" As the mental health of an individual includes a wide range of conditions each of which can vary in its intensity, the *a priori* assumption must be made that a woman's state of mental health was fully known before she had her unwanted pregnancy. All of the information obtained by the Committee points to the conclusion that women who were seeking an abortion experienced an intense short-term anxiety which was not relieved until the operation had been performed, and if this step was delayed, the level of anxiety was further heightened.

If the assumption is accepted, which the Committee does, that a high degree of anxiety is associated with the abortion procedure, then **in the broad understanding of the meaning of mental health, this condition is not being interpreted too liberally for most, if not all, women seeking an induced abortion operation. If the definition of mental health is restricted to psychiatric disorders associated with physical conditions, psychoses, or long-term neuroses, then few abortion patients had these conditions.** There is much confusion in the use of these terms generally, a confusion which is further compounded when it is linked with the issue of induced abortion. Because the diagnostic labelling practices varied so greatly across the country and between hospitals within the same community, much of the general information which is available on this point must be considered suspect, if not invalid.

The Committee was also asked to consider the question, "Is the likelihood or certainty of defect in the foetus being accepted as a sufficient indication for abortion?" The direct answer to this question is yes. Most of these committees gave a high priority to this condition and would be prepared, were it so indicated, to approve an abortion application on the grounds that it would affect a woman's health. In the few instances where it was reported to the Committee that defects of the foetus were known to be present, the diagnosis which was given related to the mother's health as a consequence of the potential birth of such a foetus.

Central to the understanding of the criteria applied by therapeutic abortion committees is the definition of health adopted by the members of these committees or stipulated by hospital boards. While most hospitals endorse a broad definition of health, often acknowledging the Charter of the World Health Organization as the basis for their general treatment activities, the question of induced abortion draws a sharp dividing line in the recognition and the application of this concept. **How danger to the health of a woman seeking an induced abortion was judged varied from the estimation that in no instance was this operation justified, a great variety of intermediate interpretations, to the broadest possible definition which allowed an abortion to be done when it was requested by a woman. Based on these different understandings of the**

concept of health, a number of requirements were set for patients seeking this procedure and a wide range of guidelines were used in the review of applications for induced abortions. If equity means the quality of being equal or impartial, then the criteria (requirements and guidelines) used by hospital therapeutic abortion committees across Canada were inequitable in their application and their consequences for induced abortion patients.

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;
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> 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.
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> 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.
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> 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.
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> 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.
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I personally feel that the laws governing abortions are much too liberal. I also feel that doctors have no right in taking human lives.

• • •

The law as it now stands does not give the poor and lower socio-economic levels the ability to have a safe abortion . . . stricter abortion laws tend to strike the people who can least afford the burden of another child. People with money and/or influence can get abortions by going elsewhere.

• • •

I feel the law is interpreted too liberally now. I think contraception should be emphasized rather than abortion. I think if abortion were not so easily obtained now—maybe contraception would be practiced more carefully.

• • •

The final decision should rest with the patient if she is of sound mind as she is the one who will have to cope with her feelings and emotions concerning the situation.

The opinions of the nurses in the hospital staff survey were also divided on who should make the decision about an abortion. Their opinions on this point were: 13.0 percent, the woman's decision; 19.9 percent, the woman and her doctor; 30.2 percent, the woman, her partner, and the doctor; 8.9 percent, the woman and two doctors; 23.3 percent, a committee; and 4.7 percent gave no reply. Almost 3 out of 4 of the nurses (72.0 percent) endorsed a method other than the therapeutic abortion committee. While nurses are not involved with the review of applications or the decision of therapeutic abortion committees, many had opinions about how they worked, or in their opinion, should work.

Abortion is leading us to think less of life. Abortion committees are merely rubber stamps and in many places never give individual consideration without bias.

• • •

I strongly feel that the abortion committee should be abolished along with removing it from the Criminal Code. The abortion committee is only present as a formality to satisfy the law and does nothing so that when it might be possible to do a simple D & C, proceedings take so long that the patient ends up waiting for a saline injection which is more traumatic to the patient.

• • •

A person who wants an abortion should have the consent of the husband and pass a committee. The committee should be more strict so people will not be coming back for another abortion.

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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 . . .

• • •

. . . 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.

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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.

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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.

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I feel that allowing therapeutic abortion has not decreased back alley criminal abortions.

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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.

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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) Delivery	Therapeutic Abortion	Other Abortions	Sterilization	One Year After (1972) 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) Delivery	Therapeutic Abortion	Other Abortions	Sterilization	One Year After (1972) 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 I, *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,

[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,

[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. Extra-billing: 0.5 percent	None opted out. Extra-billing: less than 0.5 percent
Nova Scotia	Extra-billing: 3.1 percent of payments (1971-72).	2 opted out: 2.9 percent extra- billing (1972-73).
New Brunswick	4 opted out.	4 opted out. 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. Extra-billing allowed under certain circumstances.	None opted out. 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. Andreopolous, 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		Not Local		Total	
	No.	%	No.	%	No.	%
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 No.	Local %	Not Local No.	Not Local %	Total No.	Total %
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
AGE	percent				percent			
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

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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.