Therapeutic Abortion and the Law

Le docteur Cohen dit que les avortements retardés ou refusés sont des exemples d'inégalités légales pour la femme.

May Cohen

In 1969 the Canadian Criminal Code was amended with respect to therapeutic abortion. Section 251 of the Criminal Code stated that an abortion could be performed on a pregnant woman by a qualified medical practitioner if a therapeutic abortion committee, existing in an accredited hospital, stated in writing that in its opinion the continuation of the pregnancy would, or would be likely, to endanger her life or health. It is important to note that the medical practitioner performing the abortion could not be a member of the therapeutic abortion committee.

What the law did not state was equally important. The law did not require any hospital to appoint a therapeutic abortion committee. Nor did it prevent a variety of provincial regulations from governing the establishment of hospital therapeutic abortion committees. Nor did it prohibit the diverse interpretation of the indications for this procedure by hospital boards and the medical profession.

As a result, it has become obvious that . . . the abortion law as it exists in Canada today ensures that equality of health care in this area can never be available to Canadian women.

During the early 1970s, although the number of legal therapeutic abortions performed in Canada increased, the problems associated with the application of this law became increasingly apparent and were sharply focused by the legal battles of Dr. Henry Morgentaler.

In 1975 the federal government appointed a committee to study the operation of the abortion law (C.O.A.L.), commonly known as the Badgley Committee.[1] Although close to three-quarters of a million dollars was spent in compiling this report, and although the report was submitted to Parliament in 1977, it has never been tabled for debate.

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However, some very significant findings were reported by the Badgley Committee. The committee identified inequities in the operation of the abortion law and sharp disparities in how therapeutic abortions were obtained by women within various cities, regions or provinces. The report stated that the social cost of these disparities had 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. The women who were most likely to suffer were the young, the poor and the less well educated.

More specifically, while no therapeutic abortion could be performed in a hospital that had no therapeutic abortion committee, C.O.A.L. found that only 20 per cent of general hospitals in Canada had such committees. The number of hospitals with committees has not changed significantly since that time, as reported in Statistics Canada, 1977. Two out of five Canadians lived in communities where abortion services were not available.

The criteria used by hospital therapeutic abortion committees across Canada were inequitable in their application and in their consequences for induced abortion patients.

In 1975, 10,000 Canadian women went to the United States to obtain abortions. Seven out of eight of these women would have preferred to have treatment in Canada. In 1977, 2,300 Canadian residents were still reported to have obtained legal abortions in the U.S. These 1977 figures may be lower than the actual figures, as the official Statistics Canada figures for the same year and the numbers reported by the Badgley Committee are significantly lower as well.

There was an average delay of eight weeks from the time a woman suspected she was pregnant until the actual abortion was performed. Indeed, India and Canada share the dubious honour of having the highest rate of second trimester abortions (after the 13th week of pregnancy) in the world. Christopher Tietze, in his report 'Induced Abortion,'[2] states that in India, this is due to poor access to medical care but in Canada, it is due to the fact that, . . . of all the western countries, Canada has the most restrictive law and the most cumbersome authorization procedures.

The impact on the health of Cana-

dian women is extremely serious, since the risk of complications increases significantly in the second trimester with each week that the abortion is delayed.

At the time of the publication of the Badgley report, two out of every three Canadians did not know that it was legal to have an abortion under any circumstances.

It was also documented that, in many cases, the law did not work equitably because some physicians did not handle the issue of abortion in a straightforward manner with their patients. For many patients, it was often a matter of chance whether the physician who was initially contacted tried to facilitate her request for an abortion, or whether the steps taken by the physician served to delay an application being made on her behalf to the hospital's therapeutic abortion committee. In addition, many hospitals performing the procedure developed a number of preconditions to be met by patients prior to the review of their applications by therapeutic abortion committees. Various provinces instituted different consent requirements for patients about to undergo a therapeutic abortion.

Another issue highlighted by the Badgley Committee report was the fact that the way in which the concept of health was variably defined led to considerable inequity in the distribution and accessibility of the abortion procedure. The amendment to the law did not itself define health but (as the Badgley Committee reported) by virtue of Canada's membership in the United Nations and its recognition of the constitution of that international body's affiliation with the World Health Organization, this nation has gone on record as having acknowledged a definition of health which stipulates that '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 impact of these inequities is present today as it was at the time of the Badgley report. For example, in Newfoundland as recently as late 1979, there were still only two therapeutic abortion committees. Neither of these permitted abortion past the 12th week of pregnancy and at least one committee insisted that the patient be seen by four different health professionals prior to making an application to the committee. One can well imagine the hassle required to meet all these stipulations. Furthermore, the consent of the father was required for all unmarried women under the age of 19. Dr. Henry Morgentaler has deplored the number of Maritime women who must travel up to 1,000 miles to obtain a safe abortion at his Montreal Clinic.

In Prince Edward Island, a very bitter dispute has been centred on whether the new Queen Elizabeth Hospital, scheduled to open its doors in late 1981, should have a therapeutic abortion committee.

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The 'Right to Life' group has attempted to sabotage a fund-raising campaign for the hospital unless it can obtain a promise that there will be no therapeutic abortion committee.

Last year, it was reported that 50 per cent of the Manitoba women having abortions had to arrange them in the U.S. because only two accredited hospitals in Manitoba were performing a significant number of abortions. In St. Thomas and Scarborough, Ont. and in Vancouver, the 'right to life' advocates have waged bitter campaigns within the last two years for control of hospital boards. In doing so, they hope to abolish the hospital therapeutic abortion committee (appointed by the board) or to influence its composition so no requests will be approved.

The result of these differences is obvious. In 1977, the abortion rate for Canadian women aged 15 to 44 ranged from 1.7 per 1,000 in P.E.I. to 19.8 per 1,000 in B.C. with wide regional disparities in between. It is also significant that while there were 265 hospitals with therapeutic abortion committees in Canada in 1977, 13 per cent of these reported to have performed no abortions and a further 40 per cent performed less than 50 abortions per year.

Thus, we see that in Canada today, cumbersome legal machinery prevents access to safe therapeutic abortion for many unwillingly pregnant women. Those who fight for safe legal abortions do so on the grounds that it is unjust and immoral for a state to compel a woman to continue a pregnancy against her will. Furthermore, it has now become evident that forcing a woman into mandatory motherhood is actually harmful to her health.

To begin with, the alternative to legal abortion is not the elimination of abortion, but illegal and dangerous termination. Innumerable studies support this statement. In our own country, the Badgley report stated that following the introduction of the amended abortion law, there was a sharp reduction of illegal abortions among teenagers and young women. The number of deaths of women in Canada resulting from self-induced and criminal abortions, which averaged 12.3 each year between 1958 and 1969, dropped to an average of one per year between 1971 and 1974. In Romania, following the introduction of restrictive abortion legislation in 1966, there was a sharp increase in the number of deaths due to illegal abortions.[3] In Latin America, where very strict anti-abortion laws still exist, it is estimated that there are five million illegal abortions per year. Thus, those who seek to make legal abortion more difficult to obtain in Canada would only serve to drive women to the back street abortionist.

Numerous studies now support the conclusion that the provision of safe, legal therapeutic abortions to unwillingly pregnant women, who

have been adequately counselled concerning their options, results in less risk — both psychologically and physically — than the continuation of that pregnancy to term.

The World Health Organization in 1978 reported, 'There is now a substantial body of data suggesting *frequent psychological benefit* and a low incidence of adverse psychological sequelae following abortion.'[4] When the incidence of post-abortion depression is compared to the incidence of post-partum depression, the incidence is striking. One recent English study found that post-partum depression (depression following childbirth) was six times more common than post-abortion depression.[5]

Studies from Sweden, Aberdeen, Scotland, and Czechoslovakia, comparing women who were refused access to therapeutic abortion with women who were granted permission, indicated that those women who had been compelled to continue their pregnancies were psychologically less healthy than those who were permitted to terminate.[6] Furthermore, studies with long-term follow-up of the offspring of women who had been refused legal abortion in Sweden and Czechoslovakia indicated that those children born of mothers who were refused abortion were at higher risk to maladaptive behaviour and emotional difficulties.[7]

As for physical complications, the morbidity and mortality rates associated with first trimester abortions are considerably lower than those associated with second trimester abortions. Morbidity and mortality rates associated with second trimester abortions are in turn lower than those associated with labour and delivery in a full-term pregnancy.

While on a case-by-case basis in the physician's office no one can predict how much a particular woman will suffer if she is compelled to remain unwillingly pregnant and deliver an unwanted baby, we do know, from the evidence of the studies mentioned above, that she is more likely to suffer emotionally or physically or both if her wish is denied than if her wish is granted. Following from this, therapeutic abortion committees would paradoxically be operating within both the spirit and the letter of the law if they granted every request coming before them, provided they were assured that the woman has considered and rejected the alternatives to abortion. That many existing therapeutic abortion committees fail to recognize this fact is obvious. Indeed, in December 1979 B.C.'s Health Minister, Rafe Mair, asked his officials to investigate whether 'illegal abortions' were being performed in the province's hospitals, and indicated that he felt abortions were being granted in conditions 'less stringent than that required by Canadian law [*sic*].'

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There are a number of groups in Canada that are working to outlaw abortions in this country. That they are strident beyond their numbers is obvious from a Gallup Poll of March 1979, which reported that only five per cent of the respondents would not agree to a woman having an abortion under any circumstances. Nonetheless, these groups wish to impose their point of view on all of us, ignoring the fact that they are indeed working to increase the ill health of women who are unwillingly pregnant. While they claim to be anti-abortionists, they are indeed fostering unwanted pregnancies, but by and large, they are not only opposed to legal abortion but also to sex education and the widespread availability of contraceptive services.

Unwillingly pregnant women must be given the opportunity to consider all the options available to them. One of these options must continue to be safe, legal therapeutic abortion. Women will only be able to make this choice freely when the legal encumbrances are removed, when one segment of the population ceases to try to impose its values about reproductive morality on others, and when the issue of unwanted pregnancy becomes a matter between a woman and her physician or other members of the health care team.

Notes

1 *A Report of the Committee on the Operation of the Abortion Law* (Canada: Ministry of Supply and Services, 1977).

2 Christopher Tietze, *Induced Abortion* (New York: Population Council Publication, 1977).

3 Christopher Tietze, *Induced Abortion* (New York: A Population Council Fact Book, The Population Council, 1979).

4 *Induced Abortion* Geneva: WHO Technical Report, Series 623, 1978).

5 Colin Brewer, *Incidence of Post-Abortion Psychosis: A Prospective Study*, British Medical Journal, 1977, 1, 476-477.

6 Kerstin Hook, *Refused Abortion: A Follow-up Study of 249 Women, Acta Psychiatrica Scandanavica*, Supplement 168 (1963): 1-156; Olley McCance, Peter C. and Vivian Edward, *Long-Term Psychiatric Follow-up in Experience with Abortion: A Case Study of Northeast Scotland*, edited by Gordon Horobin (Cambridge University Press, 1977); Martin Ekblad, *Induced Abortion on Psychiatric Grounds: A Follow-up Study of 479 Women, Acta Psychiatrica Neurologica Scandanavica*, Supplement 99 (1955).

7 Hans Forssman and Inge Thuwe, *120 Children Born after Application for Therapeutic Abortion Refused, Acta Psychiatrica Scandanavica* 42 (1966): 71-78; Z. Matejcek, Z. Dytrych and V. Schuller, *Children from Unwanted Pregnancies, Acta Psychiatrica Scandanavica* 57 (1978): 67-90.

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