Ontario

Echo: Improving Women's Health in Ontario

Recommendations to Improve Abortion Services in Ontario: Report from the Expert Panel

Introduction

These recommendations arise from a cross-provincial Abortion Expert Panel, who based the recommendations on their own expertise, key stakeholder consultation, and the findings of an Ontario based-study undertaken by Dr. L. Ferris through the Institute for Clinical Evaluative Sciences[1]. The panel, assembled by Echo: Improving Women's Health in Ontario, has been meeting over the past year to articulate clear recommendations and to assist in the development of the release strategy for key information from the study findings. The recommendations have implications for the health care, regulatory and training systems.

The background research conducted by Dr Ferris included a statistical examination of the provision of, and access to, medical and surgical non-emergent abortion services (particularly through hospitals) in the province, an examination of Family Physician/General Practitioners practice patterns and medical curriculum, and complications associated with non-emergency abortions[1].

After much consideration, the Abortion Expert Panel identified the following key messages about the current state of Ontario services. A variety of players will need to be involved to act on the challenges and recommendations identified.

Key Messages about Abortion Services in Ontario

1. **Abortion is a safe procedure in Ontario[1].** Abortion procedures performed at lower gestational age lowers the complication rate, **making timely access to abortion services essential.**
2. Research shows that **high quality abortion services must be readily available** to support women's reproductive health [2,3,4,5]. When women are able to make safe choices regarding their sexual and reproductive health, they are more likely to participate equally in social, political and economic life[6].
3. **The Ontario abortion system is fragile**. Abortion services are shifting from a model that relied on hospitals to one that relies on specialized clinics and private physician offices (PPOs). The current abortion system is poorly understood and is dependent upon a relatively small group of providers. Hospitals must remain core providers in the system and provide back-up support to the clinics and PPOs.
4. **Access to abortion services can be difficult and access is not equitable across Ontario**, primarily due to a complex and fragmented system. **A centralized source of information** regarding how to access services that support women's choices needs to be available.
5. Health care professionals have **a duty to** operate in alignment with **legal and ethical frameworks** that identify obligations regarding confidentiality, respectful behaviour and full disclosure of pregnancy options and choices to their patients. When women are not referred to abortion service providers, it can cause barriers in accessing an abortion provider and receiving a timely procedure or intervention putting the woman at increased risk.

Vision

To ensure accessible, safe, appropriate, timely, and non-judgmental abortion services for Ontario women through an integrated and sustainable sexual and reproductive health system.

Challenges in achieving the vision

The recommendations in this report address: (1) improving system design, (2) improving quality, (3) system monitoring and accountability, (4) improving training of health care providers, and (5) improving alignment and adherence to ethical and legal obligations of health care providers.

The following chart identifies some of the key challenges in achieving the vision. These gaps informed the identification of the key recommendations specified in this report. Abortion services and other sexual and reproductive health services are challenging to provide due to the continuing societal tensions regarding the ethical basis of these services. In Canada, these services are legal and covered by all provincial health service funding schemes. Despite this reality, women and providers continue to experience the threat of stigma and/or sanctions for accessing or providing these services. Special attention needs to be paid to ensure that abortion services are readily available to Ontario women, given the relative increase in health risks with later interventions. System efforts need to continue to support earlier and low risk interventions to the greatest degree possible to better support women and to support system sustainability by using lower cost alternatives (e.g., medical abortions, early gestational age) whenever possible.

Issues in Abortion Services to be Addressed	
Current State (Where we are now)	**Ideal (Where we want to be)**
Although abortion service provision is safe with less than 1% complication rate,[1] the abortion system is fragile (i.e., few providers offering the majority of services, operating room services affected by lack of resources and competition for operating room time).	Abortion services are stable, sustainable and integrated across the services, which includes roles for hospitals, specialized clinics, and primary care settings.
Abortion is not a part of the core content of medical school curriculum.	Sexual and reproductive health topics, abortion counselling, and abortion procedures are part of the core content of medical and nursing schools' curricula and supported by core education in medical ethics. Practical training is provided to medical students and primary care practitioners.
Access to abortion services is varied, depending on gestational age, geographic location and women's financial resources with respect to travel costs and fees.	Abortion services and support are accessible and appropriate based on gestational age and geographic location.
It is hard to access information regarding abortion services causing barriers for women seeking the service.	A centralized source of information regarding service choices is well-known.
Medical abortion[i] is not uniformly available in Ontario.	Safe medical abortion is offered to women in Ontario as a component of primary care and there is surgical back-up available within reasonable proximity wherever medical abortions are provided.
Mifepristone[ii] is not available in Canada.	Mifepristone is available to Ontario women because when used in combination with a prostaglandin (i.e., misoprostol) it is a safe, effective and more accessible abortion technique and can be used up to nine weeks gestation [7,8,9,10].

[i] Medical abortion is a generic term used to indicate when medications are used to interrupt the pregnancy process and end the pregnancy. In Ontario the drug regime that is used is only effective up to seven weeks' gestation and is an inferior option to Mifepristone.

[ii] Effective medication abortion is done with an anti-progesterone (i.e., mifepristone), a drug that stops the production of progesterone, a hormone necessary to support pregnancy, and prostaglandin (misoprostol), a drug that helps the uterus contract. The combination of these two drugs is not yet approved for medical abortion in Canada, although available in many other jurisdictions and proven to be safe.

Few services use standardized guidelines to ensure quality of care for abortions in Ontario.	Standardized guidelines for abortion care and abortion facilities are adopted and followed by all abortion providers in Ontario.
Lack of a shared understanding of ethical and legal obligations on the part of health care professionals and regulatory colleges to patients including: • Obligation to uphold confidentiality; • Obligation to provide information on options and risks; • Obligation to facilitate access to care; • Obligation to provide treatment in emergency situations; • Obligation to refer women to a willing provider when doctors object on grounds of conscience to providing indicated treatment; and • Obligation to provide services in a respectful non-judgmental manner.	Ethical guidelines are aligned with legal obligations. Ethical and legal standards are in place and enforced by regulatory bodies.

Recommendations to improve abortion services in Ontario

A. Improve System Design and Improve Equity of Access:

These recommendations need to be addressed by: Local Health Integration Networks (LHINs), Hospitals, Primary care providers, Regulatory Colleges, Telehealth Ontario and the Ministry of Health and Long-Term Care (MOHLTC).

1. **Address system fragility and build system sustainability.** Engage LHINs and providers in understanding the current state of the system and its' fragility. Address fragility locally by developing a shared understanding of the care system and addressing gaps and shortfalls.

2. **Improve abortion care in Ontario by designing an integrated system including a role for hospitals**
   - **i.** Abortion services under 12 weeks' gestation should be a component of hospital care for those hospitals with appropriate obstetrics and gynaecology services to help with geographical access and client and provider anonymity. Including a role for hospitals which provide a range of other services helps to ensure local services are available and protects providers and patients from stigma and sanctions. Hospitals need to be effective in addressing complications of both medical and surgical abortions; therefore, maintaining a core service delivery program ensures that service capability is maintained. Each region should have a hospital-based service.
   - **ii.** Designate hospitals for abortions at 16 weeks' gestation and over as a provincial resource since these procedures are less frequently required, are higher risk. Delivery of this service by skilled providers performing a critical mass of surgical procedures annually better supports patient safety.
   - **iii.** Establish a coordination mechanism for wait-time management for each region. The data should be available and local examination of waiting times from referral to procedure will help in ensuring that women are not being subjected to higher risk procedures unnecessarily due to system delays.

3. Supporting access to medical abortions

i. 'Regional Care Groups' should be created which include practitioners within a specific catchment area who provide medical abortions and where at least one member is trained in surgical abortion and has local surgical privileges (in case surgical back-up is needed). The Groups should also include professionals who can provide the full spectrum of abortion services including pre-abortion counseling, follow-up and support (e.g., nurses, social workers, physicians, and gynecologists). These Groups would require different supports depending on geographic area (e.g., low versus higher population density areas). Regional Care Groups will establish referral mechanisms for later gestational age terminations hospitals designated provincially to take on this mandate.

ii. Support the training and the development of delegation of authority mechanisms and/or medical directives to enable Nurses, Nurse Practitioners and Physician Assistants to play a role in the provision of medical abortion with appropriate backup through the Regional Care Groups. Women will benefit by early termination through medical options which are currently generally effective at seven weeks' gestation or less. Easy availability through primary care would support ease of access for women and the system costs associated with procedures. Access through primary care also supports reduced stigma for women choosing pregnancy termination.

iii. Advocate for the approval of the use of mifepristone (in combination with misoprostol) in Canada. This medication allows medical termination up to nine weeks' gestation in a safe and effective form that is not currently available in Canada. The lack of available access to this drug means that Canadian women are being served by inferior choices and subject to greater risk. This drug has a lower failure rate than the current medication regime used in Ontario and therefore is less reliant on ready access to surgical backup. A manufacturer would need to make application to Health Canada for approval for mifepristone to be available in Canada. The Society of Obstetrician and Gynecologists and others support making mifepristone available.

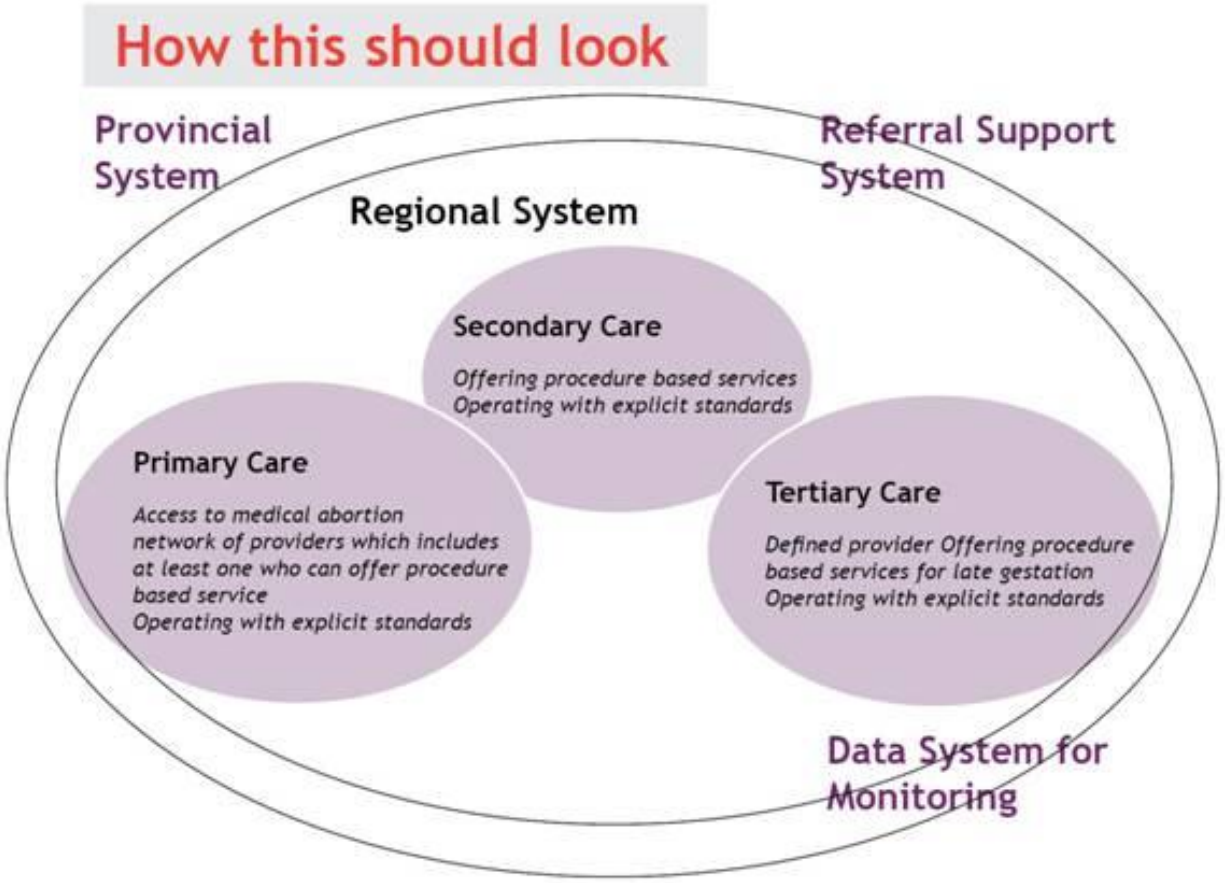
4. Improve access to information on pregnancy choices and associated services

i. Establish a centralized source of reliable information regarding accessing abortion services - without putting providers that offer services at risk. Service providers that participate in offering abortion services are currently not easily identified due to concerns for their own safety and/or community sanctions. Women, particularly outside of urban areas, therefore often struggle to identify pregnancy options in a timely fashion. They often incur costs to travel to urban areas where abortion providers are more readily identifiable.

ii. Standardize all pregnancy counseling to include all options, including abortion. There are many providers of pregnancy counselling; however, not all providers discuss abortion services as an option. This interferes with women's ability to determine how to proceed in a timely fashion should she wish to have an abortion.

iii. Engage with Telehealth Ontario about current protocols regarding pregnancy questions and ensure a centralized resource is the identified option. The increased visibility of this resource regarding discussion of pregnancy decision options may be a helpful mechanism to support women in accessing services in an effective manner.

Establishing a system of care for abortion services in Ontario:



B. Improve Quality of Abortion Care:

These recommendations need to be addressed by College of Physicians and Surgeons of Ontario, Society of Obstetricians and Gynecologists of Canada, National Abortion Federation, Health Service Providers, Ontario College of Family Physicians (OCFP), Ontario Health Insurance Plan, Ontario Medical Association and the MOHLTC.

5. Quality

i. Abortion care must operate within a defined set of established standards. There are three established standards available (CPSO, SOGC, NAF) and provider groups should determine which standards they wish to adopt (if they have not done so). Standards should include guidelines to ensure that follow-up abortion care is consistent, comprehensive and non-judgmental. There are particular concerns about the rising volume of service being delivered within PPOs.

ii. CPSO is charged with a new responsibility for physician practices that are administering anesthetics outside of hospitals. It is anticipated that the related guidelines will help support quality of care in the settings where surgical abortion procedures are being done in the community (PPOs) as an initial step.

iii. Adjust OHIP fee codes for medical and surgical abortion procedures to allow reimbursement for follow-up by email and phone to meet the needs of hard-to-reach women and increase follow-up rates.

iv. Abortion should be removed from OHIP negation procedures in primary care to maintain patient confidentiality and to support access.
v. Facilitate inter-provincial billing to better support women living at provincial boundaries.
vi. Standardize referral and pre-procedure requirements and share these requirements with primary care. This will enhance access by reducing delays to achieve and/or repeat needed testing.
vii. Increase training and use of conscious sedation and local anesthetic when possible; this will reduce the risk to women of moving a low-risk procedure into a higher- risk situation unless clinically required. Current in hospital care profiles show a high proportion of patients receive a general anesthetic for abortion procedures.

C. System Monitoring and Accountability:

These recommendations need to be addressed by Ontario Health Quality Council, BORN Ontario and/or MOHLTC.

6. **Develop a mechanism to support system monitoring and accountability to more readily identify issues in service availability and quality of care.**
   - This data system should be held by an organization that is empowered to hold personal health information.
   - Data capture regarding abortion procedures should include quality measures; in particular, barriers to access, timeliness, and women's perceptions of the services provided [4].
7. Support development of a third party complaint process for health care services, to provide better information regarding the barriers experienced by women. Current complaint mechanisms relate only to the practice of individual providers and this makes it difficult for women to complain about system barriers to access.

D. Improve Training of Health Care Professionals:

These recommendations need to be addressed by CanMeds, the Royal College of Physicians and Surgeons of Canada, and Faculties of Medicine, Nursing and Midwifery.

8. **Ensure abortion procedures, sexual and reproductive health- related medical ethics are part of core content of sexual and reproductive health curricula in medical, nursing and midwifery education programs. In particular, it is recommended that:**
   - Accreditation bodies must require mandatory sexual and reproductive health curriculum in medical school training; this should include associated elements of medical ethics through use of case studies.
   - All Obstetrical/Gynecology training programs must implement the SOGC curriculum and Abortion/Pregnancy Options and include second trimester abortion training in Obstetrical/Gynecology residency training.
   - Obstetrical/Gynecology residency programs are encouraged to implement and/or promote the Kenneth J. Ryan Residency Training Program (a privately funded initiative that strives to integrate and enhance family planning training for obstetrics and gynecology residents in the US and Canada).
   - Family Medicine training programs should be encouraged to support a 3rd year residency program in Family Medicine for Women's Care which includes comprehensive abortion training.

E. Improve Alignment and Adherence to Ethical and Legal Obligations to Patients:

These recommendations need to be addressed by Regulatory Colleges (Physicians, Nurses and Pharmacists), Provider organizations, CPSO, Canadian Medical Protective Association (CMPA), OCFP, and Clinical Ethicists.

9. **Support an understanding, alignment, and accountability of ethical and legal obligations on the part of health care providers and regulatory colleges to patients including:**
    - Obligation to uphold confidentiality;
    - Obligation to provide information on options and risks;
    - Obligation to facilitate ongoing discussion regarding access to care;
    - Obligation to provide services in a respectful, non-judgmental manner;
    - Obligation to provide treatment in emergency situations; and
    - Obligation to refer women a willing provider when doctors object on grounds of conscience to providing indicated treatment.

- **Support the CPSO in changing the *Physicians and the Ontario Human Rights code* policy to specify that physicians must refer women seeking an abortion in a timely manner to a *willing* abortion provider (and extend this policy to include other sexual and reproductive health services, such as emergency contraception).**

Conclusion

Ontario women benefit from access to well trained, committed service providers that do this important work in a generally effective and safe manner. The recommendations in this report are intended to continue to support the development of a system of care that supports improved quality and equity of access.

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