

The image features a background of a blue gradient, transitioning from a darker blue on the left to a lighter blue on the right. On the left side, there is a series of white, curved lines that originate from a single point and fan out towards the right, creating a sense of motion and depth. The lines are of varying lengths and curves, some being more pronounced than others. The text "Of What Difference?" is positioned in the center-right area of the image, rendered in a bold, black, sans-serif font.

**Of What Difference?**



20th Anniversary of Regina v. Morgentaler

# Of What Difference?

Reflections on the Judgment  
and Abortion in Canada Today

SYMPOSIUM

Toronto, Ontario  
January 25, 2008

Co-hosted by  
the National Abortion Federation  
and the Faculty of Law, University of Toronto





## 20th Anniversary of R v. Morgentaler Symposium

# Of What Difference?

## Reflections on the Judgment and Abortion in Canada Today

On January 25, 2008, in Toronto, Ontario, the Faculty of Law, University of Toronto (U of T) and the National Abortion Federation (NAF) co-hosted an interdisciplinary symposium to celebrate the 20-year anniversary of *Regina v. Morgentaler*, the Supreme Court case in which the criminal law on abortion in Canada was held unconstitutional.

The symposium brought together more than 100 participants, from legal scholars, abortion providers and journalists

to representatives from government and women's advocacy organizations. Examining abortion from a variety of perspectives, participants addressed the significance of the event and the difference the *R. v. Morgentaler* judgment has since made to women, providers and the politics of abortion in Canada.

This reader, prepared in collaboration with the Women's Health Research Institute, is a compilation of the day's presentations at this commemorative legal conference.

*This document is the property of the National Abortion Federation. Permission to reproduce this document is granted for use without fee and without formal request provided it is reproduced accurately and not used in a misleading context. The material must be acknowledged as NAF copyright and the title of the document specified. Copies may not be made or distributed for profit or commercial advantage. An electronic version of this document can be downloaded from the NAF Canada website at: (<http://www.prochoice.org/canada>).*



## Acknowledgements

NAF and its co-host, the Faculty of Law, University of Toronto, wish to thank all of the symposium attendees for their participation in the **20th Anniversary of R. v. Morgentaler Symposium**. In particular, we would like to thank all of the symposium presenters who willingly shared their stories and perspectives for this historical event. (*See Appendix 2 for a short biography of each presenter.*)

To all of the volunteers who generously donated their time before and during the symposium, grateful thanks are

extended. Symposium organizers wish to acknowledge law students Carolina S. Ruiz Austria, Chris Kaposy and Keri Bennett for their poster presentations.

We wish to thank the Canada Research Chair in Health Law and Policy for their generous support of this symposium.

NAF and the Faculty of Law, University of Toronto, in collaboration with the Women's Health Research Institute, are pleased to present these proceedings of the 20th Anniversary of R. v. Morgentaler Symposium.





# Table of Contents

<b>Forward</b> .....	<b>1</b>
<b>Introduction</b> .....	<b>3</b>
<b>Keynote Address: Dr. Henry Morgentaler</b> .....	<b>5</b>
<b>The Context: From Morgentaler to Abortion in Canada Today</b> .....	<b>9</b>
R v. Morgentaler: Charter Rights and Abortion.....	11
Post-Morgentaler Challenges: From Crime to Health .....	12
Abortion in Canada Today: Who, What, Where? .....	16
<b>Rights in Practice: Barriers to Available and Accessible Care</b> .....	<b>21</b>
Abortion in Canada: From Sea to Shining Sea.....	23
Law: Facilitating and Impeding Access .....	25
Better Never Than Late, But Why? The Contradictory Relationship Between Law and Abortion .....	29
Information Failure: An Ontario Case Study.....	35
<b>Our Providers: the Challenges of Their Work</b> .....	<b>39</b>
Challenges of Providing Abortion Care: A Provider’s Perspective .....	41
Why Do I Do This? Being a Provider.....	46
The New Generation: Abortion in Medical Schools .....	49
The Role of Media in the Abortion Debate .....	54
The Politics of Abortion: The Work of the Politician.....	57
On Being a Legal Academic in a Politically Charged Context.....	63
<b>Canada From an International and Comparative Perspective</b> .....	<b>67</b>
Canada from an International and Comparative Perspective .....	69
<b>Appendices</b> .....	<b>71</b>
Appendix 1: Symposium Programme.....	73
Appendix 2: Presenter Biographies .....	75



## Forward

The celebration of the 20th anniversary of the 1988 decision of the Supreme Court of Canada in the case of *Regina v. Morgentaler* allows us to reflect on the various factors that led to this judgment, and its subsequent implementation. First is the extraordinary courage of Dr. Henry Morgentaler in challenging what is called the modern day inquisition, the prevailing efforts to suppress women's rights and freedoms. The Court applied the Canadian Charter of Rights and Freedoms to ensure that women could exercise their fundamental right to security of the person to decide whether or not to continue with their pregnancy. The decision of the Supreme Court explained the government could not criminalize abortion in ways that infringed women's fundamental rights, and in so doing heralded in a new era of human rights and social justice. The Supreme Court used public health statistics gathered in the 1977 Report of the Royal Commission on the Operation of the Abortion Law, chaired by Professor Robin Badgley, to show how inequitably the 1969 amendment to the Canadian Criminal Code operated.

Second, is the perseverance of providers and women's health advocates across Canada to ensure implementation of the *Morgentaler* decision. As the papers that follow explain, there have been many contests around the implementation of the *Morgentaler* decision, including ensuring coverage of abortion services in provincial health plans, and controlling clinic harassment, violence against providers, and against women seeking services. It is clear from these fights that the crime and punishment mentality ebbs and flows, and it requires eternal vigilance if women's rightful place is to be secure in Canadian society.

Third, is the ingenuity of all those concerned with improving women's health

in Canada to shift the way in which health care systems generally treat women, from paternalistic and demeaning approaches to ones that respect their dignity and autonomy, and enhance their agency. Ensuring recognition and respect of women's moral agency, and their rights to make their own conscientious decisions is not always easy, particularly given the stigma women face in their pathways to obtain abortion services.

Challenges ahead include those steps that are necessary to reduce barriers and promote access, particularly to underserved populations. Measures to reduce barriers include removing therapeutic abortion from the list of excluded services under the Interprovincial Reciprocal Billing Agreement. Steps to promote access include the approval and wide availability of the safest and most acceptable means of medical abortion (that is non-surgical), which would bring Canada into alignment with those 40 countries that have now approved and provide medical abortion.

Some countries, such as Sweden, have developed a series of health service indicators that measure the quality of the delivery of the service, and health status indicators that measure the outcomes of the health service. One of the most important health status indicators is the percentage of abortions performed during the first 10 weeks of pregnancy. These indicators need to be disaggregated by age, rural status and, for example, ethnicity, to ensure that subgroups of women, particularly those that are marginalized in the health care system, have equitable and timely access to services.

In moving forward to ensure that each Province and Territory eliminates barriers, guarantees that every woman in Canada has access to dignified and timely care,

and fosters respect for women's moral agency, it is inspiring to remember the courage, perseverance and ingenuity of those who made the implementation of the Morgentaler decision possible.

*Rebecca J. Cook  
Faculty of Law  
University of Toronto*

## Introduction

Vicki Saporta, President and CEO, National Abortion Federation (NAF)

Monday, January 28th, 2008 marks the 20th anniversary of R v. Morgentaler, the Supreme Court's ruling that decriminalized abortion in Canada. This landmark decision has undoubtedly protected the health and saved the lives of countless women, and was named as one of the most important and influential Charter cases of the last 25 years. Today, we are privileged to have with us the lawsuit's namesake and a true champion of women's reproductive freedom, Dr. Henry Morgentaler.

As most of you know, in the years leading up to the Morgentaler decision, abortion was permitted only in very limited circumstances. Hospitals with Therapeutic Abortion Committees could approve and provide abortion care only in cases of life or health endangerment. In order to obtain a legal abortion, women were forced to face an intimidating process of going before a hospital committee to petition for care. This policy established unequal access to abortion throughout the provinces and territories, and made it particularly difficult for women outside major urban centers to obtain abortion care. It is estimated during this time that 35,000 to 120,000 illegal abortions took place each year. We may never know the actual number of women who sacrificed their lives and health through back alley or self-induced abortions. Many of you witnessed the devastation of illegal abortion first-hand and joined the fight to legalize abortion.

Throughout history, major movements have been started by dedicated people who were willing to stand up and give a voice to people in need. The battle for abortion rights was fought in Parliament, in the courtroom, and in the streets. Just as they had done for voting rights and human

rights, women mobilized—this time around obtaining the right to have a safe and legal abortion.

In 1970, 18 years before abortion was removed from the Criminal Code, the Vancouver Women's Caucus organized the first national feminist protest to liberalize the abortion law. The Abortion Caravan, as they were called, traveled over 3,000 miles from Vancouver to Ottawa, where 500 women demonstrated for two days demanding legal access to abortion. And 30 women chained themselves to the parliamentary gallery in the House of Commons, closing Parliament for the first time in Canadian history. This relatively small group of women stood up and demanded that all women have equal access to abortion care. These 30 women gave a voice to the tens of thousands of Canadian women who were unable to legally obtain the abortion care they needed.

As women organized in our quest for reproductive freedom, one man stood out as a leader for our cause and a champion for our rights. Dr. Morgentaler defied the law and opened the first Canadian freestanding abortion clinic in Montreal in 1969. For the next 20 years, he continued to fight the system and even served prison time for providing women with safe abortion care. At tremendous risk to his life and personal safety, Dr. Morgentaler remained committed to liberalizing Canada's abortion law and continued to speak out for women's reproductive freedom.

These efforts were successful, and today Canada is one of only a few countries without a federal law restricting abortion. Although abortion has been decriminalized for 20 years, challenges to accessing abortion care in Canada still exist. As

we gather here today to reflect on this decision's impact on the Canadian health system, the political landscape, and the women of Canada, we are reminded that in some provinces and territories women are still denied equal access to abortion care. Even though abortion is considered a safe, legal, and insured service, access is variable across the country.

Currently, there are no abortion services available in Prince Edward Island, and access remains a challenge for rural women throughout Canada. In New Brunswick, a woman can only obtain a publicly funded abortion if provided by an obstetrician/gynecologist (OB/GYN) in a hospital with written approval from two doctors. This policy contradicts the decision we are here to commemorate and unfairly restricts access for women in the province.

Women not living in their home province or territory also face challenges because abortion is not part of the inter-provincial billing agreement. In fact, abortion is the only time-sensitive and medically necessary procedure excluded from the list of services on the inter-provincial billing agreement. This policy forces students attending school in another province, or women who have recently moved and are in the process of transitioning their health care benefits, to pay the full cost of their abortion care out-of-pocket, or incur additional expenses traveling back to their home province in order to obtain a publicly funded abortion.

Anti-choice physicians can also present barriers to access. Although many abortion providers accept self-referrals, some facilities require women to obtain a physician referral before they can access abortion care. Many women often go to their family physician for this referral or simply to get information about their options. The Canadian Medical Association's policy of allowing physicians to refuse to refer patients for abortion care

is a clear violation of CMA's own Code of Ethics, which requires physicians to:

- Consider the well-being of the patient;
- Practice medicine in a manner that treats the patient with dignity; and
- Provide patients with the information they need to make informed decisions about their medical care.

The CMA's policy treats women unfairly and impedes women's access to care.

Now more than ever, it is important that we don't lose sight of the women who continue to face these obstacles in order to obtain the abortion care they need. Now more than ever, we must remain dedicated to advocating for these women. We must continue to work together to ensure that women have the same access to abortion care whether they live in an urban center or a small town, or whether they live in British Columbia or Prince Edward Island.

Some of you here today are students who have never lived in a world without legal abortion. You, most of all, must remain vigilant in preserving this freedom so that we never have to return to the days of back alley abortions where our sisters, mothers, and friends had to risk their health—and sometimes even their lives—to end an unwanted pregnancy.

The National Abortion Federation and the National Abortion Federation Canada are pleased to co-sponsor this symposium with The University of Toronto's Faculty of Law, and with generous support from the Canada Research Chair in Health Law and Policy. We've put together an insightful day-long program and have assembled leading experts to examine themes drawn from the Morgentaler decision. Thank you for joining us as we commemorate this historic decision and its impact on Canadian women. It is certainly a pleasure to welcome all of you to this symposium.

## Keynote Address: Dr. Henry Morgentaler

### Reflections on My Struggle to Make Abortion Legal and Available in Canada

This is a truly momentous occasion. I am happy to be among so many people who have taken the time to mark a very special day. It has been twenty years since a historic Supreme Court decision profoundly changed the lives of women in Canada. The Morgentaler decision by the Supreme Court of Canada of 1988 is an important milestone in the emancipation of Canadian women. This is a proud moment not only for me but for all those people who have played such an important role in this movement.

In 1988 the Supreme Court of Canada ruled that women have the right to make choices concerning their own reproductive health. I am proud to have played such a pivotal role in that decision. I also believe that the world is a kinder, gentler place for women in Canada because they do have the right to make choices.

The first case to be litigated after the decision was in Nova Scotia, where the Government was intent on destroying the clinic which I had established there. It had introduced legislation to make abortion outside of hospitals a criminal act, liable to a \$50,000 fine for each procedure. Fortunately the judge who presided over my trial in Halifax declared this legislation invalid and I was able to operate the clinic in Halifax for eight years, providing services to women from all the Maritime provinces.

Over the years, I have developed a near perfect surgical procedure. I have had the privilege of training over 100 doctors to do this procedure safely and compassionately. At one time there were eight Morgentaler Clinics across Canada. I built those clinics to ensure fair and equal access to the abortion procedure in a safe and secure environment with caring and respectful service providers. I am very proud of my

remaining clinics and of the high quality of services they continue to provide.

The past 20 years have certainly had their share of challenges, but I believe I have met those challenges head on. I have debated publicly on radio and television and unfortunately exposed myself and my family to threats and harassment.

Although we mark 20 years since the Supreme Court decision, we must be cognizant of the fact that there have been additional court battles across Canada since that time. I continue to fight the province of New Brunswick; a province whose Government continues to stubbornly insist that women have no access to abortion; where women continue to have to walk through protestors; where doctors are still being harassed.

It is clear that children, who grow up wanted, loved and cared for, grow up to be emotionally healthy adults. I believe that the documented decrease in crime today is directly related to the fact that women can now make choices concerning their own reproductive health. I believe that our society is a better society today than it was thirty years ago. I am thankful to have been able to play such an important role in ensuring that women are treated justly, with dignity and respect.

Let me review briefly the situation in Canada regarding access to abortion services across the country. Six provinces now have reasonably good access; Ontario, Alberta, British Columbia, Newfoundland, Quebec and Manitoba.

We have won a class action suit in Quebec recently and women in Quebec now have good access to abortion services under Medicare.

In Manitoba, where I had to fight the Government for 20 years, I eventually sold my clinic in Winnipeg to a group of pro-choice women. The clinic I established eventually received funding so that women can now access abortion services under Medicare.

The situation in the Maritimes is still difficult. My Newfoundland clinic got funded many years ago and women there no longer have to travel all the way to Montreal for abortions. The main Nova Scotia hospital providing abortion services hired a Halifax doctor whom I had trained and improved access so that my clinic there, which had existed for 10 years, was no longer necessary. PEI has not had a facility offering abortion services for many years, so women there have to travel to Halifax or New Brunswick for abortions.

The only province which deprives women of access to abortion is New Brunswick. I established a clinic 14 years ago in Fredericton, which the Government still refuses to acknowledge or fund, so access to abortion services is still inadequate. I have initiated legal action against the Government of New Brunswick, but the process is slow. In the meantime, women in New Brunswick are deprived of services and are obliged to pay for them out of their own pocket. Unfortunately the Liberals who replaced the Conservatives in power in that province are as anti-choice as the Conservatives; nothing much has changed since they took power.

In the major cities and population centers in Ontario, Quebec, British Columbia, Alberta, Manitoba and Nova Scotia, women now have access to abortion services under Medicare. In the smaller population centres in the Maritimes and in vast areas of Manitoba and Saskatchewan, women have to travel to obtain them, but overall the situation has improved dramatically since the 1988 decision.

I have personally been responsible for opening eight clinics across the country, of which seven still provide services. What my clinics have achieved is a standard of care based on competence and compassion; where the safety and dignity of patients is the major consideration. I am proud to say that in all the years of operation, my clinics have achieved an outstanding degree of safety. In all those years not a single woman died as a result of an operation and the rate of complications has remained very low.

Over the years, in spite of threats and harassment by anti-choice fanatics I have been able to establish clinics where women are treated with competence and dignity. I have trained many doctors and nurses who established and worked in facilities with a similar philosophy of care and compassion. I am proud of what I have been able to achieve.

I wish to thank the doctors, nurses, counselors and other staff in my clinics, who have helped me to attain a high degree of safety and competence. I wish to congratulate all staff members in abortion clinics across Canada who continue to provide services in spite of harassment and threats.

Here in Canada, I can still remember the years before the Supreme Court decision, when abortion was illegal and unsafe and was responsible for many preventable deaths of young women. Major hospitals like the Royal Victoria or Saint Luc in Montreal had entire floors filled with women who were dying or were seriously injured from unsafe, illegal or self-induced abortions. Fortunately, this is no longer the case.

In Canada abortion is available on request, the direct result of the Supreme Court ruling in 1988, which gave women the right to control their bodies, and most importantly, the ability to choose motherhood at a time that was appropriate



for them. The Supreme Court decision allowed me and other physicians to establish clinics across the country which could provide the services that women needed, with competence and compassion.

The Morgentaler decision of the Supreme Court of Canada affirmed the dignity and equality of women in this country; breathed new life into the Charter of Rights and added a new dimension to democracy and liberty in Canada. Canada is amongst the best countries in the world for mortality of women and babies in the process of childbirth. *"Every mother a willing mother; every child a wanted child"* is a slogan which, if implemented, creates stronger families, better communities and a kinder, gentler society.

Over the past 37 years I have dedicated myself to the struggle to achieve rights to reproductive freedom and to provide facilities for women. This struggle gave meaning to my life, and corresponded to the ideals that I inherited from my parents: dedication to human rights and an ability

and willingness to make this world a better place to live.

Let me end on a personal note. I am a survivor of the Nazi Holocaust, that orgy of cruelty, brutality and inhumanity. I have personally experienced oppression, injustice and suffering inflicted by those beholden to a racist, dogmatic and irrational ideology. To have had the opportunity to diminish suffering and injustice has been very important to me. Reproductive freedom and good access to safe abortion means that women will be able to give life to wanted babies at a time when they can provide love, care and nurturing.

In my fight over the past decades for reproductive freedom and in helping to make it possible in Canada, I believe that I have made a contribution to a safer and more caring society where people have a greater opportunity to realize their full potential.





**The Context:  
From Morgentaler to Abortion  
in Canada Today**



## R v. Morgentaler: Charter Rights and Abortion

Lorraine E. Weinrib, Faculty of Law, University of Toronto

Professor Weinrib's presentation was unavailable for inclusion in this Reader, however she spoke to the issue of how Canada's old abortion law, Section 251 of the Criminal Code, banned all forms of abortion until 1969, when then Justice Minister Pierre Trudeau introduced an amendment to allow it in certain cases, to protect a woman's life or health. This is generally held up in history classes as a great leap forward for women, but it mostly served the interests of doctors. She called it an "incomprehensible monstrosity."

"What it did was produced the capacity for senior members of the medical profession to open the door and control the traffic, because there were abortions they wanted to do according to their discretion, and they didn't want to go to jail," she said.

The "life and health" standard was further diminished when it became apparent that

the strongest predictors of a woman's access to abortion were her doctor's age, sex, whether it was a rural or urban practice, and her own age and marital status, none of which say very much about threats to her "life and health."

Dr. Morgentaler, who had set up a clinic in Montreal, pushed this state of affairs to its crisis by placing the decision solely with the woman, and it was his prosecution that ultimately led the Supreme Court to rule the criminal law against abortion unconstitutional. "If the judgment had gone to the dissent, I think that would have been the end of the Charter, at least for a generation and perhaps permanently," Prof. Weinrib said.

(excerpted from: *The National Post*, January 26, 2008 *Pro-life v. pro-choice: The debate beats on.*)

## Post-Morgentaler Challenges: From Crime to Health

Joanna N. Erdman,  
International Reproductive and Sexual Health Law Programme,  
Faculty of Law, University of Toronto

What happened after *R v. Morgentaler*<sup>1</sup> and the Supreme Court of Canada?

Canada followed the general trend in abortion law reform—from crime and punishment to health and welfare. At the federal level, Parliament attempted to re-enact a criminal law on abortion. This attempt, Bill C-43, *An Act Respecting Abortion*, was unsuccessful.<sup>2</sup>

Abortion—throughout pregnancy—was no longer uniquely subject to criminal regulation. In this respect, Canada itself was unique in the international context. This is no longer the case. The Canadian standard is now reflected in international human rights law. All states are advised that punitive measures imposed on women who undergo abortion should be withdrawn.<sup>3</sup>

With *R v. Morgentaler*—and the failure of Bill C-43—abortion was transferred from the criminal to the health context. Following decriminalization, abortion could be legally integrated into health systems, and governed by the laws, regulations, and medical standards that apply to all health services. Abortion could be regulated as a health service like any other, but it was not. Following decriminalization, a series of laws and regulations were enacted

to uniquely govern abortion as a health service.<sup>4</sup>

This presentation examines when and why the different treatment of abortion as a health service is legally justified. When does the different treatment of abortion serve legitimate and important goals? When does the different treatment of abortion unfairly deny women access to medically necessary care? When does it stigmatize women and abortion providers?

The move from criminal to health regulation placed us in a dilemma of difference. Meeting our goals in abortion care requires both integration and separation, both similar and different treatment in law and policy.

My objective is to examine this dilemma of difference through key legal developments from the last twenty years. These developments relate to three goals of abortion regulation: ensuring available, accessible and acceptable abortion care.

### The Dilemma of Difference and Available Abortion Care

Available abortion in hospitals and clinics has long been subject to unique legal regulation.

Under the criminal law, lawful abortion services were restricted to hospital facilities. This restriction was one ground on which the Supreme Court in *R v. Morgentaler* (1988) held the law unconstitutional.<sup>5</sup> No

1 *R v. Morgentaler*, [1988] 1 S.C.R. 30.

2 *An Act Respecting Abortion*, C-43, 2d Session 34th Parliament, 38 Elizabeth II (1989) (as defeated by Senate, Jan. 31, 1991).

3 See e.g. U.N. Committee on the Elimination of all forms of Discrimination against Women, *General Recommendation No. 24. Women and Health*. UN Doc. A/54/38/Rev.1, para 31(c), (1999): “When possible, legislation criminalizing abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion.”

4 J.N. Erdman. “In the Back Alleys of Health Care: Abortion, Equality, and Community in Canada” (2007) 56 *Emory Law Journal* 1093, 1093.

5 Justice Beetz confirmed that “no medical

medical reason required that abortions be restricted to hospitals. Clinics can offer comprehensive, supportive, and quality care.

Nevertheless, in 1989, Nova Scotia enacted a law that **prohibited abortions outside of hospitals and denied public funding for abortions performed in violation of the prohibition**. Its stated purpose: to prevent two-tiered health care and to ensure high quality care. In 1993, a unanimous Supreme Court of Canada struck down the law.<sup>6</sup> The purpose of the prohibition, the Court held, was not to regulate clinics generally. It was “to prohibit abortions outside hospitals as socially undesirable conduct.”<sup>7</sup> The intention was not to treat abortion like other health services, but to treat abortion differently. The law regulated “the place where an abortion may be obtained, not from the viewpoint of health care policy, but from the viewpoint of public wrongs or crimes.”<sup>8</sup>

A New Brunswick law was struck down for the same reasons.<sup>9</sup> The purpose of the law was to prohibit abortion clinics, in particular, Dr. Morgentaler’s clinic.

In British Columbia, hospital abortion services are currently subject to different legal treatment. After a number of hospital boards voted to discontinue abortion services, unique regulations were enacted to ensure available care in every region of the province. The regulations designate 33 public hospitals that “must provide the facilities and services necessary to

allow beneficiaries to receive abortions at that hospital.”<sup>10</sup> In this case, the different treatment of abortion functions to ensure rather than restrict its availability.

Government action to ensure available abortion services is increasingly being advocated. The Health Equity and Law Clinic at the Faculty of Law, University of Toronto, recently published an article advocating for government intervention to ensure the introduction of safe and effective reproductive health medicines—including medication abortion—into Canada.<sup>11</sup>

## The Dilemma of Difference and Accessible Abortion Care

In many countries, women’s access to abortion services is conditioned on parent or partner consent. In Canada, no such unique consent requirements apply.

Courts continue to uphold the rights of mature young women to consent to abortion without parental involvement. A young woman may consent to an abortion provided she is sufficiently mature and intelligent to understand the proposed care. No different legal requirements apply. As stated by the Alberta Court of Appeal: “The issue is not whether abortions are morally right or wrong; the issue is simply one of the capacity to consent.”<sup>12</sup>

In 1989, in *Tremblay v. Daigle*, the Supreme Court denied that any substantive rights, fetal or parental, outweigh women’s rights to access abortion services.<sup>13</sup> A partner or potential father cannot override a woman’s decision to terminate her pregnancy. Her

---

justification” required all therapeutic abortions to be performed in hospitals. According to expert testimony, “many first trimester abortions may be safely performed in specialized clinics outside of hospitals...possible complications can be handled, and in some cases better handled, by the facilities of a specialized clinic.” *R v. Morgentaler*, [1988] 1 S.C.R. 30, 115.

6 *R. v. Morgentaler*, [1993] 3 S.C.R. 463.

7 *Morgentaler*, [1993] 3 S.C.R. at 513.

8 *Ibid.*

9 *Morgentaler v. New Brunswick (Attorney General)*, [1995] 121 D.L.R. (4th) 431 (N.B.C.A.).

---

10 *Hospital Insurance Act Regulations*, B.C. Reg. 25/61, s. 5.20, enacted pursuant to the Hospital Insurance Act, R.S.B.C. 1996, c. 204.

11 J.N. Erdman, A. Grenon & L. Harrison-Wilson. “Medication Abortion in Canada: A Right-to-Health Perspective” (2008) 98 *American Journal of Public Health* 1764.

12 *C. v. Wren* (1986), 35 D.L.R. (4th) 419, 424 (Alta. C.A.).

13 *Tremblay v. Daigle*, [1989] 2 S.C.R. 530.

right to free and informed decision-making governs.

Economic accessibility or affordability remains a continuing concern. Immediately after judicial decriminalization, all provinces, with the exception of Ontario and Quebec, restricted or withdrew public funding for abortion services. British Columbia, Manitoba, New Brunswick and Prince Edward Island limited public funding to “medically necessary” hospital abortions. All regulations were legally challenged on jurisdictional grounds. Some survived scrutiny, others were defeated.<sup>14</sup>

The British Columbia Supreme Court declared the funding regulation “inconsistent with the [law], and with common sense.”<sup>15</sup> In Manitoba, the Court of Appeal called the policy perverse. By requiring that abortions be performed in hospitals rather than clinics, “an insurance scheme designed to control costs, willfully increased them.”<sup>16</sup>

Following successful challenges, many provinces enacted amended restrictions and so followed a second and more recent series of cases.

In 2006, a Quebec court ordered the province to reimburse almost 45,000 women for their out-of-pocket clinic abortion expenses.<sup>17</sup> In 2004, a Manitoba Court held that denied public funding for clinic abortions violated the *Canadian Charter of Rights and Freedoms*.<sup>18</sup> While the judgment was subsequently set aside, it remains significant in Canadian

constitution law. For the first time, a Court held that denied access to safe and timely abortion care violates women’s equality rights.<sup>19</sup> Litigation in New Brunswick remains ongoing.

Canadian courts are increasingly finding that the different treatment of abortion services under public health insurance schemes is unjustified. The opposite is true respecting the regulation of information: the right to seek and receive information, but also the right to privacy protection, and public interests in safety and health.

Privacy commissioners across the country have inquired into requests for abortion-related information and refused disclosures based on health and safety grounds.<sup>20</sup> In the past, requests for abortion-related information from public bodies were treated the same as all other information requests. There was no presumption that the information qualified for protection. A demonstrated risk of harm to health or safety was required to refuse disclosure.

Section 22.1 of the *Freedom of Information and Protection of Privacy Act* in British Columbia reverses this presumption.<sup>21</sup> A public body must refuse to disclose abortion-related information unless the request meets narrow exceptions, for example, generalized statistical information.

This different treatment of abortion-related information acknowledges the difficult context in which many abortion providers work. Given that provider safety is necessary to ensure continued abortion care, the province protects against disclosure that would deter service provision. Limited access to abortion information, however,

14 Erdman, *supra* note 4 at 1094.

15 *B.C. Civil Liberties Ass’n v. British Columbia (Attorney General)*, [1988] 49 D.L.R. (4th) 493, 498 (B.C. S.C.).

16 *Lexogest Inc. v. Manitoba (Attorney General) (Lexogest I)*, [1993] 101 D.L.R. (4th) 523, 552–53 (Man. C.A.).

17 *Association pour l’accès à l’avortement c. Québec (Procureur général)*, [2006] QCCS 4694 (Qué. S.C.).

18 *Jane Doe 1 v. Manitoba*, [2004] 248 D.L.R. (4th) 547 (Man. Q.B.); *rev’d*, [2005] 260 D.L.R. (4th) 149 (Man. C.A.); leave to appeal to S.C.C. refused, [2005] S.C.C.A. No. 513.

19 For equality rights analysis, see Erdman, *supra* note 4.

20 See e.g. *Interior Health Authority (Re)*, 2007 CanLII 7545 (BC I.P.C.) re s. 22.1.

21 *Freedom of Information and Protection of Privacy Act*, R.S.B.C. 1996, c. 165, s. 22.1(2). “The head of a public body must refuse to disclose to an applicant information that relates to the provision of abortion services.”



can be problematic. Women are without access to resources. Information deficits also impede efforts for government accountability.

## The Dilemma of Difference and Acceptable Abortion Care

The different treatment of abortion may also serve the goal of acceptability, ensuring that abortion care is provided in a manner respectful of women's dignity. The constitutionality of laws creating "access zones" to protect clinic facilities, and provider homes and offices, is one example.

The Preamble to the *Access to Abortion Services Act* of British Columbia recognizes that all persons "who use the... health care system, and who provide services for it, should be treated with courtesy and with respect for their dignity and privacy."<sup>22</sup> When this law was challenged as unconstitutional, the Crown conceded that it infringed the freedom of expression under the *Canadian Charter of Rights*

---

22 *Access to Abortion Services Act*, R.S.B.C. 1996, c.1.

*and Freedoms*. The British Columbia Supreme Court found the infringement was justified.<sup>23</sup> The objective of the law, to facilitate equal access to health care, was recognized as a fundamental value in Canadian society. The Court reasoned that "a woman's right to access health care without unnecessary loss of privacy and dignity is no more than the right of every Canadian to access health care."<sup>24</sup>

## Conclusion

The legal regulation of abortion as a health service presents us with a dilemma of difference. Ensuring available, accessible and acceptable abortion care requires that we sometimes treat abortion differently than other health services and sometimes the same. This dilemma of differences makes clear that legal regulation is a means and not an end. Our task is to use the law to achieve our desired end: to ensure available, accessible and acceptable care for every Canadian woman.

---

23 *R v. Lewis* (1996), 139 D.L.R. (4th) 480 (B.C. S.C.).

24 *Ibid.* at 509.

# Abortion in Canada Today: Who, What, Where?

Dawn Fowler, Canadian Director, National Abortion Federation (NAF)

*The following is a synopsis of the Power Point presentation given by Dawn Fowler to conference participants.*

## 2004 Canadian Abortion Statistics

Statistics Canada (SC) reports annual abortion statistics. While there are data quality issues regarding the reported data, the following is a review of published data from 2004. It must be noted the available data does not lend itself to analysis around issues of access to care, time to care or demographics such as ethnicity, income, health status, health reasons or education.

### History of Data Collection

The Therapeutic Abortion Survey (TAS) started in 1969 as part of the new law regulating abortion in Canada. The law stipulated abortions could only be performed in hospitals—no clinics were operating at this time. To monitor the impact of the new legislation, the federal department of Justice and Health & Welfare required Statistics Canada to collect, compile and publish the number of abortions being performed in Canadian hospitals. The first report was published November 20, 1970.

Representatives from Health & Welfare, SC, Society of Obstetricians & Gynecologists in Canada (SOGC) and the Canadian Medical Association (CMA) established an individual case report form to collect a core data set which included the following:

- Province of residence;
- Marital status;
- Age/date of birth;
- Previous deliveries;

- Previous abortions;
- Date of last menses/gestation period;
- Abortion procedure;
- Sterilization;
- Complications & days of hospitalization

Data collection deteriorated in 1983 when PEI no longer reported to the TAS as abortions were no longer allowed to be performed. Then in August 1986, budget cuts at SC led to the cancellation of the TAS survey. Pressure from various sectors resulted in the survey being revived in November 1987 but with a much smaller budget. This impacted timeliness of data collection and data quality.

When abortion was removed from the criminal code in January 1988, it had two significant effects upon the TAS:

- The 1969 mandated data collection, now without a law, meant the reporting system was no longer required; and
- Clinics began to emerge because there was no longer a requirement that abortions could only be performed in hospitals.

SC chose to treat the TAS as “voluntary” and encouraged hospitals and clinics to continue to supply data for health-related purposes. For the sake of continuity, the title of the survey continued to include the word “therapeutic” even though a health-related justification no longer had to be provided for a woman to obtain an abortion.

In 1995, responsibility for data collection was transferred to CIHI (Canadian Institute for Health Information) however SC remains responsible for public

dissemination of the information. The following core data is currently collected by CIHI:

- Province of report
- Facility information
- Province of residence
- Age in single years
- First day of last menses or gestation in weeks
- Date of abortion
- Inpatient days of care
- Number of previous deliveries
- Number of spontaneous abortions
- Number of induced abortions
- Initial procedure
- Subsequent procedure
- Type of sterilization
- Complications

## Statistics Canada 2004 Induced Abortion Report

### Highlights

- Fewer abortions reported in 2004 than in 2003.
- Abortions declined in every age group except the 40+ age group, where it stayed the same.

- Women in their 20s had the largest decline in abortion rates from 25.8 for every 1000 women in 2003 to 24.7 in 2004.
- Among teenage women the induced abortion rate was 13.8, down from 14.4 in 2003. The teenage abortion rate has declined gradually since 1996 when it was 18.9.
- Abortions continue to be most common among women in their 20s. They accounted for 53 per cent of all women who obtained an abortion in 2004.
- Abortions declined in Nova Scotia, New Brunswick, Quebec, Ontario, Manitoba and British Columbia.

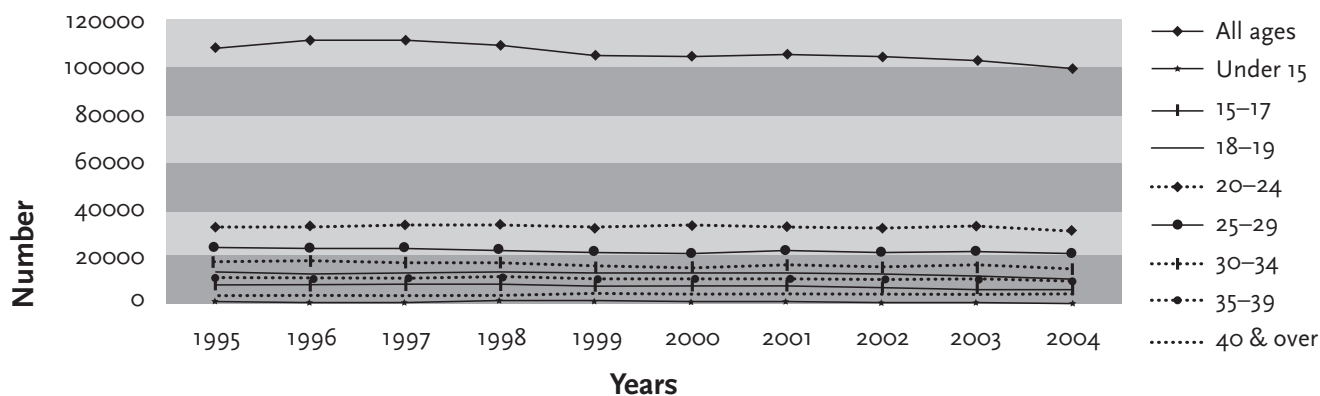
### Pregnancy Outcomes

- Estimated total number of pregnancies 2004: 445,899.
- The overall pregnancy rate hit its lowest point in 2004 at 53.3 pregnancies per 1,000 women.
- Pregnancies declined for all age groups under 30 years of age and increased for those over 30, with women aged 35 to 39 reporting the greatest increase.

### Abortion Figures for 2004

Indicator	Outcome
Total Number of Abortions	100,039
Abortion Rate (# of induced abortions per 1000 women aged 15–44)	14.6
Abortion Ratio (# of induced abortions per 100 live births)	30.1
Percentage of Pregnancies Ending in Abortion (% of abortions to total # of pregnancies)	22.4

## Abortion by age group 2000–2004



Statistics Canada Catalogue N. 11-001-XIE, July 13, 2007

### 2004 Abortion Complications

In 2004, SC based its figures on a total of 42,880 records, 86 per cent from hospital data. SC also reports on second and third reported complications. There were no reports of third complications and only 0.01 reported retained products of conception (POCs), and 0.06 reported hemorrhage for second complications.

Surgical abortion is one of the safest types of medical procedures. Complications from having a first-trimester abortion are considerably less frequent and less serious than those associated with pregnancy and childbirth.

Indicator	Outcome
Records with no complications reported	98.56%
Hemorrhage	0.07%
Infection	0.41%
Pelvic damage	0.05%
Retained POC's (products of conception)	0.72%
Death	0
Other	0

Data produced by Health Canada Statistics Division, Statistics Canada 2007  
Source: Therapeutic Abortion Survey, CIHI

## Induced Abortions Greater than 20 Week Gestation: 2003–2004

Gestation in Weeks	2003	2004
Per cent of Greater than 20 weeks Abortions to Total Number of Abortions	0.31%	401
Greater than 20 week Abortion Rate to Total Number of Pregnancies	0.0.7%	0.08%

Data produced by CIHI, 2007

According to data obtained through CIHI, 0.08% of abortions in 2004 were provided after 20 weeks gestation. This percentage does not support the notion promulgated by abortion opponents that women in Canada routinely obtain abortion care up to nine months of pregnancy. In fact, nearly 80% of abortions are provided during the first trimester (12 weeks) of pregnancy

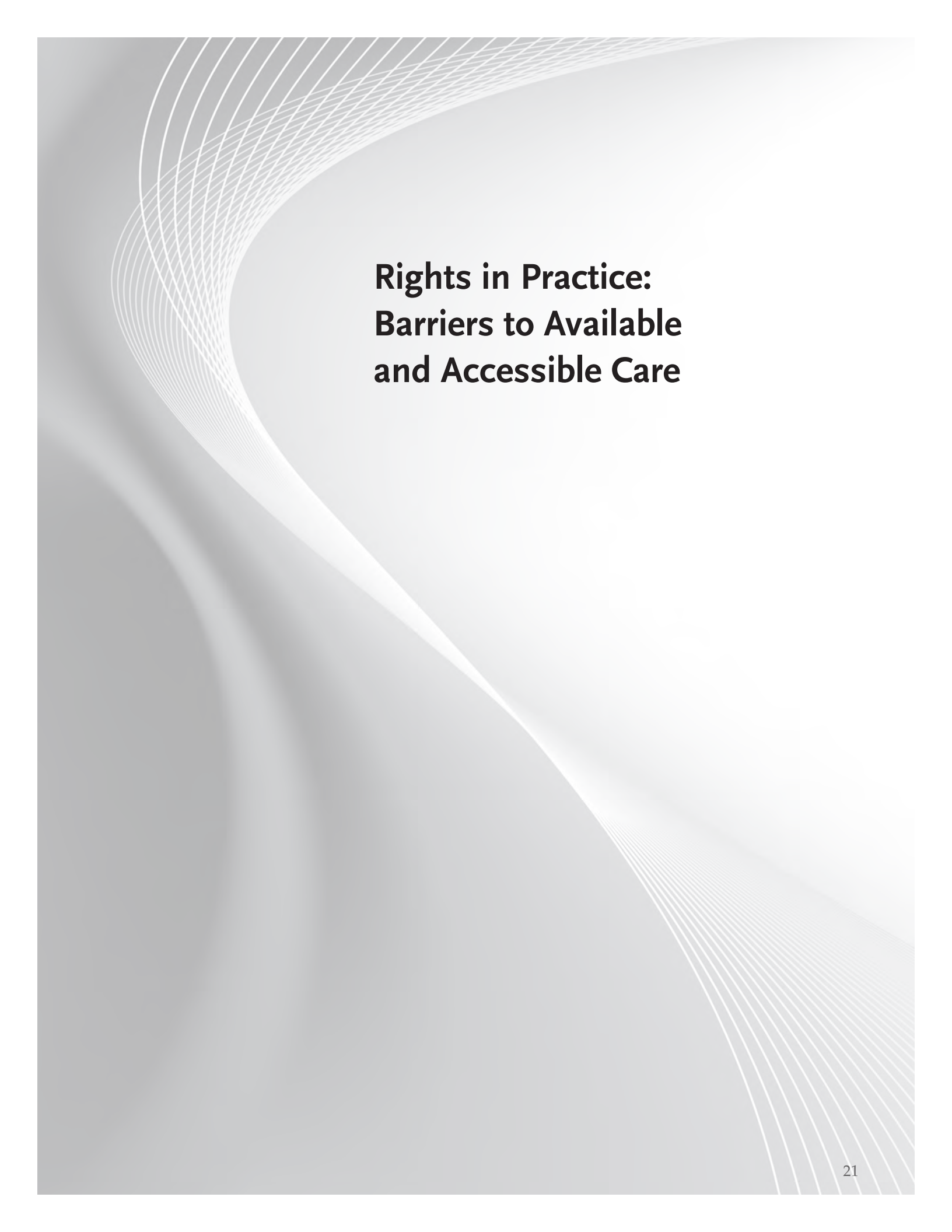
### Data Quality Issues

CIHI reports the Therapeutic Abortion Survey database represents approximately 90 per cent of all abortions performed in Canada involving Canadian residents. This means, according to CIHI, the national number of abortions would be 110,042 yet

under-representation is probably higher than the 90 per cent reported by CIHI.

In Ontario, non Independent Health Facilities Act (IHFA) facilities are not included in the count nor are medical abortions in British Columbia. More than half of these abortions are only reported as aggregate counts with no detailed information. In addition, no clinic data are reported from Manitoba and the percentage of abortions performed on non-residents and those performed on Canadians in the United States are unknown.





**Rights in Practice:  
Barriers to Available  
and Accessible Care**





## Abortion in Canada: From Sea to Shining Sea

Sheila Dunn MD, MSc, CCFP(EM), FCFP,  
Department of Family and Community Medicine, University of Toronto

### The Canadian Health System

Under the British North America Act (1867) [now referred to as the Constitution Act], health is a provincial responsibility. From the time it was initially decriminalized in 1969, and reaffirmed with the Supreme Court ruling, abortion has been considered to be a health issue. By deduction, it falls under provincial jurisdiction. The Canadian health care system is based on 13 separate provincial/territorial health insurance systems that use cost sharing with the federal government. The federal government is able to exert some control over health care funds: there are minimal conditions placed on the use of federal monies, and if provinces do not abide by the federal regulations, federal transfer payments may be withheld. Under the system there is public payment for services provided by physicians (known as private service provision) and by not-for-profit hospitals.

### Public Financing/Private Delivery

The Canada Health Act (1984) defines the requirements for publicly funded services: accessibility, universality, comprehensiveness, portability and public administration. It is important to note there is no requirement for coverage of drugs [pharmacologics/ medications/ analgesics] used outside of the hospital, nor is there required coverage for “medically necessary” services provided outside of the hospital by non-physician providers. Furthermore, the Canada Health Act does not define the term “medically necessary,” leaving it open to interpret what is considered a medically necessary service, and more specifically, if abortion qualifies

as a medically necessary service. The Charter ruling, however, suggests abortion is in fact a medically necessary service, and this understanding is supported by the Federal Government (under Liberal leadership), and one would argue, the medical profession.

### Hospital Care/Community Care

The provision of health services in general is moving from hospital care providers to community care providers (including home care, ambulatory care, and surgical centres/ clinics). Similarly, nearly half of abortion care is now being provided by clinics, a substantial shift from only a decade ago when the vast majority of abortion care was provided by hospitals. While the Canada Health Act guarantees public funding for physician and hospital services, many services (e.g. drugs, nursing care) are no longer publicly funded once outside of the hospital (i.e. in the community). Moreover, for clinic-based abortion procedures, the physician fee is covered; however facility fees vary in terms of coverage.

### Access Issues: Geography Matters

Women’s access to abortion varies according to where in Canada they live. For example, women in rural and northern areas usually have to travel long distances to receive care, and Prince Edward Island (PEI) entirely lacks in-province abortion services. Women in PEI can access funding for out-of-province abortion services; however, they require referral from a medical doctor. Such barriers to access raise the question of whether or not these women have reasonable access to these services.

In New Brunswick, only hospital-based abortions are funded, and even so, there are several caveats: only gynaecologists can perform abortions, they can only occur in the first trimester of pregnancy, and then only once two physicians deem it medically necessary. Women accessing clinic-based abortions must pay the full cost. These regulatory barriers raise significant concerns about accessibility for the women of New Brunswick, and also raise the question of universality in terms of the way in which the care is provided.

Ontario, British Columbia and Quebec are the only provinces with physicians who provide abortions past 20 weeks. Even so, access to abortion services in these provinces is variable; wait lists for service vary greatly and depend on municipality, and location with very limited availability in rural/northern regions.

The Prairie provinces require long travel for northern women to receive service, and the Territories offer only in-hospital abortions during the 1st trimester, further stimulating concerns over barriers to access. The Territories, however, are one of the few regions providing travel allowance. On the other hand, British Columbia (B.C.) provides more medical abortions than anywhere in Canada. B.C. women also have access to clinic-based and hospital-based 1st and 2nd trimester abortions and their clinic fees are covered. Similarly, there is full funding for clinic-based abortions in Newfoundland, Alberta, Quebec and in licensed Ontario clinics.

## Law: Facilitating and Impeding Access

Sanda Rodgers, BA, LLB., BCL., LLM, Faculty of Law, University of Ottawa

*The following is a synopsis of the Power Point presentation given by Sanda Rodgers. A fuller version of this discussion may be found in "Abortion Denied: Bearing the Limits of Law" in C. Flood, ed. Just Medicare: What's In, What's Out, How We Decide, (Toronto: University of Toronto Press, 2006) and in "The Charter and Reproductive Autonomy in the Supreme Court of Canada", J Downie, ed Health Law in the Supreme Court of Canada, (Toronto: Irwin Law, 2007).*

### **Bearing the Limits of Law: Morgentaler, Abortion and Equality**

#### 1. The Facts Forming the Basis of Morgentaler

Two reports studied the barriers to abortion access, the 1977 Badgley Report and the 1987 Powell Report (Ontario). These formed the basis of Morgentaler following the 1969 Criminal Code liberalization. The two reports highlighted the following issues:

- Only 20.1 per cent of hospitals had established TACs (therapeutic abortion committees).
- Major delays existed in access abortion.
- The average abortion occurred at 16 weeks gestation.
- There was increased risk to women.
- Women often had to pay extra financial charges between \$20–\$500.
- Additional requirements—spousal consent, other reports, marriage or a repeat abortion all were reasons to refuse abortion.
- Quotas existed on numbers and

gestational limits.

- Where abortions were provided, doctors failed to use techniques known to reduce complications.
- Punitive care existed—minimal anesthetic, breaches of confidentiality, forced sterilization.
- Women subjected to non-supportive behavior and outright hostility.
- Stereotypes existed including irresponsibility and promiscuity.
- Women had to assume the expense of travel, accommodation.
- Data on abortion were not collected, nor analyzed.
- Ontario had introduced legislation banning extra-billing—some reduction in abortion services resulted due to physician protest.

The Badgley and Powell reports concluded that these barriers impacted particularly on “socially vulnerable women—the young, less well educated and newcomers to Canada”. Powell recommended the establishment of free standing clinics providing a full range of reproductive health care services. At the time, Dr. Henry Morgentaler was operating abortion clinics in Quebec and Ontario.

#### 2. Decriminalization

In 1988, in Morgentaler, the SCC struck down section 251 as violating section 7 and section 2 of the Charter. Both clinic and hospital abortions were now legal and freed from the administrative structures that delayed access. The evidence provided by the Badgley and Powell reports was key to the Morgentaler decision. Both Justices Dickson and Lamer referenced these reports

in their judgements, citing the reports findings regarding delays, complication and mortality rates, psychological injury, the number of hospitals with functioning committees, the definition of health, and the need for women to travel or to leave Canada to obtain an abortion. Justice Beetz, with Justice Estey concurring, noted that the reports provided the evidentiary basis to support the claim that section 251 violated women's Charter rights.

### 3. After Morgentaler

The Federal Government moved to recriminalize abortion. Bill C-43 was defeated in 1991. There was provincial defiance to the Morgentaler decision however, legislation and regulations reinstating barriers were passed, but subsequently also were struck down. Most notably, there was an increase in anti-abortion violence in the country.

### 4. Access After 1991— Post Decriminalization

A second generation of government sponsored reports were released from Ontario (1992), the Northwest Territories (1992) and British Columbia (1994). It was 'deja-vue' all over again with these new reports repeating Badgley and Powell's original findings. There was documentation of racist delivery of abortion and reproductive health care services and of imposed contraception and sterilization. The young, the poor, women with disabilities and aboriginal women, refugees and women of colour were noted as being particularly mistreated. There was documented evidence of pressure to terminate a pregnancy or to use permanent forms of contraception such as sterilization or Depo-Provera for some women.

A third generation of non-governmental (NGO) reports was released from the

Canadian Abortion Rights Action League (CARAL), now Canadians for Choice. This private NGO released a 10 year report in 1998 and a 15 year report in 2003, with the information presented updated in the 2007 report *Reality Check*.

## 5. Current Snapshot

Prince Edward Island provides no abortions. New Brunswick and Saskatchewan fund hospital abortions but provide no funding to clinics. Quebec and Nova Scotia provide hospital abortions but only partial funding to clinics. Alberta, British Columbia, Ontario, Manitoba and Newfoundland fund hospital and clinic based abortions. In general, hospital wait times are approximately 6 weeks. The Morgentaler Clinic in Ottawa had a 6 week wait time in the fall of 2007. This is clearly too long.

Despite Morgentaler, all the barriers previously documented remain and hospital access has actually decreased.

### A) Access

In 2003, access to abortion was reduced from 20.1 per cent to 17 per cent of hospitals; by 2006 access fell to 15.9 per cent. Barriers such as travel, lack of information, long waiting periods, gestational limits, unsolicited anti-choice counseling, increased violence, fewer providers, and failure to train physicians all continue. In addition, financial barriers also continued, with women being charged between \$250 to \$1425 to obtain an abortion in some locations. Evidence exists of partner coercion and parental consent requirements. Some abortion providers have voice mail systems that require a woman to leave personal information.

### B) Hospital Closings and Amalgamations

A number of hospital closings and amalgamations of religious and non-

sectarian hospitals impacted access to abortion. From 1997 to 1998, the number of Catholic-operated hospitals grew by 11 per cent while secular public facilities declined by 2 per cent. Of the 127 hospital mergers between 1990 –1998, half resulted in the elimination of all or some reproductive health services.

In Ontario, in 2006, 17 per cent of hospitals had accessible abortion services, down 11 per cent from 2003—and only one is north of the Trans Canada Highway. In Ottawa, the hospital providing abortion services shuts down for a month in the summer. Three Ontario hospitals had the longest wait times to access abortion in the country—Ottawa, Sarnia and Peterborough.

### **C) Details of Medical Malpractice**

The following forms of medical malpractice were identified in the delivery of abortion services:

- Deliberately misleading information given by anti-choice doctors and hospital switchboard operators.
- Withholding a diagnosis of pregnancy.
- Threatening to withdraw services from the family.
- Failing to provide appropriate referrals.
- Delaying access.
- Mis-directing women to anti-choice organizations.
- Providing punitive treatment.

These are all examples of medical malpractice and violate the CMA Code of Ethics prohibiting discrimination on gender, marital status and medical condition. They also breach the self regulatory requirements of Provincial Medical Colleges. In a British Columbia decision, the College may be sued where a doctor knew or should have known that a doctor is engaging in medical malpractice and fails to investigate.

## **6. Abortion and Women’s Health**

In 2000, 105,669 Canadian women had an abortion in Canada. Two-thirds were performed in hospitals, the balance in clinics. Approximately 40 per cent of Canadian medical schools teach no aspect of the abortion procedure, in fact more class time is devoted to Viagra than to abortion law, policy, procedures and pregnancy options combined (Koyama & Williams *Abortion in Medical School Curricula* (2005) McGill J of Medicine 157). Yet access to abortion is access to essential health care.

A recent American report on women’s health identified access to an abortion provider as one of four indicators of access to health care. The report listed unintended pregnancies as a “key health condition indicator”. In contrast, the first Women’s Health Surveillance Report, done for Health Canada in 2003, listed sexual health, contraception and perinatal care, but not abortion access, as the key health indicators for women.

The Romanow Commission on the Future of Health Care in Canada opposed privatization, but “abortion” appears only once in the 357 page report, in a string reference to for-profit clinic service provision. Abortion, arguably the leading example of privatization, was not evaluated by Romanow for benefits and deficits, nor was the impact on specific women’s constituencies considered.

Women have the least to gain from for-profit private parallel health care systems because they lack autonomous household income, have fewer financial resources, are less likely to have health coverage through paid work, and are more likely to be poor. Ironically, access to abortion services is so compromised that it is privatization that resulted in increased access to some women in some provinces — particularly to women with financial resources—disproportionately white, middle class, educated women in urban areas.

## 7. Charter challenges

Two recent and successful challenges—in Manitoba and in Quebec—forced those provinces to reimburse the cost to women who accessed clinic abortions at their own private expense because of delays associated with hospital based abortions. At the time of this symposium, a New Brunswick challenge to the refusal to fund clinic based abortions was pending.

## 8. Continuing Legal and Other Impediments

Anti-choice activists remain active in Canada. One prime example is the Parliamentary Pro-Life Caucus. There is a history of private members bills of which the most recent (sic) is only the latest—Bill C-484 *Unborn Victims of Crime Act*. In the 2006 election, there were 90 declared anti-abortion members in the Liberal (16) and Conservative (74) parties. Nine of the 26 Cabinet Ministers in January 2008 were anti-abortion and an anti-abortion member was named as Parliamentary Secretary to the Prime Minister and to the Minister of Finance.<sup>25</sup>

Despite more than 105,000 annual abortions occurring in Canada, we cannot conclude that women who would choose **or have no choice** but to terminate their pregnancies are able to do so. Women are unable to terminate pregnancies in accordance with their own needs and aspirations.

Thirty years after *Badgley* and twenty years after *Morgentaler*, ineffective and insufficient provision of abortion services continues to violate women's Charter equality protections. We have detailed reports of multiple gatekeepers, provider malpractice and delays by professionals

and governments that increase risk. We have descriptions of interference with women's security of the person, equality and freedom of conscience. We know that some women—aboriginal, disabled, racialized, rural, poor, immigrant and young—bear an even greater share of the burden.

Discriminatory delivery of medically necessary health services needed only by women is sex discrimination. Where discriminatory delivery of medically necessary services disproportionately impacts racialized, immigrant, aboriginal and poor women, it violates s. 15 of the Charter on grounds of race and citizenship.

Charter protections have proven elusive at best for Canadian women. The costs, delays and lack of public funding for further legal challenges, and the limited impact of the victories, suggest that it is women who will continue to bear law's limitations despite their right to law's protection. For women who find themselves pregnant, access delayed is justice denied.

---

25 John-Henry Westen, *Nine Pro-life Members of Parliament in New Canadian Government Cabinet* Feb 6, 2006 <http://www.lifesite.net/ldn/2006/feb/06020603.html>

## Better Never Than Late, But Why? The Contradictory Relationship Between Law and Abortion

Shelley A. M. Gavigan, Osgoode Hall Law School, York University

I am honoured to have been invited to be a panelist in such distinguished company at this important event. I am particularly attracted to the invitation in the title of the Symposium to reflect upon the 1988 decision of the Supreme Court of Canada in *R. v. Morgentaler*.<sup>26</sup> In reflecting upon the case, its significance and legacy, I want to talk about the importance of history, the contradictory nature of law and the enduring importance of ideology.

I take this liberty of insisting upon the importance of historical experience and perspective and I do so because I am of the view that it is due entirely to my historical, as opposed to current, engagement with the critically important issues of abortion and law that I have been honoured with this invitation.

### Reflections on the Importance of History

I was reminded recently of the importance of history and how quickly something “becomes” history by my own lapse in precision: I asked my research assistant to pull the Supreme Court’s *Morgentaler* decision for me, which she dutifully did: the Supreme Court’s *R v Morgentaler* 1993 decision.<sup>27</sup> Of course, this was my fault—I had not been clear enough. But it then occurred to me that my smart feminist research assistant may not have known there had been other, indeed, a few other, *Morgentaler* decisions.<sup>28</sup> To my feminist colleagues in the academy I ask, are we confident that we are teaching

this generation of law students about this decision and its importance? One has to hope that they are not relying on the mainstream media for their introduction—or misinformation—about the *Morgentaler* case? Clearly this Symposium is an important event, intended as it is to re-insert abortion and reproductive rights on our collective agenda.

I was speaking last week about today’s Symposium to a friend who graduated from Law School in 1989. She said her time at law school was marked by preoccupation with the issue of abortion law and that for her and women law students of her generation, the 1988 *Morgentaler* decision was a defining moment of victory. I remember it so well, and so personally.

On the early evening of January 28, 1988, almost two weeks after our daughter’s first birthday celebration, we had bundled her into her stroller and joined hundreds of kindred spirits in a spontaneous rally in front of the then still standing *Morgentaler* clinic on Harbord Street in Toronto to celebrate the decision of the Supreme Court historic decision. Women, abortion and law had become the issue around which I politicized when I embraced feminism in my twenties, to the great chagrin of my Irish Roman Catholic father and my French Roman Catholic mother who was a maternity ward nurse. For the next twenty years my political and academic work focused on abortion. As a law student in a seminar on Advanced Administrative Law, I tried to research the processes and practices of therapeutic abortion committees in Saskatchewan hospitals. This proved to be difficult research, as it was nigh unto impossible to find any working

26 [1988] 1 S.C.R. 30; [1988] SCJ No. 1.

27 *R v. Morgentaler* [1993] 3 S.C.R. 463

28 e.g. *Morgentaler v The Queen* (1975) 30 C.R.N.S 209.

committees. Like many Canadian feminists of my class and generation, I marched in countless International Women's Day and pro-choice demonstrations. Who can forget how cold our feet got in those frosty March 8 marches on Women's Day before the arrival of global warming? We marched and carried signs that demanded the state get its laws off our bodies, repeal abortion law and drop the charges, again and again and again.

I studied the legal history and context of the criminalization of English abortion law, the genesis of the statutory prohibition in 1803, the demise of the relevance of quickening and the ousting of the jury of matrons, and the extension of the criminal law's scope over the entire period of pregnancy.<sup>29</sup> I studied the issue of the criminal liability of the non-pregnant woman attempting the self-induce a miscarriage of a non-existing pregnancy which took me into the snakes and ladders of the law of impossible attempts. But, there was not much 'action' in the criminal cases—one encountered abortion in criminal legal history principally in homicide, where a woman had died, and her lover, friend, doctor, midwife was prosecuted for willful murder.

When I turned to social history and women's history, I found a different story. Indeed, it was in the course of this research that I learned my most profound political and intellectual lessons: to appreciate the importance of women's agency and self-determination, and the ways in which in the abortion context they had defied the law and medical men: I found the voices of women who said to doctors, "Nonsense, doctor, there is no life yet..." and "Doctor, I do not believe it is a crime."<sup>30</sup>

29 Shelley Gavigan, "The Criminal Sanction as it Relates to Human Reproduction" (1984) 5 J.

30 see Shelley A.M. Gavigan, *The Abortion Prohibition and the Liability of Women: Historical Development and Future Prospects* (Master of Laws thesis, Osgoode Hall Law School, York University, 1984) at 96-97. See also, Shelley A.M. Gavigan, "On

The historical record of coercive and restrictive abortion law in the Anglo-Canadian context is filled with relatively few criminal prosecutions and far more expression of women's resistance. One need think no further in our recent history than of an ordinary young woman, Chantal Daigle, thrust unwillingly into the national news in 1989 when her former boyfriend attempted to prevent her from terminating her pregnancy—neither the first nor last man to attempt to do so, neither the first nor last man to fail in the Canadian courts.<sup>31</sup>

During that summer, under the watchful eyes of an entire nation, Daigle resisted her former boyfriend, the Canadian anti-choice movement, the courts, among others. Daigle reminded us that "women's individual and collective struggles for choice and self-determination may have been constrained, but have never been wholly confined nor determined by the legal and judicial processes."<sup>32</sup>

## The Contradictory Nature of Law

It was also in this work into the social and legal history of abortion that I began to develop an understanding of the contradictory nature of law, including criminal law, and what I later characterized as the "fragile, incomplete and contradictory" nature of legal victories,<sup>33</sup> including the decision we are invited to reflect upon today. As but one illustration,

---

bringing on the menses': The Criminal Liability of Women and the Therapeutic Exception in Canadian Abortion Law" (1986) 1 C.J.W.L. 279.

31 *Daigle v. Tremblay* [1989] 2 S.C.R. 530; for earlier unsuccessful 'father's rights' injunction applications in Canada, see *Whalley v. Whalley et al* (1981), 122 D.L.R. (3d) 717 (B.C.Co.Ct); *Medhurst v. Medhurst et al* (1984), 9 D.L.R. 252 (Ont.H.Ct.). For a later one, see *Murphy v. Dodd* (1999), 63 D.L.R. (4th) 515 (Ont.H.Ct.).

32 Shelley A.M. Gavigan, "Morgentaler and Beyond: Abortion, Reproduction and the Courts" in Janine Brodie, Shelley A.M. Gavigan and Jane Jenson, *The Politics of Abortion* (Toronto: Oxford University Press, 1992) 117 at 146.

33 *Ibid.*



the 1969 introduction of the therapeutic exception in the Canadian criminal code had at least one surely unintended consequence; in casting abortion as a medical matter, the law inhibited husbands who went to court—prior to 1988—to attempt to prevent their wives from terminating their pregnancies.<sup>34</sup> This is one small instance, in my view, of the law not only mediating but inhibiting patriarchal relations. In many ways, the legal history of abortion taught me most of what I ever learned about women, law and the state, about law and patriarchal relations, and law's contribution to social change.

But back to the evening in January twenty years ago—as we left the rally on Harbord Street and walked back to our car, we encountered a small, disgruntled, venomous group of anti-choice women. Looking at the baby in the stroller, they hurled an epithet at us, one that embodied all the contradiction and hatefulness of their self-proclaimed pro-life stance: “Why didn’t you abort that one?” I had never doubted their commitment to life was confined to the invisible and unborn, but in that moment I came to appreciate that their hatred and disrespect for women extended to living and breathing children.

The historic *Morgentaler* decision was but the first of many legal defeats their movement would experience in Canadian courts. But, the experience of the last twenty years suggests their defeats at the hands of the law have not been fatal. As I have suggested elsewhere, it takes more than “feeble law reform and litigation” to defeat patriarchal institutions, practices and relations.

I am happy to leave close analysis of the Supreme Court decision to the Constitutional scholars. Suffice it to observe that as a feminist activist and veteran of marches, all-candidates meetings,

campaigns, days of action, struggles to get the sisters in the early days of National Association of Women and the Law to take a pro-choice position—I hope I will be indulged for saying simply that after years of struggle—reading Chief Justice Dickson’s and Madam Justice Wilson’s words made one a bit lightheaded:

*Forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman’s body and thus a violation of her security of the person.*<sup>35</sup>

Theoretically, I take the view that law is a social form in and through which social relations are mediated and expressed. But with respect to abortion, I look outside the law to civil society. I do acknowledge legal abortions tend to be safer than illegal abortions. And so I am not agnostic about the efficacy of legality and its importance as a foundation for safety and access—it is most assuredly a necessary but insufficient precondition.

In the area of abortion, Canadian women have experienced many legal victories in Canadian courts, some by the skin of their teeth, some at the hands of judges who are more grudging than others, with dissents that give cause for alarm.

## The Importance of Ideology

It is now axiomatic to observe the Supreme Court’s 1988 decision resolved some questions but left many more dangling—tantalizing and inviting to the opponents of women’s right to choose. For instance, the precise nature and expression of what all judges of the Supreme Court characterized as the “state’s interest in the foetus” remained to be elaborated and tested.

34 E.g. *Medhurst*, supra note 7.

35 *Morgentaler* (1988), supra note 4 at 408.

Long-time anti-choice renegade, Joe Borowski, had been granted standing by the Supreme Court in 1981 to bring an action challenging the validity of the therapeutic abortion amendments to the Criminal Code in the name of foetal legal personhood.<sup>36</sup> He lost the foot race with Morgentaler to the Supreme Court, and by the time he reached the Court, the abortion section of the Code had been struck down, and his appeal was dismissed as moot.<sup>37</sup>

Still, the discourse of the 'unborn child' began to appear in the judgments, and is now ubiquitous, even as the Courts resisted the claims advanced in favour of foetal legal personhood and so-called father's rights.<sup>38</sup> Having lost the legal fight in the context of criminal law and access to abortion, anti-choice advocates looked to other legal forms, such as child welfare, to advance their cause. In 1996, they found what they surely believed to be the poster child for foetal rights in the pregnancy of a poor pregnant woman addicted to glue, who had lost three children to child welfare apprehension, and who refused to stop and refused treatment.<sup>39</sup>

The child welfare agency sought a declaration that the superior court's inherent *parens patriae* jurisdiction over children extended to "unborn children." And they lost, taking comfort from a dissent by Justice Major that my Children and the Law students thought was right on.

In 1992, I wrote,

*The potential cultural and political successes of the foetal rights movement... lie in its ability to both capture the*

36 *Borowski v. Minister of Justice of Canada and Minister of Finance of Canada* (1982), 39 N.R. 331 (S.C.C.).

37 *Borowski v. Canada* (Attorney General), [1989] 1 S.C.R. 342 (S.C.C.).

38 e.g. *R. v. Sullivan*, [1991] 1 S.C.R. 489; see also *Daigle v Tremblay*, *Murphy v Dodd*, *supra* note 7.

39 *Winnipeg Child and Family Services (Northwest Area) v. G. (D.F.)*, [1997] 3 S.C.R. 925.

*imagination and tap the anxiety of people who are receptive to the notion that pregnant women are capable of extreme acts of selfishness and irresponsibility. The foetus is presented as helpless and vulnerable, the most innocent of innocent victims. Again, what is striking is that this campaign has been so successful without significant support in Canadian law for its fundamental underlying premise: that the foetus is a person with legal rights.*<sup>40</sup>

But, as Rosalind Pollack Petchesky argued with prescience in the American context,<sup>41</sup> the legalization of abortion contributed to the ascendance of an aggressive anti-abortion movement, one that has continued to organize in the churches and religious schools. Their discourse of the unborn child has become a dominant ideology of our time. Their ability to present all pregnant women as risky, possibly irresponsible, always potentially hostile to their own pregnancies, has in my view become pervasive and I believe socially shared. So, rather than speak of maternal mortality, or of women's inherent dignity, of the complexity of the abortion decision, never not a complex decision, never an easy choice,<sup>42</sup> or of sexual coercion, they assert only a chorus of the unborn child in a self-impregnated woman.

40 Gavigan, *supra* note 8 at 132.

41 Rosalind Pollack Petchesky *Abortion and a Woman's Choice: The State, Sexuality and Reproductive Freedom* (Boston: Northeastern University Press, 1985).

42 See Wilson J. in *Morgentaler* (1988), *supra* note 2 at para 242: The decision is one that will have profound psychological, economic and social consequences for the pregnant woman. The circumstances giving rise to it can be complex and varied and there may be, and usually are, powerful considerations militating in opposite directions. It is a decision that deeply reflects the way the woman thinks about herself and her relationship to others and to society at large. It is not just

The law is implicated in the ideology of the unborn child, but it seems to me that some of its currency and legitimacy derives from its opposition to the law—as a form that needs to be protected, and the law is not doing that. I take the view that ideologies become dominant not necessarily through law and occasionally in opposition to law, but emergent as well as dominant ideologies may nonetheless be imported or incorporated into law. When I last wrote about abortion fifteen years ago (hence my commitment to an historical perspective today), I wrote that the strongest weapon in the arsenal of the anti-choice movement had not yet proven to be a legal one—and I continue to hold that view.

I am mindful that the Symposium's dedicated organizer, Dawn Fowler, would have liked me to discuss the dilemma of the dearth of availability of late trimester abortions in Canada—and this I have not done. But I do want to make the point that ideologues like David Frum<sup>43</sup> attempt to cultivate in the national imagination that late trimester abortions are a ubiquitous menace, a direct legacy from Madam Justice Wilson's courageous reminder of the limits of men to be able to respond—'even imaginatively'—to something so out of his personal experience.<sup>44</sup> It is difficult to discern even a kernel of truth in David Frum's construction of the crisis—for the world is truly upside down through his lens. The image of the scourge of late trimester abortion could not be further from the truth, and yet it is asserted as truth.

Increasingly, I believe we must situate the struggle of Canadian women within

the broader context of women around the world who are struggling under adverse conditions to deal with unintended pregnancies. A recent study by Gilda Sedgh and her colleagues, published in *Lancet*,<sup>45</sup> found that 48 per cent of all abortions worldwide were unsafe and that 97 per cent of all unsafe abortions were in developing countries—so many of the world's women have access only to unsafe abortions, if they have access at all. I am neither a Constitutional Law nor International Law scholar. Currently I am interested in legal history of criminal law, but I know something of the historic struggle of women to control their fertility against the odds of men, medicine the state, the law and religion. Is it at all surprising that women have always had to resist and challenge their relegation to social invisibility as moral agents? But feminists have long known that there are no easy victories,<sup>46</sup> certainly not in the area of reproductive health, and we have the expertise in this area, in this room, starting with the person sitting next to me.

I do struggle with how to engage with the dominant ideology of the unborn child. But there are some lessons that can be drawn from historical reflection. For me, it is important to remember the most meaningful victories, especially those derived from law, need to be extended and experienced outside the four corners of the courtrooms, and celebrated beyond feminist circles, especially feminist legal

---

a medical decision: it is a profound social and ethical one as well. Her response to it will be the response of the whole person.

43 David Frum, "The Morgentaler Decision Cheapened the Worth of Human Life" <http://network.nationalpost.com/np/blogs/fullcomment/archive/2008/01/21/david-frum-the-morgentaler-decision-cheapened-the-worth-of-human-life.aspx>.

44 Wilson J, in *Morgentaler* (1988) *supra* note 2.

---

45 Gilda Sedgh, et al, "Induced Abortion: Estimated Rates and Trends Worldwide" (2007) 370 *Lancet* 1338 at 1342 ([www.thelancet.com](http://www.thelancet.com)). Unsafe abortions are defined as "Abortions done either by people lacking the necessary skills or in any environment that does not conform to minimum or medical standards, or both. These include (a) abortions in countries where the law is restrictive and (b) abortions that do not meet legal requirements in countries where the law is not restrictive" (at 1339).

46 Kathleen McDonnell, *Not An Easy Choice: A Feminist Re-Examines Abortion* (Toronto: The Women's Press, 1984).

circles. For twenty years prior, leading up to the *Morgentaler* decision, women activists and their allies made abortion a public, political issue in Canada, starting with the Abortion Caravan in 1969. Dr. Morgentaler lent his name, his professional reputation, his career and indeed his life to the support of this important campaign. But it was never just about the law. It was about and for Canadian women.

In closing, my last thought is this—if we acknowledge the current ascendant discourse is one of the unborn child, then we as feminists and supporters of choice for women must re-insert the women in the social vernacular, and start again from the premise that the pregnant woman and the unborn child speak with one voice, and that voice is hers.

# Information Failure: An Ontario Case Study

Lorraine E. Ferris, Faculty of Medicine, University of Toronto

*This is a synopsis of the Power Point presentation given by Lorraine Ferris.*

## Why Do We Need Information About Abortion Services?

Information about abortion services has several uses such as:

- To examine if women have access to abortion services in their geographic area;
- To understand if access is timely;
- To plan services and programs; and
- To ensure quality of care.

The focus of this presentation is on information gaps concerning provincial information from administrative/registry databases. The information contained in this presentation has resulted, in part, from the Studies on Access to Abortion Services (SAAS), funded by the Ontario Women's Health Council through full funding from the (Ontario) Ministry of Health and Long-Term Care (MOHLTC). SAAS Study 1 describes Ontario abortion services (1994–2005) by examining utilization patterns, distribution of abortion services and complication rates in the province by geographic area.

### SAAS Study 1

- SAAS Study 1 was conducted at the Institute for Clinical Evaluative Sciences (ICES): ICES is named as a prescribed entity in the [Ontario] Personal Health Information Protection Act.
- SAAS is subject to ICES policies/procedures and falls within understandings/agreements between the (Ontario) MOHLTC and ICES.

- No SAAS study data contained personal patient identifiers—a unique encrypted patient identifier is used to link data.
- Complete data from the Ontario Abortion Database (JB06) was only available until 1997; this information was collected and maintained by the (Ontario) MOHLTC.
- Information was sourced from standardized physician case reports (no patient or provider identifiers were provided).
- The database contained information on both hospital (1985–1997) and clinic abortions (1992–1997). Detailed patient demographic and clinical information were available, including:
  - Age, marital status, county of residence; and
  - Initial and subsequent surgical procedure, gestational age, subsequent complications (if applicable), number of days in hospital (if applicable), number of previous abortions/deliveries (if applicable), facility type.

### Data Limitations

- Data did not contain patient identifiers or encrypted universal patient identifiers, thus there could be no record linkage with other databases which:
  - Limits examination of longer-term complications or follow-up care; and
  - Limits examination of access issues / barriers as only “county” information is available.

- The accuracy and completeness of the data was dependent on physician diligence.

### Data Post-1997

- The Ontario Abortion Database was discontinued after 1997 and there is lost information for 1998.
- Post-1997, a number of administrative databases must be used to gather this information. There are both pros and cons to this change.

### Context

- Over the ten year study period covered by SAAS, there was a distinct trend to non-hospital abortions. In particular, a trend away from same-day hospital abortion procedures.
- However, after 1997, most of the detailed information available concerns hospital-performed procedures.

### Hospital Abortions Post-1997

- The Canadian Institute for Health Information (CIHI) and the National Ambulatory Care Reporting System (NACRS) databases collect data on:
  - Inpatient Abortions—CIHI Discharge Abstracts Database (DAD)
  - Outpatient Hospital Abortions—NACRS, CIHI Same Day Surgery (SDS) Database
- These databases provide a reasonably complete picture of hospital abortions, such as:
  - Patient age, postal code, gestational age, past history of therapeutic and spontaneous abortions, procedure(s) performed, co-morbidities, immediate complications, length of stay, and hospital.

- They can be linked to other databases using an encrypted patient identifier.

### Data Limitations

- There is no standard definition for a “complication”.
- The data is by hospital and not by physician; therefore it cannot be linked to any other database to obtain physician information.
- Key information is missing for some years (e.g. gestational age).
- There are specific problems with the Canadian Classification of Health Interventions (CCI) system (e.g. use of laminaria).
- Changes to the definition of day surgery/surgical day/night care make comparison difficult over time.
- Changes to the diagnosis and procedure coding systems. (ICD-9/CCP to ICD-10/CCI) impact longitudinal trend analyses.

### Free-Standing Abortion Clinic Abortions Post-1997

- After the discontinuation of the Abortion Database, the only information available for non-hospital abortions is from the Ontario Health Insurance Plan (OHIP) billing records.
- SAAS use of OHIP includes the use of encrypted patient identifiers which provide some linkability.

### Data Limitations

- OHIP data undercounts the number of abortions.
- OHIP data is very limited with respect to clinic abortions (e.g., only that the procedure occurred).
- Records must be linked to other databases to learn more about the abortion.

- Demographic information (patient age, postal code) available from the Registered Persons Database (RPDB) but postal code may be out-of-date
- No information about gestational age, parity, number of previous abortions/ spontaneous abortions
- The utility of OHIP fee codes in determining the method of termination is limited.

### Gaps in Abortion Information

- There is virtually no information on out-of-hospital abortions since 1997.
  - Major gap as these represent the majority of abortions in the province;
  - Cannot provide a complete picture of Ontario abortions.
- This means one cannot fully examine accessibility and timeliness because information on gestational age is lacking.
- There is a lack of information necessary to examine predictors of complications for *all* Ontario abortions. (e.g., gestational age is not available).

### Addressing the Gap

- SAAS is supplementing the information from the administrative databases through primary data collection (i.e. surveys of hospitals and clinics).
- The studies within SAAS will provide a comprehensive picture of abortion services in Ontario.
- Ontario needs a more permanent solution to this information gap.
- Information on out-of-hospital abortions needs to be collected routinely using a standardized form with clear definitions.
- This information should be available by site and comparable to information we have for hospital abortions.
- We believe sites performing abortions may be the best catalyst for this change.
- Still, there are no simple solutions and moving forward will require practitioners, lawyers, policy-makers, and others to work together to address the information gap.







**Our Providers:  
The Challenges of Their Work**



## Challenges of Providing Abortion Care: A Provider's Perspective

Konia Trouton MD, CCFP, FCFP, MPH, Vancouver Island Women's Clinic

Providing abortion care in 2008 in Canada still has political, economic and regulatory challenges. Because the existing facilities and provider numbers seem to be fairly stable, this also poses challenges to enhance abortion care, and to allow new providers to obtain and maintain experience in the field. Education about abortion has improved, but we have not yet made our profession in abortion, or in reproductive health, part of mainstream medicine either by regulation or certification.

I want to start by highlighting a few of the small “p” political challenges of abortion, as my legal colleagues have spoken to many of the federal, provincial and inter-provincial issues. I have encountered many political challenges in trying to enhance abortion care—so I am going to use the experience of my clinic in Victoria as a case study to highlight some of these issues.

I have had the privilege of working on staff in 15 different facilities providing abortion care in five provinces and territories in Canada over the past 15 years. From this experience, in 2003, I started working to establish my own clinic in Victoria.

I came to Victoria believing that in the new millennium, abortion care should be linked to related women's health issues for two main reasons: 1) to provide more comprehensive care to women who seek abortions, and 2) to mainstream abortion practice within a women's health care framework. In other words, I wanted to set up a women's clinic that included abortions, and not have a clinic that focused only on abortions.

For the three years prior to that, I was based in Vancouver, but was unable to find more than a day and a half a week work in abortion care. When I came to BC, I had 10 years experience in abortion care, up to 20

weeks gestation, but the clinics had a stable group of providers. During the three years in Vancouver, I flew to Toronto one-to-two times a month to keep up my skills. I have since met and trained other providers who have been unable to get enough work in abortion care, and have moved onto other more stable forms of work.

When the opportunity came up in Victoria, due to the retirement of the main provider there, I saw the chance to set up a women's clinic. This was not as easy as I thought and sometimes I am naive. What existed five years ago was dedicated hospital time for 20–30 procedures per week in the first trimester, and under general anaesthetic. This dedicated operating time for abortion is unheard of in most of Canada. However, this provider worked alone, did all her own counselling and follow-up, and was a target for some anti-choice activity.

I sought to find family physicians who would be excited to have me work alongside their practice, offering surgical abortions, medical abortions and IUD care. Strangely enough, there are not many of those types of clinics, or doctors. I called the local birth control clinic, and their board did not want me to work, even just a day a week, doing pre-operative abortion assessments and scheduling the abortion in the hospital. Paradoxically, they supplied many referrals for abortion and provided after care. They were much more vigorously opposed than I ever expected, and while I continued to work there once a week doing IUD insertions, I knew to look elsewhere for office space. I called some physician colleagues in the peace and justice movement, whom I knew for many years, and I called some alternative health care facilities, but the doors were shut for office space.

I eventually found a clinic home with three physicians who agreed abortion is part of normal women's health and could be integrated alongside their family practice and obstetrics care. Once I started doing surgical abortions (MVAs) in the office and offering medical abortions, they were anxious but remained with me for three years, taking call for patients at night. However, while I was able to see their family practice patients, I still had no clinical back up from them—they would not provide methotrexate for the medical abortion and did not plan to learn how to do an assessment prior to an abortion. It was not a true collaborative practice. At that time, I also talked to the physicians at the birth control clinic about doing abortion assessments in our clinic while I worked in Vancouver or was away. After calling each of the 12 doctors, two agreed, but they only lasted for a few months, and never expressed interest in learning how to do the procedure.

During those first three years, I felt constrained by the restrictions of the hospital because they only permitted first trimester abortions and all were done under general anaesthetic. I was traveling once too often on the ferry with patients whose laminaria I had inserted, and we were both going to one of the Vancouver clinics so that I could do her dilation and evacuation (D&E) there. I worried about the risks and costs to women travelling under these conditions and lamented about the inefficiency.

In the first year there were also some challenges with two other providers who did three-to-four abortions per month, and who had increased their volume in the six months before I started. It became apparent that the complication rate was about 30 per cent. It may seem odd to you, but the hospital does not generate annual statistics on each type of surgery for the quality assurance committees to review.

Speaking only about the gynaecology committee, we review complications brought to our attention from the nursing staff, unexpectedly long lengths of stay, and surgeries that have generated complaints. In addition, it is unusual that a family physician is on the gynaecology quality assurance committee.

As a family physician, my privileges come from the family medicine department, not gynaecology, even though gynaecology theoretically reviews quality of gynaecological surgery. I had to have my D&E ability assessed by a gynaecologist at the hospital who does not do D&Es. So, as a family physician doing abortion work, I could fall through the crack of having my work fall between two departments. In the end, the physician with the complications voluntarily retired, and the committee continually tells me they appreciate my involvement. This year, the hospital is putting together an application for the National Abortion Federation (NAF) so that they can become accredited as an institution.

In the hospital, abortions are part of the regular day surgery case load, so women are surgically prepped in one area, sent to the OR, and moved to the Recovery Room alongside those receiving other care—in orthopaedics, neuro-surgery, general surgery and gynecology. I am assigned to work with one of the 20 anaesthetists and three of the 60 Operating Room (OR) nurses daily—different ones every day. Remember, the nurses in general hospitals have not done the patient counselling prior to the abortion, they did not come to work necessarily because they care about choice, they do not necessarily work in that hospital because we do abortions—for the most part they are just doing their job. All this led me to reflect that a better model could be provided, and old dogs can learn new tricks. I work in some hospitals in Canada that have a separate floor or

wing where abortions occur, including counselling, and I was resistant to repeat that model, as it moves abortion care again out of the realm of normal women's health, and can stigmatize it further. It is also a more costly model of care compared to clinic care or integrated hospital care.

So, first, my challenge was to work on the anaesthetists. Physicians are a one-on-one crowd, I have concluded, and yet I have been thinking that in the public system, we are all of a similar training and subscribe to a similar ethical code. Over the last five years, the 20 anaesthetists have all managed to switch from general anaesthetic to their own particular version of monitored anaesthetic, or conscious sedation, that those of us in the abortion clinics are familiar with in name. Only two anaesthetists will not work with me, and a few nurses. Moving to D&E required some gradual work, first to 16 weeks, and then six months later to 20 weeks. I led some group sessions with the nurses in all areas—pre-operative assessment, operating room and recovery—having the sessions both before and after the change in practice. The nurses responded really well in groups, and seemed to find it helpful sharing stories. So, while no one is legally obligated to explain or justify why a woman seeks an abortion, many health care workers find it easier to care for women as a group when they know some of the inside stories like the failed IUD, the fiancé who was found cheating, the fifth pregnancy to a couple struggling financially to raise four children, the holiday without the pill, the genetic anomaly...all the stories those of us in the field know. Once they realize why I do what I do, they have been supportive to any efforts to keep the wait list down.

So, back to my space issue and wait list. By increasing my gestational limit and making clinics up Island aware of our services, our volume was increasing. I realized that I had to start offering more abortions in a

clinic, needed bigger space, and needed accreditation from both the National Abortion Federation and the College of Physicians and Surgeons. This meant a lot of work creating manuals and seeking help from the clinics in BC and Alberta, and from colleagues at the hospital. I found clinic space in a professional building where several family physicians, and also two midwives worked—they were supportive of choice and wanted to work together. However, one of the family physician groups which does high volume obstetrics tried to block our purchase. She contacted all the other owners, told them I was an “abortionist” and that they should stop the sale. Fortunately, the pharmacist, the other groups of family physicians and the specialists did not mind, and were extremely welcoming when the sale went through.

Since then, I have been able to work on that one extremely hostile relationship and she has recently referred a few patients for post partum IUDs and even one woman who had a lethal anomaly needing D&E. Our accreditation with NAF went through in 2004 and our College approval in 2006, so now we are the only NAF approved clinic on Vancouver Island and a designated non-hospital surgical facility. We can do abortions, but we are not yet funded, so women pay for the medications and disposable equipment needed. The family physicians moved out a year ago due to our need for space, and the midwives stayed.

The clinic now offers care for unplanned pregnancies, wanted pregnancies and women seeking contraceptive management and well women examinations. We have a solid presence in the community as a woman's health clinic. We are now the referral point for Vancouver Island for pregnancy terminations—the gynaecologists refer to me for the D&Es for anomalies and over half of the women are from outside Victoria. While I do three-

quarters of our work with women seeking termination, I also do many IUDs, many well women assessments and endometrial biopsies. Women coming to the clinic may be seeing the midwives for care, me, or the nurse practitioner.

There has never been any problem in the waiting room, or reflected in the patient evaluations women fill out at follow up. In fact, many in the midwifery community regularly refer to the Clinic for post partum IUDs, for prolonged bleeding post delivery, for management of fetal demise, and for fetal anomalies. Even the anti-abortion members in that group have acknowledged their clients receive good care and are pleased with their visit. Some women, therefore, come to the clinic and never know that we do abortions. The midwives share the view that the woman is central to all care and want to manage normal women's health in the community rather than in a tertiary care hospital. They appreciate that not all wanted pregnancies result in a live birth, and these women need care as well.

This unexpected alliance led me to think about working with other disciplines in health care. I have trained midwives, nurses, members of the sexual assault team, and nurse practitioners in addition to the usual host of medical students, residents and some physicians. One of the nurse practitioner students suggested I apply for provincial funding for a three year grant to involve a Nurse Practitioner (NP) in a fee-for-service practice. I applied, argued my case for the clinic, and for women of Vancouver Island, and I now have a full time NP who can do counselling, education, follow up and well women examinations. Her salary and a contribution to overhead is paid by the regional health authority. This was our first breakthrough in getting any funding.

A few people have appeared to block progress toward outpatient care of abortion. The head of the blood bank was not

supportive of non-hospital management of abortion. With some struggle and two years of negotiating, we are able to do our own blood testing at the clinic. However, while the hospital recognizes this and supplies us with WinRho, they will not accept our Rh test results, so women needing a hospital abortion must attend the lab in the hospital at least two days prior to her abortion. The blood issue is one shared by most clinics and this delicate partnership with the local blood bank is usually not worth tampering with.

The current goal is to get total coverage for all the costs to women. Two years ago the hospital put out a Request for Proposals (RFP) for outsourcing surgical services. It was a general call for all types of surgery and while abortion was not specifically mentioned, nor were D&Cs, we applied. After hearing nothing back for over a year, earlier this month we started fleshing out the details of a contract.

Looking back, my goal was to set up a woman's health clinic that included fully funded abortion care. There have been many challenges but when I look at why this has been a successful story, it is because it has been about establishing trust and working across disciplines. I have worked hard to get to know the hospital staff, the health authority personal and invited them into the clinic to see the work done and to convince them the clinic and hospital partnership benefits them in reducing wait lists, costs and increasing training opportunities and retention of excellent staff.

Here are some big picture questions for you, although you may have some of your own:

- How do we evaluate if there really is a provider shortage?
- How do we address issues of rural care, both the quality of that care and the maintenance of skills?

- What is the relationship between birth control clinics and abortion providers?
- How can changes be brought about in hospital based care?
- How can we lobby for funding—is interdisciplinary partnership the way of the future?

## Why Do I Do This? Being a Provider

Garson (Gary) Romalis MD, FRCSC, FACOG,  
Elizabeth Bagshaw Women's Clinic, Vancouver

I am honored to be speaking today, and honored to call Henry Morgentaler my friend. I have been an abortion provider since 1972.

Why do I do abortions, and why do I continue to do abortions, despite two murder attempts? The first time I started to think about abortion was in 1960, when I was in second year medical school. I was assigned the case of a young woman who had died of a septic abortion. She had aborted herself using slippery elm bark.

I had never heard of slippery elm. A buddy and I went down to skid row and without too much difficulty, purchased some slippery elm bark to use as a visual aid in our presentation. Slippery elm is not sterile, and frequently contains spores of the bacteria that cause gas gangrene. It is called slippery elm because, when it gets wet, it feels slippery. This makes it easier to slide slender pieces through the cervix where they absorb water, expand, dilate the cervix, produce infection, and induce abortion.

The young woman in our case developed an overwhelming infection. At autopsy she had multiple abscesses throughout her body, in her brain, lungs, liver, and abdomen. I have never forgotten that case.

After I graduated from University of British Columbia School of Medicine in 1962, I went to Chicago, where I served my internship and Obstetrics/Gynecology residency at Cook County Hospital. At that time, Cook County had about 3000 beds, and served a mainly indigent population. If you were really sick, or really poor, or both, Cook County was where you went.

The first month of my internship was spent on Ward 41, the septic obstetrics ward. Yes,

it's hard to believe now, but in those days they had one ward dedicated exclusively to septic complications of pregnancy. About 90 per cent of the patients were there with complications of septic abortion. The ward had about 40 beds, in addition to extra beds which lined the halls. Each day we admitted between 10–30 septic abortion patients.

We had about one death a month, usually from septic shock associated with hemorrhage. I will never forget the 17-year-old girl lying on a stretcher with 6 feet of small bowel protruding from her vagina. She survived. I will never forget the jaundiced woman in liver and kidney failure, in septic shock, with very severe anemia, whose life we were unable to save. Today, in Canada and the U.S., septic shock from illegal abortion is virtually never seen—like Small Pox, it is a “disappeared disease”.

I had originally been drawn to obstetrics and gynecology because I loved delivering babies. Abortion was illegal when I trained, so I did not learn how to do abortions in my residency, although I had more than my share of experience looking after illegal abortion complications. In 1972, a couple of years after the law on abortion was liberalized, I began the practice of obstetrics and gynecology, and joined a three-man group in Vancouver.

My practice partners and I believed strongly that a woman should be able to decide for herself if/when to have a baby. We were frequently asked to look after women who needed termination of pregnancy. Although I had done virtually no terminations in my training, I soon learned how. I also learned just how much demand there was for abortion services.



Providing abortion services can be quite stressful. Usually an unplanned, unwanted pregnancy is the worst trouble the patient has ever been in her entire life. I remember one 18 year old patient who desperately wanted an abortion, but felt she could not confide in her mother, who was a nurse in another Vancouver area hospital. She impressed on me how important it was her termination remain a secret from her family. In those years, parental consent was required if the patient was less than 19 years old. I obtained the required second opinion from a colleague, and performed an abortion on her.

About two weeks later I received a phone call from her mother. She asked me directly "Did you do an abortion on my daughter?" Visions of a legal suit passed through my mind as I tried to think of how to answer her question. I decided to answer directly and truthfully. I answered with trepidation, "Yes, I did" and started to make mental preparations to call my lawyer. The mother replied: "Thank you, Doctor. Thank God there are people like you around."

Like many of my colleagues, I had been the subject of anti-abortion picketing, particularly in the 1980's. I did not like having my office and home picketed, or nails thrown into my driveway, but viewed these picketers as a nuisance, exercising their right of free speech. Being in Canada, I felt I did not have to worry about my physical security.

I had been a medical doctor for 32 years when I was shot at 7:10 AM, November 8, 1994. For over half my life, I had been providing obstetrical and gynecological care, including abortions. It is still hard for me to understand how someone could think I should be killed for helping women get safe abortions. I had a very severe gun shot wound to my left thigh. My thigh bone was fractured, large blood vessels severed, and a large amount of my thigh muscles destroyed. I almost died several

times from blood loss and multiple other complications.

After about two years of physical and emotional rehabilitation, with a great deal of support from my family and the medical community, I was able to resume work on a part time basis. I was no longer able to deliver babies or perform major gynecological surgery. I had to take security measures but I continued to work as a gynecologist, including providing abortion services. My life had changed but my views on choice remained unchanged, and I was continuing to enjoy practicing medicine. I told people that I was shot in the thigh, not in my sense of humor.

Six years after the shooting, on July 11, 2000, shortly after entering the clinic where I had my private office, a young man approached me. There was nothing unusual about his appearance until he suddenly got a vicious look on his face, stabbed me in the left flank area and then ran away. This could have been a lethal injury, but fortunately no vital organs were seriously involved, and after six days of hospital observation I was able to return home. The physical implications were minor, but the security implications were major. After two murder attempts, all my security advisors concurred that I was at increased risk for another attack.

My family and I had to have some serious discussions about my future. The National Abortion Federation provided me with a very experienced personal security consultant. He moved into our home and lived with us for three days, talked with us, assessed my personality, visited the places that I worked in, and gave me security advice. In those three days he got to know me well. After he finished his evaluation, when I was dropping him off at the airport, his departing words to me were "Gary, you have to go back to work". About two months after the stabbing I returned to the practice of medicine, but with added

security measures. Since the year 2000, I have restricted my practice exclusively to abortion provision.

These acts of terrorist violence have affected virtually every aspect of my and my family's life. Our lives have changed forever. I must live with security measures that I never dreamed about when I was learning how to deliver babies. So why do I continue to perform abortions, and what am I doing here? It's a fair question.

Let me tell you about an abortion patient I looked after recently. She was 18 years old, and 18–19 weeks pregnant. She came from a very strict, religious family. She was an only daughter, and had several brothers. She was East Indian Hindu and her boyfriend was East Indian Muslim, which did not please her parents. She told me if her parents found out she were pregnant she would be disowned and kicked out of the family home. She also told me that her brothers would murder her boyfriend, and I believed her. About an hour after her operation my nurse and I saw her and her boyfriend walking out of the clinic hand in hand, and I said to my nurse, "Look at that. We saved two lives today".

I love my work. I get enormous personal and professional satisfaction out of helping

people, and that includes providing safe, comfortable, abortions. The people I work with are extraordinary, and we all feel that we are doing important work, making a real difference in peoples' lives. I can take an anxious woman, who is in the biggest trouble she has ever been in her life, and by performing a five-minute operation, in comfort and dignity, I can give her back her life.

After an abortion operation patients frequently say "Thank You Doctor" but abortion is the only operation I know of where they also sometimes say "Thank you for what you do". Before any questions, and you can ask me anything you like, I want to tell you one last story that I think epitomizes the satisfaction I get from my privileged work.

Some years ago I spoke to a class of UBC medical students. As I left the classroom, a student followed me out. She said: "Dr. Romalis, you won't remember me, but you did an abortion on me in 1992. I am in second year med school now and if it weren't for you, I wouldn't be here now."

## The New Generation: Abortion in Medical Schools

Pat Smith MD, Grand River Hospital, Kitchener, NAF, NAF Canada

Thank you for asking me to talk at this very important honouring of the Supreme Court Morgentaler Decision. I have not had the opportunity to hear lawyers in Canada speak about this decision which so fundamentally changed the lives and health of Canadian women and I have found the content to be very interesting. It is also a pleasure for me to participate in an occasion which acknowledges those men and women who worked so hard to make it possible for this case to go forward and of course, in particular, Dr. Morgentaler. Dr. Morgentaler is a friend and mentor and someone who has influenced my career many times and in many ways.

My task is to talk about the future of abortion care in Canada, in particular as it relates to future providers. Education and training for new abortion providers is fundamental to ensuring access to high quality care. I am going to restrict my comments to physician's education today because of the necessity of time and because I am not qualified to speak about other disciplines but I do want to make it clear that I know very well that physicians are only one member of the team of folks it takes to provide high quality care.

### Provider Training: Past & Present

The current generation of abortion providers came to their work very differently than new providers today. The story of my own training parallels that of many other providers I have talked with. I came to medical school after training and working as a social worker. I was a feminist who had worked for many years in the pro-choice community. I had friends who had had illegal abortions. I had experienced first hand the ordeal of going through a

therapeutic abortion committee to obtain an abortion in the hospital. While an undergraduate at McMaster University in Hamilton there was no exposure to abortion care or indeed to women faced with an unplanned and unwanted pregnancy. Women's health as a discipline was not yet born.

As a resident in Family Medicine, I approached the Department of Obstetrics and Gynecology to organize an elective that would train me to do abortions. I was flatly turned down and clearly told that abortions were done by gynecologists, not family doctors. Toward the end of my residency program, I was recruited to do training at the Morgentaler Clinic in Toronto. It was part of a public relations strategy to inform the public and politicians that no matter what they did to Dr. Morgentaler, there were physicians who were training to take his place.

A small group of us committed to train and then publicly indicate our willingness to provide care. I was very pregnant at the time and the protestors at the clinic were vicious toward me. It was not easy to even enter the clinic. Although our group met with legal counsel and were reassured it was unlikely there would be legal action against us or if we were arrested it was unlikely we would spend time in jail, I could not contemplate having my baby in prison or leaving my baby behind were I arrested. I was not made of the same stuff as Dr. Morgentaler and I dropped out at that time.

A few years later, I was practicing as a family doctor. Another family physician who I had been a resident with recruited me to train to do abortions urging me to put my "money where my mouth was" so to

speak. I began training at Choice in Health Clinic and from there went on eventually to narrow my clinical work entirely to abortion provision. Most of my colleagues today began in the same way, either starting because of their own political convictions or at the urging of friends and colleagues because of the need for coverage in both clinic and hospital programs.

An important first point is for you to realize how different this path to clinical practice is in comparison to other activities and disciplines in medicine. Most students do not enter medical school knowing the area of work they will ultimately settle in to. They come to their decisions via exposure to study, practice and/or practitioners who inspire or interest them. It is completely possible, even now, to complete an undergraduate and residency program without any exposure to abortion care. It is completely possible a student might never be prompted to think about including the provision of abortion services to women as an option. This leaves a huge task for those of us hoping to ensure abortions will remain an option for women in the future or hope to someday retire ourselves.

In addition, one of the impacts of the Morgentaler decision that led to relatively good access to abortion services throughout most of Canada is that access to abortion is no longer the grass roots issue it once was among feminists and the general public. There is not the same social justice community activity that was necessary to mobilize people to demand a change for women in Canada that was there in the 70s and 80s. Students may not be coming to their medical school training with the social justice agenda on this issue many of us had in the past.

There are other reasons to include abortion education in undergraduate programs. Contraception, unplanned and unwanted pregnancies and the repercussions of unwanted children being born are all

significant public health issues. No matter if you choose to provide abortions or not, most physicians in whatever area of practice they end up in will come in contact with these issues and must be trained to understand and treat patients appropriately. In terms of global health, lack of access to safe, legal and timely abortions has a very negative impact on the health of women, families and communities. These are very important issues for new physicians to understand and perhaps address.

## Influences on Curriculum

Whether or not an area of study is included in undergraduate or residency programs is determined by several factors. At the undergraduate level, licensing bodies, such as the Medical Council of Canada influence curriculum by including specific topics in their certification exams. The Medical Council of Canada produces a set of objectives to aid academic programs and students to understand the breadth and depth of the information that will be assessed in the licensing exams.

Abortion is listed only in the section on the legal and ethical aspects of practice.

The CLEO objectives do list abortion as an example of one of the “controversial and evolving ethical issues in practice” and sets as an objective that a student should be able to speak in a non-judgmental way, understand the rights of patients and ensure they receive full access to relevant and necessary information. However, abortion is only one of a list of several controversial topics like euthanasia and is not listed in any other area of their objectives related to licensure. It is also interesting to note abortion is included in a list that also includes euthanasia, physician assisted suicide, stem cell research, etc. There is no question that abortion in this country is controversial but it is not illegal

as these other activities are. The message this gives is just another reinforcement that abortion education is marginalized and would therefore not be appropriate in the standard curriculum. Medical Students for Choice did a curriculum mapping survey which confirmed a complete lack of consistency across programs for abortion education and training.

The Royal College of Physicians and Surgeons of Canada is responsible for overseeing medical education for specialists in Canada, including Obstetrics and Gynecology. Their website indicates all Obstetrician and Gynecologists must have an extensive level of knowledge of Pregnancy Termination. Having extensive knowledge is described as being able to:

- Investigate, diagnose and/or manage (including counseling and/or referral for grief support):
  - Termination of pregnancy in the first trimester
  - Termination of pregnancy in the second trimester

The only technical skill required though is for “dilation and curettage, diagnostic”. A graduating Obstetrician/Gynecologist must have knowledge about pregnancy termination in both the first and second trimester but is not required to be able to do one.

The College of Family Physicians of Canada does not address the issue of pregnancy termination or the management of unplanned and unwanted pregnancy. It only speaks to being able to establish the “desirability” of the pregnancy.

## Trends in Student Exposure to Abortion Practice

In addition to the policies and requirements of our professional and licensing bodies, there are other factors that influence whether or not medical students are exposed to

abortion content. I am going to highlight a couple of the trends that may have a negative influence and then talk about some of the positive things that are happening.

Changing practice patterns indicate there is an increase in the number of abortions being done in clinics and fewer hospitals provide any abortion services. Most of undergraduate medical education is done in hospitals and this changing practice pattern does negatively impact on exposure. There is also a decrease in the number of gynecologists doing abortions and therefore less exposure to residents during their normal training rotations.

There have been several studies that indicate students exposed to abortion practice and education are more likely to become providers. It is of great concern that there is less and less exposure of practice to students and residents and again, this is very different than other areas of specialty.

There are other factors that influence whether or not a particular topic is covered in medical school. Interests of faculty both in clinical work and research may be one of the most significant determinants of whether or not any particular group of students are exposed to abortion content. In Canada, there have not been many academic physicians interested in or practicing abortion care. There has been very little research on abortion care done in academic settings. Because of this our hospital rounds, professional journals and academic meetings, where practicing physicians, residents and medical students learn new and quality practice standards, have not had the theoretical content that would also expose and encourage other scholarly work. This is somewhat different than in the United States in recent years where there has been increasing research and publication of research data. There are many well recognized and respected academic physicians involved in residency programs and undergraduate training.

There has also been the establishment of post graduate training programs for family planning that encourage and support academic work in this area.

However, it is not all bleak. There are physicians working very hard in their clinical situations to increase curriculum content and opportunities for training. There are community and hospital-based physicians who lecture and tutor in undergraduate programs and who include abortion content when they have the opportunity. There are doctors who work with Medical Students for Choice and who offer workshops and lectures outside the standard curriculum that augments reproductive health content.

There are two initiatives in Toronto right now that are very exciting. The first is a day long workshop being offered jointly between the Departments of Family Medicine and Obstetrics and Gynecology aimed at residents in both programs. It is intended to inform residents so they can provide better pre and post abortion care and to perhaps identify some students who might train to become providers. It is hoped this workshop will eventually be offered to a more multidisciplinary group and to practitioners outside of the Toronto system.

There is also an official elective experience offered to Gynecology residents that will provide a great deal of exposure to abortion services, again to improve care by consultants and to perhaps interest future providers. These initiatives provide good examples of what is possible when you have academic physicians involved in providing care, teaching and doing research. I know there are other physicians across the country also involved in these kinds of initiatives. Many clinics have relationships with medical schools and residency programs and accept students to observe and train.

We also have physicians who are working from within professional organizations

trying to influence specific committees so our issues are brought to the attention of people in a position to change expectations. Dr. Trouton is working closely with the College of Family Physicians and others of us are working with the SOGC, the CMA and others.

Medical Students for Choice is doing an outstanding job, trying to influence things from the bottom up. MSFC began in the U.S. as part of an effort to address the provider shortage. The group is now active across the US and is very active in Canada. Of the 17 medical schools in Canada, 11 have active MSFC chapters. They work at the grass roots level organizing lectures and other events to raise both the political awareness and medical knowledge of students. Through their externship program they have 125 host facilities that provide opportunities for students to meet and work with providers, increasing that important exposure I mentioned earlier. They also hold a national conference each year bringing together many well known providers to lecture and inspire students to pursue careers in abortion care whatever specialty they chose. It is always fun to spend time with these incredibly motivated and interesting young people.

The problem with many of these efforts is that they are not imbedded in the curriculum. They are reliant on the time, interest and availability of individuals often donating their time. There is not systematic integration into medical school or residency curriculum and no requirements this content be covered for licensure or credentialing. I just want to make a comparison here with other areas of medicine. It is inconceivable any undergraduate medical program would rely on the individual interests of faculty to be sure respiratory is covered in their curriculum. They would always have faculty who are respirologists and would always include the material necessary to

understand and deal with lung problems. If a faculty person left who had this expertise, there is no question it would be a part of the requirements for a new faculty person being recruited. Reproductive health issues are treated very differently. There is no priority set on having faculty in Family Medicine or Gynecology who can provide scholarly research and teaching on this important topic.

I am going to close with what I see should be the goal for teaching abortion care in medical schools and residency programs.

Standard curriculum should include:

- Pregnancy options counseling
- Contraception
- Descriptions of the different methods and procedures of medical and surgical abortions
- Pre and post medical and surgical management of patients choosing abortion

- Abortion from the perspective of human rights
- Global issues related to unsafe abortion and its impact on women's health

Abortion training should include:

- Exposure to clinical settings where women facing unplanned and unwanted pregnancies should be mandatory
- Opportunities to rotate through and train to do abortions should be routinely offered to residents
- Appropriate and standardized relationships should be established between clinical settings that provide abortions and training programs
- Some emphasis should be placed on recruiting faculty who have both interest and expertise in this important part of comprehensive reproductive health education

## The Role of Media in the Abortion Debate

Heather Mallick, Journalist and Author

As a feminist mainstream journalist, I have a lonely life. Every now and then I have lunch with Michele Landsberg, who is retired from writing, and she tells me to cheer up, things can only get better.

I particularly appreciate that the symposium today has been practical as well as theoretical, because journalism is very much a “let’s get down to brass tacks” field. I have to win the attention of the reader. Being reasonable or logical isn’t enough. Although, as you’ll have noticed from media coverage of women’s rights in recent years, being reasonable or logical isn’t even required.

Two things worry me about media coverage of abortion rights today. The first is complacency; the second is what will emerge from an increasing tide of misogyny in public life. One thing I always tell audiences: Never underestimate how much women are hated—by men and women.

Media coverage of abortion rights scarcely exists in Canada. Canadians in general think abortion is a personal matter and are therefore complacent about abortion rights, which is a nice state to be in although it isn’t terribly helpful if you’re poor and you’re pregnant. And since media coverage needs a news angle, it’s hard to cover a slide in accessibility in certain parts of the country. You try getting the word “accessibility” into a headline.

The Ottawa Citizen ran a marvelous story recently on how hard it is to get an abortion in the Ottawa area. And that’s the genius of local coverage. There’s your angle, especially in a city that runs the country. Politicians’ daughters can’t get an abortion? In Ottawa, where you’d think things would be more civilized? Now that’s interesting.

But the fact that women in New Brunswick can scarcely get a hospital abortion, much

less have their abortion in a Morgentaler clinic in Fredericton covered by Medicare? That’s a great local story and the subject of an important lawsuit, but New Brunswick newspapers are owned by the Irvings. There is a media silence. We had a great event sponsored by the University of New Brunswick, Faculty of Law, in April last year, with an overflow audience, and a great legal panel. The paper refused to cover it.

But there’s a side issue. Media in Canada are in a terrible state. Media companies are, I think, the worst-managed sector of the economy and the recession will make this more apparent. This is a time of fragmentation. The consequences will be: newspapers will disappear, more online sites will spring up, less money will be spent on TV newsrooms, reporting will be shared more across the country, there will be fewer journalists, they will be a combination of less-trained and overtrained, which is not good for anyone, and so on.

One of the side effects of this is that newsrooms tend not to attract young people, especially bright young people who will go elsewhere for a career that will provide a solid future. And this is a disaster for all Canadians. But it leads to a particular problem when it comes to covering abortion rights. The older people who run newsrooms are decades past the baby-making years. They don’t care about the consequences to women of the sex they’re not having.

I think the fact that newsrooms are run mainly by males, especially the middle-aged and elderly, is responsible for the freak show that is coverage of female sexuality. This might be dismissed as a



matter of men being controlling. But I really do wonder why most female columnists in Canada tend to be single and childless. Is this by choice or is there no way to have a family life? Male columnists manage it. And why are women columnists so often really hard-core woman-haters? I may be wrong: perhaps the pool of women columnists in Canada is too small to draw a conclusion.

But when it comes to editors and managers, matters of sex and procreation are not going to be covered in a normal, sane way by people who, frankly, are probably not getting any. Or much. So there's a weird prurience to these stories. There was a front-page story in the *National Post* in 2006 on why anti-abortionists are getting nowhere. The headline wondered why Canadians wouldn't discuss the A-word. Maybe because they're busy talking about new technologies like the C-word, cloning? It failed to answer that question. But it's also funny when neo-con newspapers wonder out loud why readers don't care about the stuff they care about. Is it any surprise that newspapers are said to be dying in their current form? Readers are smarter than journalists. You think otherwise at your peril.

Now we come to the demonizing of young women. *Maclean's*, which is not a newsmagazine—more of a weird underdeveloped-guy cult plus a weird elderly lady named Amiel—has the latest in a series of covers on the sexuality of girls and young women. Why do our daughters dress like skanks? Why is teen pregnancy cool (or “hot” to use that all-purpose media word)? And that's the approach that neoconservative men would take to the issue of abortion rights, that the issue can be reduced to “sex with hot babes.” When in fact abortion is just as much about privacy and patriarchy and poverty and sheer human desperation.

So lascivious frustrated male editors might well use abortion and teen pregnancy

movies as an excuse to expound on young females thinking they can control their own bodies, their gorgeous, glowing, hot young bodies. Anything to get a babe on the cover. Not a baby, a babe.

My first point was that Canadians are complacent about abortion rights and this is perpetuated by the media. Then I said that women's sexual rights are reported on in a distorted way because of the massive changes in modern journalism and the kind of people who run newsrooms.

But my second point concerns forces outside Canada. Yes, our first problem is what we would do if Stephen Harper were to be elected with a majority government. All bets are off, and we know that.

But what happens in the United States matters a great deal as well, largely because they have a lock on our culture and our media. Young people watch American TV shows and American movies; their cultural mores seep in. I'm always astonished when women talk to me about *The Wire* and never mention that it is a womanless show. In other words, just like real life. That's seepage, when you fail to notice the erasure of females from the landscape.

Liberal American websites like Salon criticize a Canadian university campus when students refuse to finance an anti-abortion group. What about free speech, the feminist Americans say. But on a Canadian campus, the rights of women are not up for debate.

I was going to entertain you all with a very funny story about American support groups for people who allegedly suffer from post-traumatic stress disorder from their relatives' abortions. Broken parents, grandparents, weeping boyfriends who go on to kill abortion providers and so on. But then I realized that it's an American story. Why should I publicize this lunacy in Canada? The transfer of reporting on American extremism, amusing as it is,

makes us more believing and tolerant of lunacy here, and that's a terrible danger.

Anyway, the big problem would be the U.S. Supreme Court overturning *Roe v. Wade*, which I think they may well do. And the second problem is how any of the candidates would react, once in office, to that. I think we know they would all react with cowardice.

I think if abortion rights disappear in the U.S., there will be a resultant anti-choice pressure here transmitted via the media. There are very few feminists in the media. I'm hoping American laws will be ignored, the way Canadians fly off to Cuba for their winter vacation, but I'm not confident. On the other hand, depending on how American states react, it may well be that American women will cross the Canadian border for their abortions. And we will have to support them to the same degree we have failed to support American war-resisters, some of whom are women.

I'd like to make a request. When you see something in the media that damages women's rights, when you see a reporter go out on a limb for the rights of, say, a poor woman seeking an abortion, will you send an email or write a letter to the editor speaking up? The anti-abortion people use this tactic. Can we get up to speed here? Can someone publicly defend abortion rights, please?

It's all very well to call Canadians complacent, but feminists are complacent too. It's all very well to support each other in academia and in specialist publications and in guarded online forums, but the mainstream needs to hear from you. And Dawn Fowler, whose group wants to help poor women get the abortions they want, needs a cheque from you.

# The Politics of Abortion: The Work of the Politician

Hon. Carolyn Bennett MD, MP, St. Paul's, ON

*The following is an overview of the Power Point presentation given by Hon. Carolyn Bennett.*

## Life before Politics

- Advocacy
- Public position
- Profession
- Consistency/values/principles
- "Immunization"

## Personal Experience Pre-Politics

- High school in the 60's
- Medical school
  - Bracebridge, Gravenhurst elective... 1st patient needing an abortion was a 14 year old daughter of a prostitute serving her mother's clients...seemed clear to me she should return as soon as possible to Grade 9
  - OB/GYN rotation
  - Marion Powell
- Clerkship elective in Barbados...septic very sick patients result of criminal abortions
- Family practice residency
- Locums in Bracebridge, Midland
- Practice in Toronto's Annex area in 1977
  - Read *Our Bodies, Ourselves* (under the arms of 'every' patient)
- Women's College Hospital
  - Bay Centre for Birth Control
  - Impressive work on how women decide

## Life as a Family Doctor

I had the best patients in the world. They were:

- Empowered patients
- Effective Advocates
- Engaged Citizens

## Big 'P' Politics

- Ran provincially in '95 and lost...
  - Platform of same sex benefits, adoption
- 1996...Provincial Liberal leadership campaign...
  - 7/8 candidates practicing Catholics
  - "Women have been trying to terminate pregnancies for as long as they have been getting pregnant. We have to ensure they don't die doing it."
- 1997 Federal Election...
  - "we'll have to agree to disagree"
- Vigilance...ongoing
- Private members' business
- 2002: Bill C-13, Assisted Human Reproduction Act ... proposed amendments
  - Criminalize vs. Regulate
- 2005 Dispute resolution commenced on New Brunswick

## Historical Listing of Anti-Abortion Motions

- **March 14, 1996**—Reform MP Garry Breitkreuz (Yorkton-Melville, Saskatchewan) calls for national referendum on tax-funding for abortions.
- **October 29, 1996**—Reform leader Preston Manning calls for national referendum to place a ban on abortion in the Constitution.
- **March 1997**—Reform MP Keith Martin introduces private member bill to charge pregnant women who abuse alcohol, drugs etc. with criminal endangerment of fetus.
- **November 20, 1997**—Breitkreuz reintroduces private member’s motion M-268 calling for a binding national referendum on government funding for “medically unnecessary” abortions.
- **April 18, 2002**—Breitkreuz introduces motion M-392 asking the Standing Committee on Justice and Human Rights to examine the current definition of “human being” in the Criminal Code to see if the law needs to be amended to provide protection to fetuses and to designate a fetus/embryo as a human being.
- **October 30, 2002**—MP Maurice Vellacott (Saskatoon-Wanuskewin) reintroduces his conscience clause legislation for debate, for health care workers who refuse to take part in procedures such as abortion
- **September 30, 2003**—Breitkreuz introduces motion M-83, asking the justice committee to examine whether abortions are medically necessary as defined by the Canada Health Act
  - Breitkreuz got over 10,000 Canadians to sign petitions supporting this motion, which was defeated Oct. 2.

- **October 23, 2003**—Breitkreuz introduces motion M-482 asking Parliament for a Woman’s Right to Know Act, which would “guarantee women are fully informed of all the risks before deciding to abort their baby”.
- **March 11, 2004**—Breitkreuz introduces motion M-560 calling on the government to create a new criminal code offence for the “murder of an unborn child” when a third party murders a pregnant woman.
- **June 2006**—Paul Steckle introduces Bill C-338, a private members bill that, if passed into law, would make abortion illegal after the 20th week of pregnancy.
- **November 21, 2007** —MP Ken Epp introduces Unborn Victims of Crime legislation.

## Other History

- **May 1998**—First Annual March for Life on Parliament Hill organized by Campaign Life Coalition, Canada’s national anti-choice group.
- **February 24, 2002**—During a nationally televised leadership debate, all four Alliance leadership candidates tell potential voters they would not lead a push to have abortion banned or delisted as a surgical procedure covered by Medicare.
- **May 25, 2002**—MP Jason Kenney speaks at the Alberta Pro-Life Conference in Edmonton and says most abortions are not medically necessary and should not be funded.
- **November 26, 2002**—Anti-choice MPs Tom Wappel (Liberal), Elsie Wayne (Conservative), and Maurice Vellacott (Alliance) release an open letter questioning Dr. Morgentaler’s motivations and accusing him of

hiding lucrative profits from his abortion clinics.

- **January 2003**—Three anti-choice MP's issue a press release criticizing the idea of awarding Dr. Henry Morgentaler the Order of Canada. Paul Steckle (Liberal), Maurice Vellacott (Alliance), and Elsie Wayne (Conservative) claim that Morgentaler's "legacy" is one of harming women.
- **May 13, 2004**—20 MPs, mostly Conservatives, attend the annual March for Life in Ottawa, organized by Campaign Life Coalition, Canada's national anti-choice group.
- **May 30, 2004**—Conservative Rob Merrifield says in an interview with the Globe and Mail that women considering abortion should be required to seek counselling first.
- **June 2004**—Conservative Cheryl Gallant draws a parallel between abortion and the beheading of an American man working in Iraq.
- **Sept. 8, 2004**—Conservative Vic Toews told the National Pro-Life Conference, in a speech entitled "Abuse of the Charter by the Supreme Court," that the right to abortion is a result of "activist judges" abusing the Charter of Rights and Freedoms to develop and implement their own social policy.
- **March 2005**—The Conservative Party adopts a resolution at their convention (by a vote of 55% to 45%) that "a Conservative government will not initiate or support any legislation to regulate abortion."
- **May 2006**—8th Annual March for Life on Parliament Hill, over 21 MPs in attendance.
  - Former Liberal MP Pat O'Brien was awarded the Joseph P. Borowski award for his "heroism in battling in Parliament for life and family."

- **May 2007**—9th annual March for Life on Parliament Hill. MPs Paul Steckle and Maurice Vellacott, co-chairs of the Parliamentary pro-life caucus, held a news conference preceding the march.

## Summary of "Morality" Bills being Debated in the House/Senate

We have just updated our "GET INFORMED" page with a concise listing of many the bills currently being debated in the House or Senate that would fall under the category of 'moral' issues. These bills touch on drugs, sexual offenses, the rights of wanted children, internet pornography and more. We encourage you to take a scan through and e-mail/call your MP to let them know what you think about these bills, especially the ones that are currently being debated.

## Support the Protection of Pregnant Women and their Babies

On Nov. 21st, 2007, the House of Commons began the process of looking at a bill by Ken Epp that, if it is passed, will make it a criminal offense to harm a 'wanted' child in the womb (e.g. if violence against the mother hurts the child). Mr. Epp has posted a poll on his website and is asking for the opinion of Canadians. If you are in support of protecting pregnant women and their children, please click on the image to the left and go to Mr. Epp's site to vote "Yes!"

## Pressure ??

Calls to the constituency office this week about my participation in this event:

- "How can you properly represent the people of St. Paul's if you are prepared to participate in the abortion event when 70% of the riding oppose abortion".

- In May 2004, Life Canada (a national association of municipal and provincial educational pro-life groups) ran an ad in the *National Post* that listed the number of tax-funded abortions done per year in Canada. A note at the bottom invited readers to send letters of protest to politicians.
- Type in [www.carolynbennett.ca](http://www.carolynbennett.ca) to get to her actual website.

- But [www.carolynbennett.net](http://www.carolynbennett.net) gives you LifeSiteNews.com—an anti-choice website.

### What do Canadians Think?

“Do you think abortions should be legal under any circumstances, only certain circumstances, or illegal in all circumstances?” According to polls:

Year	Legal Under Any Circumstances	Only Under Certain Circumstances	Illegal in All Circumstances
1975	23%	60%	16%
1978	16%	69%	14%
1983	23%	59%	17%
1988	25%	59%	15%
1993	31%	56%	10%
1998	30%	55%	12%
2001	37%	51%	9%

### American and Canadian Views

According to the 2002 Gallup poll:

- Abortion is morally acceptable
  - US 38%
  - Canada 57%
- But how much does public opinion matter?
  - The Canadian Conscience: Grenville and Canseco, Angus Reid pollsters found:
    - Thoughtful Conservative—33%
    - Laissez Faire— 25%
    - Accepting Middle of the Road —18%
    - Strict Moralists—12%
    - Uncertain Relativist—12%

### The Role of the Elected Representative

*Voting on Abortion in the House of Commons: A Test for Legislator Shirking.* University of Regina, Professor Neil Longley.

- Examines the degree to which legislators’ votes on a 1988 parliamentary vote on abortion reflected constituent preferences, versus the degree to which the votes reflected the personal ideological preferences of the legislators themselves.
- It finds that MP voting on this issue did not appear to be influenced by the preferences of constituents, but was significantly influenced by the personal ideologies of the MPs themselves.

## Trustees versus Delegates

Longley says legislators are “trustees” not “delegates”. Let’s examine the issue of “trustees” versus “delegates”

- Under the delegate view, the legislator acts simply as the “voice” of his or her constituents.
- Legislators are not to use their own discretion to make decisions. They are expected to represent constituent interests on all issues at all times.
- Standard to legislative voting (e.g. Legislators should cast their votes strictly in accordance with the preferences of their constituents).
- Under the trustee view:
  - Constituents grant legislators relatively wide latitude to make decisions as legislators see fit.
  - This is justified on a number of grounds:
    - Legislators should be “leaders” and not “followers,”
    - Legislators must also serve national interests, and not simply the interests of their own constituency.
    - No legislator should ever be forced to vote against his or her conscience on ethical and moral matters
- When Professor Longley discovered that MPs voting on the abortion issue did not appear to be influenced by the preferences of constituents, he described it as evidence of “shirking” behaviour by legislators.
  - He’s wrong.
- As elected officials, MPs are obligated to uphold the *Charter of Rights and Freedoms* and protect the equal rights of minorities. Human rights are not subject to majority rule in a democracy.

## Role of an Elected Representative

- Human rights are not subject to majority rule in a democracy.
- Should an MP represent their constituent’s views or their own personal views on issues as contentious as abortion?
  - The true role of the government and its MPs is to respect and support women’s constitutional rights by ensuring abortion access and funding.
  - Politicians have no “right to choose” — that is the sole domain of women.

## The “Responsible” Elected Representative:

- ‘Representative democracy’
- How do we know?
- No \$\$\$\$ for polling
- Town halls, tabulating phone calls, emails
- Still a guess...
  - Was the question genuine?
  - Was the context explained?
- The seduction of direct democracy...

## Miles to Go

- Freedom, equality, safety
- Dignity
- Bias-free framework: Mary Anne Burke, Margrit Eichler; Global Forum for Health Research
- Research, trusted data

## Equal Access?

- Over half of abortions in Canada are still done in hospitals because clinics only exist in the larger cities.

- 80% of hospitals don't even perform abortions.
- Hospitals have:
  - Long waiting lists
  - Requirements for doctor referrals
  - Quotas or gestational limits
  - Anti-abortion staff who misinform or judge patients seeking abortions.
- It's harder for rural women to access abortion services than it is for city women.
  - Many women must travel long distances to find an abortion provider.
- Access is also poor in more conservative areas, especially the Atlantic provinces.

#### Anti-Choice MPs in the House of Commons Before and After 2006 Election

	Before Election	After Election
<b>Total Anti-Choice MPs</b>	93 of 306 MPs (30%)	100 of 308 MPs (32%)

Anti-choice MPs are deemed to be publicly anti-choice if they have an anti-choice voting record, or have publicly spoken at or attended events organized by anti-choice groups, or have publicly stated they are "pro-life," or would support abortion only in limited circumstances.

For example, MP David Sweet was the President of Promise Keepers Canada (1998–2004). He stated: "Men are natural influencers, whether we like it or not. There's a particular reason why Jesus called men only. It's not that women aren't

co-participants. It's because Jesus knew women would naturally follow". (*Christian Week*, November 27th 2001).

Hon. Carolyn Bennett closed her presentation with this quote:

*"Physical and mental energy come from being in control of your life, having real choices, and being involved with others to find ways of organizing change for the better."*

Barbara Rogers



## On Being a Legal Academic in a Politically Charged Context

Jocelyn Downie, Faculty of Law, Dalhousie University

Thanks are due to Sanda Rodgers for her initial partnership in the editorial and responses discussed in this piece, for her comments on earlier versions of this piece, and for her unwavering commitment to advancing women's equality through her work as a legal academic in this highly politically-charged context.

### The Story

A few years ago, an opportunity came along to write a guest editorial in the *Canadian Medical Association Journal*. Reflecting on possible topics, I realized if I had to pick one message I wanted to get out to practicing physicians (apart from the need to protect our Canadian health care system—a topic on which there had just been an editorial in the *CMAJ*), it was on access to abortion. I had the distinct pleasure of writing this editorial with Sanda Rodgers. We described the severe problems with respect to access to abortion in Canada (particularly for the most vulnerable women) and we argued that “physicians are not required to perform abortions (except in emergency circumstances); however, regardless of their personal beliefs, they should not prevent women from accessing abortion. Health care professionals who withhold a diagnosis, fail to provide appropriate referrals, delay access, misdirect women or provide punitive treatment are committing malpractice and risk lawsuits and disciplinary proceedings.”<sup>47</sup> We also argued that “physicians should work to ensure that abortion is available to all women who seek it, that the promise of reproductive

---

47 Sanda Rodgers and Jocelyn Downie, guest editorial, “Abortion: ensuring access” (July 4, 2006) 175(1) *CMAJ* 9.

choice is fulfilled and that initiatives to compromise access are resisted.”<sup>48</sup> The editorial was published on July 4, 2006. We were immediately targeted on right to life websites (the very day the editorial was put up on the *CMAJ* website, negative notices about it, and us, went up on various right to life websites). This reaction was not a surprise. But what came next was.

### Where was Editorial Independence?

In February 2007 (more than six months after the editorial was first published), the *CMAJ* printed a number of letters to the editor submitted in response to our editorial as well as our response to those letters. In our response we argued that, given the Canadian Medical Association Code of Ethics together with the Policy on Induced Abortion, “all physicians are under an obligation to refer” and “[the policy] does not allow a right of conscientious objection in relation to referrals.”<sup>49</sup> Given the realities of our health care system (e.g., the severe shortage of family physicians), without a referral, women face barriers and delays in access to abortion services. Failing to provide a referral thus violates the CMA policy provisions that “the patient should be provided with the option of full and immediate counselling services in the event of unwanted pregnancy”<sup>50</sup> and “there should be no delay in the provision of abortion services.”<sup>51</sup> Our response prompted an e-letter from Jeff Blackmer, the Executive Director of the Office of Ethics for the CMA in which he

---

48 *Ibid*

49 Sanda Rodgers and Jocelyn Downie, letter, “Access to abortion” (February 13, 2007) 176(4) *CMAJ* 494.

50 *Ibid*

51 *Ibid*

claimed we were mistaken in our claim that physicians have an obligation to refer. This letter was posted on the *CMAJ* website six days after our response to the first set of letters was published.<sup>52</sup> On April 24, 2007, another letter from Jeff Blackmer was published in the *CMAJ*.<sup>53</sup> This letter was headed "Clarification of the CMA's position concerning induced abortion." Blackmer offered no argument in support of his interpretation of the CMA policy. Nor did he indicate any process was followed within the CMA to arrive at that interpretation of the organization's policy. Merely holding the position of Executive Director of the Office of Ethics would not make one the final authority on the meaning of an organizational policy.

We were not given an opportunity to respond to Blackmer's April letter. Furthermore, his letter was accompanied by an "Editor's note" which stated "We received a large number of letters in response to the editorial by Rodgers and Downie, with particular regard to the CMA's policy on induced abortion. We asked the CMA to assist our readers by clarifying their position using a case-based example, which they have provided here. We will not publish any further letters on this topic, unless they present new information or state a new position on this matter."<sup>54</sup> In other words, they shut down an important policy debate and, contrary to convention in many academic journals (wherein authors are given an opportunity to respond to letters published in response to their articles), gave the CMA the "last word." It was particularly surprising they did this in this way given that, not less than a year earlier, the *CMAJ* had been embroiled in a serious controversy

with respect to its editorial independence from the CMA (and its subsidiary CMA Holdings Inc.).<sup>55</sup> Following a review of the controversy, the *CMAJ* Governance Review Panel (chaired by Dick Pound) recommended that "any response submitted from the CMA intended for publication in the *CMAJ* should go through the same process as all third-party submissions to the *CMAJ*."<sup>56</sup> The CMA officially accepted all recommendations made in the report and yet here the *CMAJ* provided a staff member of the CMA the opportunity to pronounce unchallenged on the interpretation of policy.

### Where were Journalistic Standards?

On May 5, 2007, the *National Post* ran a story by Anne Marie Owens with the headline "The a word. How did abortion, that most contentious of issues, become one that is simply not discussed publicly?" In this article, Owens stated "In their essay 'Abortion: Ensuring Access', law professors Sanda Rodgers and Jocelyn Downie misstated what turns out to be a key aspect of the Canadian Medical Association's moral compromise on the issue: the physicians' conscientious objector status and the referral of patients desiring an abortion."<sup>57</sup> Although she clearly spoke with Jeff Blackmer, Ms Owens never

52 Jeff Blackmer, e-letter, "Clarification of CMA Policy" (February 19, 2007) *CMAJ*.

53 Jeff Blackmer, letter, "Clarification of the CMA's position concerning induced abortion" (April 24, 2007) 176(9) *CMAJ* 1310.

54 "Editor's Note" to *ibid.*

55 The *CMAJ* Editor-in-Chief and senior deputy editor were fired and most of the *CMAJ*'s editorial board resigned in protest over the firing and concerns about editorial independence of the *CMAJ* from the CMA. See, for example, Peter Singer and Gordon Guyatt, "Deeper lessons from the *CMAJ* debacle" (May 2006) *The Lancet* 367(9522) 1551-1553.

56 *CMAJ* Governance Review Panel Final Report, [www.cmaj.ca/pdfs/GovernanceReviewPanel.pdf](http://www.cmaj.ca/pdfs/GovernanceReviewPanel.pdf) (date accessed February 25, 2009) Recommendation 25 at 41.

57 Anne Marie Owens, "The a word. How did abortion, that most contentious of issues, become one that is simply not discussed publicly?" (May 5, 2007) *National Post* available at <http://www.nationalpost.com/news/story.html?id=c9fb6309-0a11-4951-b859-f1f5135915b8&p=1> (date accessed February 24, 2009)

called Sanda or me for comment. Her unexamined claim that we “misstated” or “misrepresented” CMA policy has since been repeated a number of times in various journals and newspapers—none of whom have contacted us to ask for an explanation or defence of our interpretation of CMA policy (which we would, of course, gladly have provided).

## Where was Respect for Academic Freedom?

Some months later, our editorial surfaced again. In August 2007, my Dean (and Sanda’s Dean) received a letter in the mail from Paul Steckle and Maurice Vellacott, the Liberal and Conservative Co-Chairs of the Parliamentary Pro-Life Caucus, signed as Co-chairs of the PPLC and as members of the federal parliament. The letter to the deans began “[i]t has come to our attention that a faculty member of the Dalhousie Law School, Professor Jocelyn Downie [Professor Rodgers in the letter to her Dean], has made false claims in an editorial published by the Canadian Medical Association Journal regarding the legal status of abortion in Canada.”<sup>58</sup> It went on to claim we were “wrong” and concluded:

*We are concerned that Professor Downie [Professor Rodgers in the letter to her Dean] has presented a false statement as truth. It is particularly disturbing coming from a professor of law who will be perceived by the uninformed as authoritative on legal matters—in this case, the legal status of abortion in Canada, and particularly the question of a constitutional ‘right to abortion’. We respectfully ask that you take the necessary steps to ensure that your Faculty members—who have tremendous power to influence the minds of our future lawyers and doctors—not allow their own personal*

*biases to impair their ability to accurately represent the law.*<sup>59</sup> (emphasis added)

Fortunately, my Dean responded forcefully in defence of Sanda and me and the position we had taken on the law and, most importantly, the principle of academic freedom:

*Universities operate on the principle of academic freedom, and in my view the editorial written by Professors Downie and Rodgers falls squarely within the appropriate exercise of that freedom, commenting as it does on an important matter of public and legal debate. It is essential that they be able to do so free of political or administrative interference. You and others are of course free to present contrary arguments, but any attempt by me to take what you call “necessary steps” to prevent the expression of such views would clearly violate the academic freedom of faculty members.*

*Entirely apart from the issue of academic freedom, I also note that you have suggested that Professor Downie and Professor Rodgers have made what you call “false claims”, have presented “a false statement as truth” and allowed “personal biases” to affect their legal analysis. I do not see any factual basis for these assertions. It is clear that you disagree with the arguments and views they have presented, but that in itself is not a basis for the serious allegations you have made in your letter.*<sup>60</sup>

## The Coda

Obviously neither Sanda nor I were silenced by the events that followed the publication of our editorial. However, I was shocked and disappointed by the actions of the journal, journalists, and parliamentarians. Clearly legal

58 Letter from Paul Steckle and Maurice Vellacott to Phillip Saunders, August 14, 2007.

59 *Ibid.*

60 Letter from Phillip Saunders to Paul Steckle and Maurice Vellacott (August 22, 2007).

academics working in politically charged contexts must continue to be ready for, and vigorously resist, attempts to shut down debate on important matters of public policy and interfere with academic freedom. The question is, will the journals, journalists, and members of parliament step back from the political fray and adhere to the journalistic and ethical standards and values that should guide their conduct?



# **Canada from an International and Comparative Perspective**



# Canada from an International and Comparative Perspective

Katherine McDonald, Action Canada for Population and Development

*The following is a synopsis of the Power Point presentation given by Katherine McDonald.*

## Abortion Rights in International Law

- Right to non-discrimination and equality
- Right to health
- Right to life
- Right to liberty and security of the person
- Right to decide on the number and spacing of children
- Right to freedom of conscience and religion

## International Law

- Treaties and conventions signed and ratified by States
- Customary international law
- General principles of law
- Judicial decisions, legal scholars

## Human rights treaties

1. International Covenant on Civil and Political Rights (ICCPR): CCPR Committee
2. International Covenant on Economic Social and Cultural Rights (ICESCR): CESCR Committee
3. Convention to Eliminate All Forms of Discrimination Against Women (CEDAW): CEDAW Committee
4. Convention to Eliminate All Forms of Racial Discrimination (CERD): CERD Committee
5. Convention Against Torture (CAT): CAT Committee

6. Convention on the Rights of the Child (CRC): CRC Committee

## First Provision on Abortion in a Human Rights Instrument

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa:

*“Protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, and where continued pregnancy endangers the mental and physical health of the mother or the life of the mother or foetus”*

## Treaty Bodies Hold States to Account

States that have ratified the treaty report to the treaty body. Treaty bodies issue:

- General recommendations
- Specific comments (concluding observations a or comments)
- Precise and concrete standards

## 275 Concluding Observations on Abortion Identifying Multiple Rights Violations

Such as...

- Right to life
- Right to health
- Non-discrimination and equality
- Right to liberty and security of the person
- Right to be free from cruel, inhuman and degrading treatment
- Right to freedom of conscience and religion

### **Concluding Observations: CCPR Committee Right to Life**

- Unsafe abortion as a cause of maternal mortality = 8
- Restrictive abortion laws as violating human rights = 27
- Amend laws to permit abortion in certain circumstances = 15
- Abortion as a means of family planning = 2
- Inappropriate use of conscientious objection = 2,
- TOTAL = 42

### **Right to Health**

The right to health is found in four international treaties with the exception of the ICPPR and Torture Convention

- All except CERD define the right to health in relation to abortion
- Condemned restrictive abortion laws as a violation of women's human rights

### **Concluding Observations: CESCR**

- Decrease use of abortion as means of family planning = 6
- Link between high maternal mortality rate and unsafe abortion = 20
- Urge states to amend laws to permit abortion in certain circumstances = 4
- Inappropriate use of conscientious objection = 2
- Permit therapeutic abortion = 2
- TOTAL = 43

### **Concluding Observations from CEDAW**

- Unsafe abortion as cause of high maternal mortality rate = 28
- Derides abortion as means of family planning = 19
- Critique sex selection = 2
- Review restrictive abortion legislation = 16
- Where abortion legal ensure services = 7
- Conduct national dialogue = 3
- TOTAL = 92 to 81 countries

### **Concluding Observations from CRC**

- High incidence of teen pregnancy and abortion = 33
- High incidence of maternal mortality due to unsafe abortion = 15
- Abortion as a means of family planning = 15
- Sex selective use of abortion = 2
- Deploring lack of data on teen pregnancy, maternal mortality and abortion = 16
- Permit abortion in cases of rape and incest = 2
- TOTAL = 60 to 66 States

### **Conclusion**

Restrictive laws that force women to risk their lives and health through resort to unsafe abortion constitute violations of women's rights to life and to health.





# Appendices



## Appendix 1: Symposium Programme

The Faculty of Law, University of Toronto and the National Abortion Federation Present

A Symposium to Mark the 20th Anniversary of R v. Morgentaler

### Of What Difference: Reflections on the Judgment and Abortion in Canada Today

Friday, January 25, 2008  
9:00am–5:00pm  
Faculty of Law, University of Toronto

This interdisciplinary symposium celebrates the twenty year anniversary of R v. Morgentaler, the Supreme Court case in which the criminal law on abortion in Canada was held unconstitutional. The symposium examines the significance of the judgment twenty years on. What difference has it made to women, providers and the politics of abortion in Canada?

#### REGISTRATION AND LIGHT BREAKFAST

(8:30–9:00am)

#### WELCOMING REMARKS

(9:00–9:30am)

**Dean Mayo Moran**  
*Faculty of Law, University of Toronto*

**Vicki Saporta**  
*National Abortion Federation*

**Colleen Flood**  
*CIHR—Institute of Health Services and Policy Research, Faculty of Law, University of Toronto*

**Dr. Henry Morgentaler**

#### THE CONTEXT: FROM MORGENTALER TO ABORTION IN CANADA TODAY

(9:30–10:30am)

**R v. Morgentaler: Charter Rights and Abortion**  
Lorraine Weinrib  
*Faculty of Law, University of Toronto*

#### Post-Morgentaler Challenges: From Crime to Health

Joanna Erdman  
*Faculty of Law, University of Toronto*

#### Abortion in Canada Today: Who, What and Where?

Dawn Fowler  
*National Abortion Federation, Canada*

#### RIGHTS IN PRACTICE: BARRIERS TO AVAILABLE AND ACCESSIBLE CARE

(10:45–12:15pm)

#### Geography: Variation Across the Country

Sheila Dunn  
*Bay Centre for Birth Control, Department of Family and Community Medicine, Women's College Hospital, University of Toronto*

#### Law: Facilitating and Impeding Access

Sandra Rodgers  
*Faculty of Law, University of Ottawa*

#### Better Never Than Late, But Why?: The Contradictory Relationship between Law and Abortion?

Shelley Gavigan  
*Osgoode Hall Law School, York University*

#### Information Failure: An Ontario Case Study

Lorraine Ferris  
*Faculty of Medicine, University of Toronto*

**LUNCH WITH STUDENT POSTER PRESENTATIONS**

(12:15–1:15pm)

**When Freedom Fails: Free Speech and Women’s Right to Safe Abortion in the Philippines**

Carolina S. Ruiz Austria  
*Faculty of Law, University of Toronto*

**The Other Morgentalers**

Chris Kaposy  
*Dalhousie University*

**Permitted Exceptions to Abortion Law in Brazil: Helpful or Harmful?**

Keri Bennett  
*Faculty of Law, University of Toronto*

**OUR PROVIDERS: THE CHALLENGES OF THEIR WORK**

(1:15–2:45pm)

**Challenges of Providing Abortion Care: A Provider’s Perspective**

Konia Trouton  
*Vancouver Island Women’s Clinic*

**Why I Do This? Being a Provider**

Gary Romalis  
*The Elizabeth Bagshaw Women’s Clinic, Vancouver*

**The New Generation: Abortion in Medical Schools**

Pat Smith  
*Grand River Hospital, Kitchener and NAF and NAF Canada*

**ABORTION IN LAW AND POLITICS**

(3:00–4:30pm)

**The Role of Media in the Abortion Debate**

Heather Mallick  
*Journalist and author*

**The Politics of Abortion: The Work of the Politician**

Carolyn Bennett  
*Hon. Carolyn Bennett MD. MP St. Paul’s*

**Legal Reform in a Politically Charged Context**

Jocelyn Downie  
*Faculty of Law, Dalhousie University*

**CANADA FROM AN INTERNATIONAL AND COMPARATIVE PERSPECTIVE**

(4:30–5:00pm)

**Canada from an International and Comparative Perspective**

Katherine McDonald  
*Action Canada for Population and Development*

**SYMPOSIUM CONCLUSION AND THANKS**

## Appendix 2: Presenter Biographies

The Honourable, **Dr. Carolyn Bennett, PC, MP**, was first elected to the House of Commons in 1997 and re-elected in 2000, 2004 and 2006 representing the Toronto riding of St. Paul's. Carolyn has served as Opposition Critic for Social Development, a portfolio that includes social policy areas such as child care, people with disabilities, homelessness and housing. Carolyn also served as the Vice Chair on the Standing Committee on Health and sat on the Standing Committee on National Defense and traveled with the Committee in January 2007 to Afghanistan. Presently Carolyn is the Opposition Critic for Public Health, Seniors, Canadians with Disabilities and the Social Economy Portfolio. Dr. Bennett obtained her degree in medicine from the University of Toronto in 1974, and received her certification in Family Medicine in 1976.

Prior to her election, Dr. Bennett was a family physician and a founding partner of Bedford Medical Associates in downtown Toronto. She was President of the Medical Staff Association of Women's College Hospital and Assistant Professor in the Department of Family and Community Medicine at the University of Toronto. Dr. Bennett served on the Boards of Havergal College, Women's College Hospital, the Ontario Medical Association, and the Medico-Legal Society of Toronto.

**Jocelyn Downie** holds a Canada Research Chair in Health Law and Policy and is a Professor in the Faculties of Law and Medicine at Dalhousie University. Jocelyn received an honours BA and MA in Philosophy from Queen's University, an MLitt in Philosophy from the University of Cambridge, an LLB from the University of Toronto, and an LLM and doctorate in law from the University of Michigan. After

graduation from law school, she clerked for Chief Justice Lamer at the Supreme Court of Canada.

Jocelyn's work is geared to contributing to the academic literature and affecting change in health law, policy, and practice in a variety of areas. Past work has explored assisted death, organ donation and transplantation, and the governance of research involving humans. She has just embarked upon a new program of research focusing on legal determinants of women's health and relational theory—both of which have significant potential implications for abortion law and policy in Canada.

**Sheila Dunn MD, MSc, CCFP(EM), FCFP** is an Associate Professor in the Department of Family and Community Medicine at the University of Toronto. She works as a family physician at Women's College Hospital and is the Research and Program Director at the Bay Centre for Birth Control, a large sexual health clinic for women. She is involved in undergraduate, graduate and post-graduate teaching in women's health, abortion and family planning, sexually transmitted infections, and office gynecology. Her research interests include new contraceptive methods, provision of contraceptive care, medical abortion, and access to emergency contraception.

**Joanna N. Erdman** is the Co-Director of the International Reproductive and Sexual Health Law Programme and Director of the Health Equity and Law Clinic at the Faculty of Law, University of Toronto. Joanna has published in the areas of access to reproductive health care, Canadian health care policy and human rights law. Her primary scholarship concerns sex and

gender discrimination in the regulation, structure, and financing of health care systems. Joanna obtained her B.A. and J.D. from the University of Toronto and her LL.M. from Harvard Law School. Joanna is a member of the Law Society of Upper Canada.

**Lorraine E. Ferris** is a Professor of Public Health Sciences in the Faculty of Medicine, U of Toronto and a Senior Scientist, Clinical Epidemiology Unit, Sunnybrook Health Sciences Centre and in the Institute for Clinical Evaluative Sciences (ICES), Toronto, Ontario. She has a PhD in Psychology, is licensed to practice (C.Psych.), and holds two Masters of Laws degrees (LLM, LL.M). Dr Ferris focuses on women's health, health services research, and medico-legal issues, especially issues concerning public protection, standards of care, confidentiality, regulation, and research environments. She is currently the Principal Investigator, Studies on Access to Abortion Services in Ontario (SAAS) funded by the Ontario Women's Health Council. Ten years ago, she was the Principal Investigator of the Studies on Access to Therapeutic Abortion Services (SATA) funded by the Ontario Ministry of Health and Long-Term Care that provided the first provincial comprehensive picture of access to abortion services through an analysis of primary and secondary data.

**Colleen M. Flood** is a Canada Research Chair in Health Law and Policy. She is also the Scientific Director of the Canadian Institutes for Health Research, Institute of Health Services and Policy Research. She is also an Associate Professor of Law at the University of Toronto and is cross-appointed into the Department of Health Policy, Management and Evaluation and the School of Public Policy. Professor Flood obtained her B.A. and LL.B. (Honours)

from the University of Auckland, New Zealand and her LL.M. and SJD from the University of Toronto, Canada. Her primary area of scholarship is in comparative health care policy, public/private financing of health care systems, health care reform, and accountability and governance issues more broadly. She has been consulted on comparative health policy and governance issues by both the Senate Social Affairs Committee studying health care in Canada and by the Commission on the Future of Health Care in Canada (the Romanow Commission). She is the author of numerous articles, book chapters, and reports as well as the author and editor of five books.

**Dawn Fowler** is the Canadian Director for the National Abortion Federation. This newly created position started in 2006 and Dawn has been working on trying to have abortion included on the inter-provincial billing agreement and to ensure that physicians have to provide a referral for abortion care when a woman requests such care. She worked at Health Canada for 11 years as Chief of Reproductive and Child Health and developed Canada's Perinatal Surveillance System which included abortion. Dawn also headed up the Health Surveillance Division and created the women's health surveillance system. Dawn also worked as a consultant with WHO—EURO Office and worked on reproductive health and quality assurance issues in the newly independent states of the former Soviet Union. Upon her return to Canada she organized the opening of a new abortion clinic in Victoria, British Columbia and became its Manager.

**Shelley A.M. Gavigan** is an Associate Professor and member of the faculty of Osgoode Hall Law School and the Graduate Programs in Sociology and Women's

Studies at York University. She joined the faculty of Osgoode Hall Law School in Toronto in 1986 and is currently serving her third term as Academic Director of Parkdale Community Legal Services in Toronto. She was Associate Dean of Osgoode Hall Law School from 1999 to 2002, and Osgoode's Director of Clinical Education from 2004 to 2006. Her publications include the book, *The Politics of Abortion*, with Jane Jenson and Janine Brodie (Oxford, 1992). Her recent research includes a doctoral project, "Criminal Law on the Aboriginal Plains: The First Nations in the First Criminal Court in the North-West Territories, 1870–1903;" a community-based project on access to justice for low income and marginalized youth, in collaboration with colleagues in clinical legal education at Osgoode and the Faculty of Education at York University.

**Heather Mallick**, who writes for CBC.ca as well as the Guardian online, has written about abortion rights throughout her journalism career. She has been nominated four times for National Newspaper Awards, winning for Critical Writing and Feature Writing. She has worked at the Toronto Star, The Financial Post, The Sunday Sun in Toronto and As If columnist in the Review section and Focus section of the Globe and Mail. Last spring, Knopf Canada published the paperback version of her second book, a collection of essays on surviving in the Bush era called *Cake or Death*. In 2007, she gave the annual Hurtig lecture at the University of Alberta on the threat to Canada as it allows itself to be taken into the American sphere.

**Katherine McDonald, LL.B., LL.M.**, is the first Executive Director of Action Canada for Population and Development, which was formed in 1997. ACPD is a human rights advocacy organization that seeks to enhance the quality of life of women, men

and children by promoting progressive policies in the field of international development with a primary focus on reproductive and sexual rights and health and an emerging focus on international migration and development.

Before joining ACPD Katherine McDonald practiced law for ten years, was the Executive Director of the Nova Scotia Public Legal Education Society, and President of the Nova Scotia Advisory Council on the Status of Women. She is a Past President of Planned Parenthood Federation of Canada, and a former member of the regional and international governing bodies of International Planned Parenthood Federation (IPPF).

**Sanda Rodgers, B.A., LL.B., B.C.L., LL.M.** is a professor and former Dean of the Faculty of Law, University of Ottawa. She holds the Shirley Greenberg Chair in Women and the Legal Profession. She has been a Bencher of the Law Society of Upper Canada and Commissioner of the Ontario Law Reform Commission and is a recipient of the Women Lawyers Association President's Award for Outstanding Contribution to the Legal Profession and of the Business and Professional Women's Association of Ottawa Women's Choice Award for Outstanding Contributor to Gender Equity.

**Garson Romalis, MD, FRCSC, FACOG** is on the Honorary Staff of the Vancouver General Hospital and the Active Staff of BC Women's Hospital, and is the Medical Director of the Elizabeth Bagshaw Women's Clinic. He graduated from the University of British Columbia Medical School in 1962. Gary served his rotating internship and Ob/Gyn residency at Cook County Hospital in Chicago from 1962–1966. Gary did further residency training in general

surgery, pathology, and gynecologic cancer at the Vancouver General Hospital from 1967–1968.

Gary has been in the private practice of Ob/Gyn, including abortion services, in Vancouver since 1972. Gary has survived to two murder attempts in 1994 and 2000 in connection with abortion. Since 2000 he has limited his practice to the provision of abortion services.

**Vicki Saporta**, President and CEO of the National Abortion Federation. Under Vicki's direction, the National Abortion Federation has played a critical role in promoting and preserving women's access to safe, legal abortion care. Since taking the helm in 1995, Vicki developed a public policy program that brought abortion providers and the women they serve into the forefront of the public debate about abortion; guided NAF in setting the standard for quality abortion care in North America; led the introduction of medical abortion (RU-486) in the U.S.; and broadened NAF's outreach and direct assistance to underserved women. Vicki is an expert on public policy issues, reproductive health, and anti-abortion violence.

**Pat Smith, MD** is a family doctor by training and has been an abortion provider for 16 years. She has provided care in a variety of settings, including a large academic medical centre, small community hospitals and free standing clinics. She is very interested in training new providers and works closely with residents and medical students. Pat has been on the Board of Directors of the National Abortion Federation for 8 years and is currently the Chair of the Board. While on the Board of NAF Pat has worked on the Medical Education, Clinical Policy Guidelines, and Quality Assessment and Improvement

Committees. She is also the current Chair of the Board of Directors of NAF Canada. Pat participated in the NAF international program, training physicians to use manual vacuum aspiration in Russia. She has worked with Medical Students for Choice in Canada and the United States and has been a speaker at many of their meetings. She was the faculty advisor for the first Canadian group when it formed in Hamilton.

**Konia Trouton MD, CCFP, FCFP, MPH** is the medical director of the Vancouver Island Women's Clinic, which she established with her partner in 2004. She has worked for over 15 years providing pregnancy terminations in 5 provinces and territories. She offers medical abortions with methotrexate and misoprostol, and surgical terminations to 20 weeks. Konia does research and provides workshops on abortion and reproductive health topics. She particularly enjoys regular teaching opportunities with midwives, nurses and doctors through her appointment as a clinical associate professor with UBC and UVIC.

**Lorraine E. Weinrib** was appointed to the Faculty of Law and the Department of Political Science of the University of Toronto in 1988. Previously, she worked in the Crown Law Office—Civil, Ministry of the Attorney General (Ontario), holding the position of Deputy Director of Constitutional Law and Policy at the time of her departure. Her work included legal advice and policy development on constitutional issues, as well as extensive litigation, frequently in the Supreme Court of Canada. At the Faculty of Law, Professor Weinrib teaches the first year constitutional law course as well as advanced courses on the Charter, constitutional litigation, and comparative constitutional law.



Her writing, in which she advocates the institutional coherence of the Charter, includes articles on the interpretation of sections 1 and 33, the theoretical dimension of the Supreme Court of Canada's Charter jurisprudence, the process leading up to the 1982 amendments to the Constitution, and studies of leading cases, e.g., Morgentaler (abortion), Ford (override), Keegstra (hate promotion) and Rodriguez (assisted suicide). Professor Weinrib holds law degrees from Yale and Toronto, and an undergraduate degree from York.





