

BARRIERS TO ACCESS TO ABORTION THROUGH A LEGAL LENS

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Introduction

In addressing whether the procedure for obtaining abortions was operating equitably across Canada, the 1977 Badgley Report concluded that for many women, access to abortion was “practically illusory.”¹ Sadly, although abortion on request became legally permissible for Canadian women in 1988, access to a safe and legal abortion remains practically illusory for many women today. A woman seeking an abortion in Canada must overcome numerous barriers. She must find a way to secure for herself some of the limited resources that our health care system provides for abortion. She must also expend her own, often scarce, personal resources: her time, her money, and her emotional energy. Access is also compromised by other factors such as the lack of information, support, and privacy.

In this paper, we will examine both legal and non-legal barriers to abortion through a legal lens. That is, we will provide a comprehensive description of the multitude of systemic, personal, and other barriers that have been identified in various places in the literature and then explore ways in which law could be used to deconstruct these barriers. The ultimate goal is to contribute to the development of legal strategies aimed at achieving meaningful access to abortion for all women in Canada.

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1 *The Report of the Committee on the Operation of the Abortion Law* (Ottawa: Ministry of Supply and Services Canada, 1977) (Chair: Robin Badgley).

1. Barriers

For a variety of reasons, it is important to comprehensively review the barriers to abortion before launching into a consideration of possible responses to the barriers. First, there is no single source that has brought together in one place an up-to-date and complete description of all of the barriers to access to abortion faced by Canadian women. Second, we need to reawaken the generations who fought for the *Morgentaler*² decision and believe, mistakenly, that access was won through that case. Third, we need to awaken the generations who were children at the time of the *Morgentaler* decision and grew up without any awareness of a time when many abortions were illegal and access egregiously denied. The objective of this section is to help the reader share the experience faced by many women seeking abortions in Canada as they are blocked at all turns and, thereby, to educate and motivate for change.

a. Systemic resources

The majority of abortions in Canada are performed in hospitals³ and women seeking abortions in hospital can find themselves blocked by referral requirements or preferences. At a number of Canadian hospitals, a heavy emphasis is placed on physician referral prior to obtaining an abortion.⁴ Obtaining the referral can be difficult for women who do not have a primary care physician or family doctor; while the number of family physicians per capita in Canada has remained relatively constant, only 20% of these physicians accept new patients.⁵ It is estimated that Canada is short 3000 general practitioners, and that a further 1400 will retire by 2007.⁶ This shortage creates delays and

2 *R. v. Morgentaler*, [1988] 1 S.C.R. 30, 62 C.R. (3d) 1 [*Morgentaler*].

3 Statistics Canada, *Induced Abortion Statistics 2003* (Ottawa: 2006) at 10-12, online: Statistics Canada <<http://www.statcan.ca/english/freepub/82-223-XIE/82-223-XIE2006000.pdf>>.

4 Canadian Abortion Rights Action League, *Protecting Abortion Rights in Canada: A Special Report to Celebrate the 15th Anniversary of the Decriminalization of Abortion* (Ottawa: Canadian Abortion Rights Action League, 2003) [CARAL].

5 National Physicians Database, *Full-time Equivalent Physicians Report* (Ottawa: Canadian Institute for Health Information, 2006) at 31.

6 College of Family Physicians of Canada, "The Family Physician Shortage," online: C.Health <http://chealth.canoe.ca/channel_section_details.asp?text_id=29946&channel_id=7&relation_id=3621>.

waiting lists for access to family physician services and consequently hinders women's ability to obtain referrals.⁷ This is a particularly acute problem for women in rural areas.

There are also reports of women who do have a primary care physician, but who discover that their doctor is anti-choice when they try to get a referral. As well as refusing to provide them with a referral, women have reported that their doctors have actively tried to block their attempts to obtain a referral elsewhere, either by lying about the legality of abortion, delaying tests until the pregnancy is too advanced for the procedure, or by pretending that they have sent a referral when in fact they have not done so.⁸ Some anti-choice doctors have threatened to deny women and their families future medical attention should they continue to seek an abortion.⁹ Some women are afraid to anger their anti-choice primary care physicians by asking for or insisting upon a referral, because the shortage of general practitioners in Canada makes it difficult to find a family doctor. In some communities, there might only be one doctor.

Many women are also not aware of alternative channels for physician referrals, such as sexual health and family planning centres. Many hospitals tell women only that they need to see their own doctor before they can be admitted, and neglect to mention these alternatives.¹⁰

It should be noted here that it is often possible to self-refer to a free-standing clinic (and thereby to avoid the referral barriers in some hospitals). However, many women do not have the financial resources to access clinic services or they live in an area of the country where they cannot physically reach a clinic. Some women would simply prefer to have their abortion done in a hospital, because of the broader range of sedation options or techniques available or because they perceive hospitals to have a higher level of expertise.¹¹ When they cannot obtain a referral, this option is more often closed to them.

Even in circumstances where a woman is able to get a referral or to self-refer to a hospital abortion provider, hospital abortions may only be avail-

7 CARAL, *supra* note 4.

8 *Ibid.* at 9.

9 CARAL, *supra* note 4.

10 *Ibid.* at 11; see also Ferris et al., "Factors Influencing the Delivery of Abortion Services in Ontario: A Descriptive Study" (1998) 30(3) *Family Planning Perspectives* 134 at 134-138 [Ferris].

11 CARAL, *supra* note 4.

able if a set of criteria are met and they are determined to have been met by one or more additional individuals. These criteria and assessment processes may be set out in provincial regulations or hospital policies. For example, in New Brunswick, a woman is not entitled to have her abortion paid for by the province unless the "abortion is performed by a specialist in the field of obstetrics and gynaecology in a hospital facility approved by the jurisdiction in which the hospital facility is located and two medical practitioners certify in writing that the abortion was **medically required**."¹²

In addition, even where a woman is able to get a referral or to self-refer to a hospital, she may be deterred by threats to her privacy: in many hospitals, women attempting to self-refer will be asked to provide identifying details to administrative staff before they are granted information that will allow them to access a provider.¹³ A woman who feels she requires anonymity may be unwilling to volunteer that information and therefore be unable to self-refer. Women have also reported being greeted with suspicion when attempting to contact abortion providers without a referral. Some providers are unwilling to disclose information about their practices over the phone because they fear harassment, limiting a woman's ability to obtain services without going through her doctor.¹⁴

Human resource problems in the health care system can also have a direct effect on the accessibility of abortion. When there are not enough providers to meet the demand, some women will inevitably be unable to obtain abortions. It is quite clear that, in many parts of Canada, there are simply not enough providers. For example, there are only two hospital-based providers in New Brunswick, no providers in PEI, one provider in the Yukon, and one willing provider in Nunavut (but the hospital in which this provider was performing abortions has lost its accreditation).¹⁵

One reason that doctors may be unwilling to provide abortions is the fear of anti-choice harassment and violence that plagues abortion practice. In the US and Canada, there have been over 15,000 reported incidents of violence against medical professionals and staff associated with abortion provision in

12 *Medical Services Payment Act*, R.S.N.B. 1973 (Reg. 84-20), c. M-7, s. 2(a.1) [emphasis added].

13 CARAL, *supra* note 4.

14 *Ibid.*

15 Personal communication Dawn Fowler, Canadian Director, National Abortion Federation (February 2007).

the last thirty years.¹⁶ In the late 1990s, three Canadian abortion providers were shot by anti-choice activists.¹⁷ Abortion providers routinely experience harassment and intimidation at their places of business and at their homes. The threat of harassment, compounded by the sense that the government and law enforcement officials will not provide adequate support to prevent this harassment, has led providers to cease performing abortions.¹⁸ The fear of violence and harassment also deter many students from becoming providers, or even learning how to perform the procedure.¹⁹

The potential for violence and harassment makes privacy a major issue for abortion providers.²⁰ Abortion providers face threats to their privacy due to anti-choice activists' attempts to "unmask" them. Doctors describe anti-choice activities such as distributing pamphlets to their neighbours to warn them that they are living near an abortion provider.²¹ When they feel that their profession has encroached too much on their home life or has caused their families and children to be victimized by threats and harassment, some doctors cease providing abortions.²² Privacy issues seem to be particularly deterrent to physicians considering providing abortion services in small communities.²³

Some doctors also seem to be unwilling to become providers because of financial considerations. Provision of abortions is not a lucrative area of practice and tends to lack non-pecuniary 'rewards' as well.²⁴ Canadian medical students seem to be choosing instead areas of practice which offer prestige and greater quality of life as well as greater financial rewards.²⁵ This

16 Medical Students For Choice, *Fact Sheet: The Lack of Abortion Training and Providers in Canada*, online: Medical Students For Choice <http://www.ms4c.org/ca_factsheet.pdf> [Medical Students]; see also Ferris, *supra* note 10.

17 Anne Mullens, "7:10, November 8, 1994" (1998) 158(4) C.M.A.J. 528 at 528 [Mullens].

18 *Ibid.* at 529; see also Ferris, *supra* note 10.

19 *Ibid.*

20 Medical Students for Choice, "Home," online: Medical Students For Choice <<http://www.ms4c.org>>.

21 Ferris, *supra* note 10.

22 Mullens, *supra* note 17.

23 *Ibid.*

24 *Ibid.* at 529.

25 The College of Family Physicians of Canada, "Disappointing Numbers of Students Choosing Family Medicine," (2003), online: The College of Family Physi-

problem is compounded by the perception that providers face poor working conditions due to overwork, because there are not enough other providers, and stress, due to harassment and the potential of violence.²⁶

Yet another reason for the shortage of abortion providers is that many doctors who are willing to provide abortions are only willing to do so up to a certain point in the pregnancy. Reported gestational limits in place in Canada range from 10-23 weeks²⁷ and are determined by a number of factors, including individual physician and staff preferences and hospital policies (written and unwritten). The number of providers willing and able to provide later-term abortions is much lower than those willing to perform abortions in the first trimester.²⁸ As a woman's pregnancy progresses, she may exceed the period in which local abortion providers are willing to operate. This negatively affects the number of providers a woman can access, or whether she can access services at all, particularly if she lives outside of an urban area.²⁹

The shortage of abortion providers in Canada can also be attributed to the fact that while some doctors might be willing to be providers, they are not able because they lack training. Doctors in Canada do not routinely learn how to perform abortions, the nature of the procedure somehow relegating it to optional status. Canadian medical schools, on average, spend less than one hour over the four year curriculum discussing abortion techniques.³⁰ Moreover, 18% of hospitals that provide abortion services indicate that their physicians and staff do not receive any further abortion training once they have left medical school.³¹ Many doctors therefore do not have the skills

cians of Canada <<http://www.cfpc.ca/>>; see also Wright et al., "Career Choice of New Medical Students at Three Canadian Universities: Family Medicine Versus Specialty Medicine" (2004) 170(13) C.M.A.J. 1920.

26 Ferris, *supra* note 10.

27 *Ibid.* and CARAL, *supra* note 4; see also Laura Eggertson, "Abortion in Canada: A Patchwork Quilt with Many Holes" (2001) 164(6) C.M.A.J. 847 [Eggerton]; see also Robert P. Kouri, "Emergency Oral Contraception and Abortion in Quebec" in Colleen M. Flood, ed., *Just Medicare: What's in, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) at 173 [Kouri].

28 CARAL, *supra* note 4.

29 *Ibid.*

30 Atsuko Koyama & Robin Williams, "Abortion in Medical School Curricula" (2005) 8(2) M.J.M. 157 at 159; see also Medical Students, *supra* note 16.

31 Ferris, *supra* note 10.

necessary to perform abortion services, and if they wish to develop them, they have to seek out training because the framework for training providers is absent in teaching hospitals.³² The number of available providers is further diminished because doctors who do learn abortion techniques are often limited by their training to certain types of procedures, which can in turn lead to self or externally imposed gestational limits on their practice.³³

However, the shortage of doctors able to provide abortions is not attributable only to the fact that new providers are not being trained. It is also the result of the fact that many current providers are ageing and retiring. This “graying” phenomenon has been a source of great concern among Canada’s current abortion providers, as the number of new abortion providers being trained is not adequate to counter this attrition. One explanation offered for this phenomenon is that most physicians who are currently being trained have never experienced a time when abortions could not be obtained legally. “Graying” physicians describe fears that, without the spectre of the results of illegal abortions, new doctors lack the moral impetus that years back compelled them to become providers.³⁴

Apart from ageing, there is also the phenomenon of urbanization. Increasingly, willing abortion providers live in urban centres and there is a shortage of providers in rural and remote areas throughout Canada. If a region’s sole provider leaves practice and migrates to another part of the country, the women in that area lose their access to abortion information and services. The general shortage of rural doctors in Canada then means that when regions lose their sole provider, it can be very difficult to recruit another.³⁵

There are also problems with abortion providers’ access to operating facilities. The majority of abortion services in Canada are provided in teaching hospitals in which seniority is the predominant factor in determining which practitioners are granted operating room time.³⁶ Therefore, some provid-

32 Medical Students, *supra* note 16.

33 Ferris, *supra* note 10.

34 Mullens, *supra* note 17 at 530; see also *CARAL*, *supra* note 4.

35 The College of Family Physicians of Canada, “National Family Physician Survey Results Reported Widely Across Canada” *CFPC Headlines* (1 June 1998), online: The College of Family Physicians of Canada <<http://www.cfpc.ca/English/cfpc/communications/newsletters/cfpc%20headlines/vol%201%20issue%203/default.asp?s=1>>.

36 Marion G. Powell, “Ensuring Access to Abortion in an Era of Cutbacks” (1997) 156(11) *C.M.A.J.* 1545 at 1546.

ers cannot obtain sufficient operating room time to meet the demand for abortion services. If willing abortion providers cannot get hospital privileges, they are unable to provide the service, further decreasing the number of active abortion providers in Canada.

Women often discover, when attempting to obtain abortion services through the Canadian health care system, that a lack of facilities is a further significant systemic barrier to timely access. Hospitals do not have enough operating facilities available to meet the demand for abortions. Downsizing of staff, hospital closures and the delisting of certain services have had the effect of reducing general operating room hours and the availability of hospital personnel.³⁷ Hospitals grapple with competing priorities and limited resources, and expenditures for abortion often come second or worse to other funding priorities.³⁸ While some facilities which are capable of providing abortions do not do so for moral/ policy reasons, some simply do not provide abortions because of financial factors which affect all of the services offered in the hospital.³⁹ Cut-backs and funding issues are not unique to abortion services, but because of the low number of providers and some hospital policies already limiting access to operating facilities, abortion services are particularly limited by a lack of available operating facilities.⁴⁰

Canadian women who choose a hospital abortion, for financial or medical reasons, or because of personal preference, must often wait for services.⁴¹ In some cases, waiting lists can push a woman past the facility's gestational limits, requiring her to invest resources in traveling to another location to obtain an abortion.⁴² While free-standing clinics can relieve some of the burden on hospital facilities, in many areas hospitals are the only option.

Many women cite a preference for a clinic abortion, because they perceive the environment to be more supportive, the staff or techniques to be more expert, or privacy to be better maintained.⁴³ Free-standing clinics also afford the advantage of self-referral and a way to circumvent hospital wait lists and bureaucratic requirements. However, there are no free-standing

37 *Ibid.*

38 *Ibid.*; see also Kouri, *supra* note 27 at 173.

39 Ferris, *supra* note 10.

40 *Ibid.*

41 *CARAL*, *supra* note 4 at 6.

42 *CARAL*, *supra* note 4.

43 *Ibid.* at 10.

abortion clinics in PEI, Saskatchewan, Nunavut, the Northwest Territories, and Nova Scotia.⁴⁴

Before concluding this section on systemic barriers to abortion, a brief discussion of RU-486 is warranted. RU-486 is a combination of mifepristone, which stops fetal development, and misoprostal to induce contractions to expel the products of conception.⁴⁵ RU-486 makes abortion more widely available because it can be administered by nurses or midwives, with physician supervision. It can increase the number of individuals able to be providers, and the places in which abortion services can be offered, as well as the number of abortions that can be performed in any given facility.⁴⁶ As well, many abortion providers require that a woman wait until she is 5-6 weeks pregnant before performing vacuum aspiration, while medical abortion can be initiated as soon as the pregnancy is confirmed, diminishing access issues due to timing and travel.⁴⁷

However, despite these benefits, RU-486 is not yet legally available in Canada. While it is available in the United States and Europe, it has not been approved by the Canadian government. The problem does not appear to be legitimate concerns about safety or efficacy – there is sufficient data from Europe and the United States to prove the drug's safety and efficacy.⁴⁸ The legal barrier to legal mifepristone seems to be that the current program for drug approval consists only of drugs presented for approval by the manufacturer.⁴⁹ No manufacturer has yet applied to market mifepristone in Canada, likely because they fear anti-choice protest, but also because the application

44 Abortion Rights Coalition of Canada, "Home," online: Abortion Rights Coalition of Canada <<http://www.arcc-cdac.ca/>>.

45 Rachel K. Jones & Stanley K. Henshaw, "Mifepristone for Early Medical Abortion: Experiences in France, Great Britain and Sweden," online: The Alan Guttmacher Institute <<http://www.guttmacher.org/pubs/journals/3415402.html>> [Jones & Henshaw].

46 *Ibid.*

47 *Ibid.*

48 Health Canada, *Access to Therapeutic Products: The Regulatory Process in Canada* (Ottawa: 2006), online: Health Canada <http://www.hc-sc.gc.ca/ahc-asc/alt_formats/hpfb-dgpsa/pdf/pubs/access-therapeutic_acces-therapeutique_e.pdf>.

49 Barbara Sibbald, "Will Canada Follow US Lead on RU 486?" (2001) 164(1) C.M.A.J. [Sibbald]; *Food and Drug Act* R.S.C. 1985, c. F-27; *Food and Drug Regulations*, C.R.C., c. 870.

for approval costs between \$52 000 and \$117 000⁵⁰ and the annual number of Canadian abortions which would be eligible for mifepristone use may not be seen to be sufficiently lucrative.⁵¹

b. Personal resources

Gaining access to the limited abortion resources of the Canadian healthcare system is daunting for many women. However, when seeking an abortion, the barriers women face are not only systemic but also personal. One of the greatest obstacles that women face is the time required to obtain an abortion.⁵² Women who cannot access services in their own area must invest the time to travel to the urban centres where providers are located. Many women must prolong their stays in urban areas if preliminary services, such as ultrasounds, and follow-up care are not available in the woman's own community.⁵³ The time required to travel increases in proportion to the distance from the woman's home to an abortion provider and also in proportion to the requirements of the facility in which she is having the abortion.

Across Canada, the number of separate appointments an individual woman must have to obtain a hospital abortion varies between one and three, in order to accommodate consultations, ultrasounds, and examinations.⁵⁴ For example, in New Brunswick, a woman is required to obtain the approval of two different physicians before she can have her abortion funded by Medicare, a system similar to the therapeutic abortion committees which existed in Canada before 1988. This can present a significant time barrier to New Brunswick women. While in most clinics, women can obtain an abortion with a single appointment, if a hospital abortion is a woman's only option in some provinces, it can create difficulties regarding extended or multiple trips to major cities. This is especially problematic for women who live in remote communities and transient women.

50 Interview of Martin Bernard, Health Canada, Submission and Information Policy Division; see also Health Canada, online: <http://hc-sc.gc.ca/dhp-mps/alt_formats/hpfb-dgpsa/pdf/prodpharma/feef_fraisf_e.pdf>.

51 Jennifer LaLiberte, "Still no mifepristone for Canada: is it safe?," online: (2005) 2:16 National Review of Medicine <http://www.nationalreviewofmedicine.com/issue/2005/09_30/2_policy_politics02_16.html> [LaLiberte].

52 CARAL, *supra* note 4 at 8.

53 CARAL, *supra* note 4.

54 *Ibid.*

Travel expenses are also a major barrier women face when trying to access abortion services.⁵⁵ The cost of travel, like the time needed to travel, is compounded when women live in more remote areas or have to prolong their stays or make multiple trips because of waiting lists, or preliminary and follow-up care. There are no abortion services available in Nunavut or PEI, which means all women must travel out of the province and some must bear the costs of this travel.⁵⁶

Compounding the problem of cost is the fact that, in Canada, women are more likely than men to have minimum wage jobs, and are therefore less likely to be able to afford the travel or to take the time off work required for travel.⁵⁷ Poor women are habitually denied equal access to abortion services because they cannot afford to get to where the services are provided. Women who are parents or primary caregivers have additional costs and challenges associated with accessing abortion. They have to find and finance childcare while having the abortion; again, this is more costly and difficult when they must travel long distances or make multiple trips.

The cost of the abortion itself is also problematic for many Canadian women. As already noted, some women prefer to have, or only have the option of, an abortion in a clinic setting. Clinic abortions in Canada can cost from \$400 to \$1425.⁵⁸ In New Brunswick, the provincial government does not cover the cost of procedures done in clinics⁵⁹ and so, for many, the choice to have a clinic abortion is not financially feasible.⁶⁰ In British Columbia, where the cost of surgical abortions in clinics is covered, women seeking medical abortions in physicians' offices must cover the costs of the associated drugs. In Ontario, clinics were funded under the *Independent Health Facilities*

55 *Ibid.* at 8.

56 *Ibid.*

57 Statistics Canada, *Perspectives on Labour and Employment: Fact Sheet on Minimum Wage* (Ottawa: 2005) [Statistics Canada].

58 CARAL, *supra* note 4 at 9; see also Pro-Choice Action Network, "Home," online: Pro-Choice Action Network <<http://www.prochoiceactionnetwork-canada.org/abortioninfo/bc.shtml#costs>> [Pro-Choice].

59 National Abortion Federation, "Abortion Coverage by Region," online: National Abortion Federation <<http://www.prochoice.org/canada/regional.html>>; see also Eggerton, *supra* note 27.

60 Sanda Rodgers, "Abortion Denied: Bearing the Limits of Law" in Colleen M. Flood, ed., *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) at 117.

*Act*⁶¹ in 1990. However, in 1995 the Conservative government stopped funding for any new abortion clinics and services. Due to this change, women who seek to access abortions in clinics established after 1995 must pay up to \$600 for facilities fees not covered by OHIP, a burden not experienced by women with access to other facilities.⁶²

Even in provinces where the government does cover the full cost of abortions performed in clinics, women who are not insured by the provincial healthcare plan must pay for their own abortions.⁶³ Although in these provinces citizens and landed immigrants are covered by Medicare for clinic abortions, individuals in Canada on work or student visas are not. As well, some provinces, like British Columbia, have a requirement that individuals reside in the province for a minimum amount of time before they can be insured for an abortion.⁶⁴ This disadvantages students in particular.⁶⁵

Residents who live near provincial boundaries or live in provinces in which abortions are not available (e.g., PEI) face additional challenges with respect to the costs of an abortion. If the residents of one province live closer to medical facilities in an adjacent province than in their own, or if abortion services are simply not available at all in their province, they will often visit doctors out of province and hope to receive reimbursements from their own province's health insurance. The Inter-provincial Health Insurance Agreements Coordinating Committee (IHIACC) is responsible for the determination of what is included and excluded from the Interprovincial Reciprocal Billing Agreement. It is comprised of federal, territorial and provincial health officials⁶⁶ and all provinces participate in reciprocal hospital billing agreements and all provinces and territories except Quebec participate in reciprocal physician services billing agreements.⁶⁷ Abortion is on a list of services excluded from the Interprovincial Reciprocal Billing Agreement; interest-

61 *Independent Health Facilities Act*, R.S.O. 1990, c.I-3.

62 Canadian Federation For Sexual Health, "Abortion in Canada Today: The Situation Province by Province," online: Childbirth by Choice Trust <<http://www.cbctrust.com/provincebyprovince.php>> [Canadian Federation].

63 Canadian Federation For Sexual Health, "List of Providers," online: Childbirth by Choice Trust <<http://www.cbctrust.com/providers.php>>.

64 Pro-Choice, *supra* note 58.

65 CARAL, *supra* note 4.

66 Health Canada, *Canada Health Act Glossary of Terms* (Ottawa: 2006), online: Health Canada <http://www.hc-sc.gc.ca/hcs-sss/medi-assur/res/gloss_e.html>.

67 Abortion Rights Coalition of Canada, *Position Paper #4: Reciprocal Billing* (April

ingly, the other medical procedures excluded from the Agreement are elective procedures, experimental, or not time sensitive procedures.⁶⁸ The fact that abortion is on this list may reflect a perception that the procedure is not medically necessary and ignores the fact this it is very time sensitive.

Some jurisdictions appear to have negotiated bilateral agreements outside the Interprovincial Reciprocal Billing Agreement. This has resulted in a confusing patchwork. For example, Quebec has arranged inter-provincial billing for some hospital and physician services in Ottawa and North Bay but beyond that residents often have to pay upfront for out-of-province medical services. Furthermore, residents are only reimbursed the Quebec fee for the service, and so often end up paying for a significant portion of their own healthcare.⁶⁹ If a woman from Saskatchewan has an abortion in the Kensington Clinic in Alberta, the Clinic will direct bill the Saskatchewan government but if she has an abortion at the Peter Lougheed Hospital, she will have to pay for it herself and apply for reimbursement. If a woman from the Northwest Territories has an abortion in a hospital in another province, then that province will direct bill the government of the NWT. However, if she has it in a clinic, then she must explain why it must be done in a clinic and she must have prior approval from the government based on evidence about why it had to be done in a clinic.⁷⁰

The travel and costs associated with obtaining an abortion in Canada tax women's emotional as well as financial resources. For women living in remote or rural areas, travel to urban centres means separation from family, partners and support networks. It takes women away from their friends and family during what is often a stressful time and, as can be the case for example for women flying south from Nunavut, women may find themselves in an environment which is linguistically and culturally isolating.⁷¹ Furthermore, some women may be able to finance their own travel, but cannot afford to pay to have someone accompany them to an urban centre. This is

2006), online: Abortion Rights Coalition of Canada <<http://www.arcc-cdac.ca/positionpapers/04-Reciprocal-Billing.PDF>>.

68 Canadian Institute for Health Information, *National Physicians Database: Reciprocal Billing Report, Canada 2003-2004* (Ottawa: 2006) at 69.

69 Régie de l'assurance maladie Québec, "Services Covered Outside Quebec" online: Régie de l'assurance maladie Québec <http://www.ramq.gouv.qc.ca/en/citoyens/assurancemaladie/serv_couv_ext/au_canada.shtml>.

70 *Supra* note 15.

71 CARAL, *supra* note 4.

particularly problematic for young women who may be leaving their communities for the first time, and creates a barrier to access for women who are unwilling or unable to travel alone.⁷²

c. Other barriers

Although systemic and personal barriers are significant factors in determining whether a woman can or cannot access abortion, other factors come into play before women even attempt to overcome these obstacles. These factors can limit a woman's perception of the choices available to her, as well as her ability and willingness to explore the option of an abortion.

Some women are afraid of potential violence and harassment when they seek abortion. These women are deterred by confrontation or pressure from anti-choice picketers outside clinics and hospitals which provide abortions, or by reports of anti-choice violence in Canada and the United States.⁷³

Some women also experience coercive pressure from families or partners who are anti-choice. Pressure to make certain decisions, to seek counselling from anti-choice organizations, or threats to withhold financial and emotional support can limit a woman's ability and willingness to seek an abortion, particularly if the woman is in a vulnerable financial or physical position.

Possible coercion makes privacy an important factor in determining women's access to abortion. Women who have partners may wish to keep the abortion from their partners, fearing that they will not be supportive of the choice or that they will be angry about the pregnancy. A woman desiring privacy from her partner can have difficulty explaining, hiding or obtaining the money, time and travel that are required for the abortion, and so may find herself unable to obtain an abortion.⁷⁴

Difficulties with privacy can be further compounded if a woman is a minor seeking an abortion. For many young women, particularly those who live outside urban centres or in provinces without abortion services, the difficulty of maintaining privacy from their families prevents them from accessing abortion. Even in the absence of parental notification or consent policies, many minors would have to notify their parents about their abortions to explain absences or obtain the money or transit necessary to get to an

72 *Ibid.*

73 *Ibid.*

74 *Ibid.*

urban centre to access abortion services. Even minors living in urban centres would experience difficulty with privacy should they have to ask guardians or partners to help pay for an abortion in a clinic.⁷⁵

Caregivers and parents are also faced with privacy issues; namely, the obstacle of having to explain the reason for their absence to their child care provider, and with a lack of privacy to recover emotionally and physically once they resume childcare duties. This obstacle is particularly significant for women who do not have support as a parent or caregiver.⁷⁶

Women who live in small communities also face additional challenges with respect to privacy. In many small towns, the impossibility of anonymity is a serious barrier to abortion access. Despite the fact that doctors are required to maintain confidentiality, the prospect of seeking a referral from a doctor who knows one's family and neighbours, and who may or may not be pro-choice, can be extremely daunting.⁷⁷ For many women, it is equally difficult to have to interact with that doctor on a daily basis, whether or not they have agreed to provide an abortion. In communities where facilities are available, some women also fear being seen going into a building where abortions or information about abortions is provided. Yet if such services are not available locally, women may be prevented from accessing abortions because they fear being accountable to neighbours for absences from the community.

Women's ability to seek abortions is also affected by the information which is or is not available to them. Many women do not have access to accurate information about how to access abortion services, how health care coverage of abortions works, and what their legal rights are with respect to abortion and access.⁷⁸ Moreover, many women do not know how to get this information. There are national hotlines and websites detailing the contact information about abortions and clinic contact information, but if a woman does not have access to the Internet or know about organizations such as the National Abortion Federation⁷⁹ or Childbirth by Choice,⁸⁰ she could have

75 *Ibid.*; see also Eggerton, *supra* note 27 at 849.

76 CARAL, *supra* note 4.

77 *Ibid.* at 9.

78 *Ibid.*

79 National Abortion Federation, "Home," online: National Abortion Federation <<http://www.prochoice.org/canada/index.html>>.

80 Childbirth by Choice Trust, "Home," online: Childbirth by Trust <<http://www.cbctrust.com/>>.

trouble accessing this information. Many women living in rural and remote areas have their family physician as their only resource, and if that doctor is anti-choice, they may not be able to find the information they need.

Moreover, some of the sources from whom women might seek abortion information are themselves sometimes poorly informed. At hospitals, the switchboard operator or a member of the administrative staff is often the individual who answers questions about service provision and availability. Many of these individuals do not know about abortion services.⁸¹ Even when administrative staff could provide information about abortion services, they are poorly informed about costs, Medicare, and reciprocal billing arrangements for out-of-province patients.⁸²

There are also many reports of women being given false or misleading information by anti-choice staff, nurses and physicians. The CARAL Report described several instances where members of administrative staff at hospitals were unwilling to provide information about abortions because of personal belief, and “only the most forceful of women are able to overcome such institutional roadblocks.”⁸³ These staff members sometimes direct women seeking abortions to anti-choice “pregnancy counselling” centres. These centres often provide misleading information about abortion or attempt to persuade women not to have abortions.⁸⁴

One final barrier arises because of age of consent law in Canada. In some provinces, legislation has been passed specifying an age at which minors can consent to treatment.⁸⁵ In some provinces, cases and/or legislation have established a mature minor rule at common law. That is, if a minor is capable of understanding the nature and consequences of a treatment decision, then the minor’s consent is both necessary and sufficient.⁸⁶ In other provinces, all

81 CARAL, *supra* note 4 at 11.

82 *Ibid.* at 7.

83 *Ibid.* at 2.

84 *Ibid.* at 12.

85 Ontario, British Columbia, Saskatchewan, Prince Edward Island, Quebec and Manitoba. C.M.A.J., “Bioethics for clinicians: 3.Capacity,” online: C.M.A.J. <http://www.cmaj.ca/misc/bio_capacity_tab1.shtml>; Joan M. Gilmour, “Children, Adolescents and Healthcare” in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 2nd ed. (Toronto: Butterworths, 2002) [Gilmour].

86 *Medical Consent of Minors Act*, S.N.B. 1976, c. M-6.1; see also *C. (J.S.) v. Wren*, [1987] 2 W.W.R. 669 (Alta. C.A.).

that exists is the age of majority (18 or 19).⁸⁷ In some provinces, therefore, minors must have parental consent for abortion. This can create an obvious, and sometimes insurmountable, barrier.

Furthermore, hospital policies can create additional barriers to access for minors. Some Canadian hospitals have policies requiring parental consent for minors to receive treatment and thereby limit access for young people seeking abortion.⁸⁸ Minors who cannot access abortion in hospitals without parental knowledge and consent must seek services from an abortion clinic (which tend to take the position that consent from individuals aged 14 and up is both necessary and sufficient and therefore there is no parental consent or notification requirement); for many this is a financial or logistical impossibility.

It should also be noted here that there also appears to be some confusion about the law with respect to parental consent and abortion. Planned Parenthood Nova Scotia states that there is no age limit whatsoever before which parents must consent to abortion.⁸⁹ One abortion clinic website indicated that anyone younger than twelve must have parental consent.⁹⁰ The Canadian Federation for Sexual Health (Formerly Planned Parenthood Canada) states that there are no parental consent requirements for abortion in Canada.⁹¹ And yet, a review of the legislation and common law does not admit of such clear and permissive conclusions about access for minors. Confusion about the law is itself a barrier to access.

Finally, Bill C-2 should also be considered here.⁹² This Bill increased the age of consent to sex from 14 to 16 (with some exceptions relating to the relative age of the two parties). It is possible, if not likely, that regulations under this Bill will include a reporting requirement. The implications for abortion for some minors are obvious; minors under 16 may seek out illegal (and unsafe) abortions rather than risk being reported for having had sex

87 *Age of Majority Act*, R.S.P.E.I. 1988, c. A-8.

88 Canadian Federation, *supra* note 62.

89 Interview of Rhonda Phillips, Executive Director, Halifax Sexual Health Centre (13 July 2006).

90 Bloor West Women's Clinic, "Home," online: Bloor West Women's Clinic <<http://www.bloorwestwomensclinic.com>>.

91 Interview of Linda Capperauld, Canadian Federation for Sexual Health (22 July 2006).

92 Bill C-22, *An Act to amend the Criminal Code and to make consequential amendments to other Acts*, 2nd Sess. 39th Parl., 2007-2008 (assented to 28 February 2008).

in violation of the legislation, and they may fail to seek birth control (and thereby increase their risk of pregnancy and resulting need for abortion services) to avoid being reported.

2. A Deconstructive Role for Law

The barriers women face when seeking abortions in Canada can be overwhelming. Building real access in Canada requires overcoming public complacency and creating the political and professional will to bring about change. Many of the barriers women face are the result of deeper social problems, such as poverty. However, many of the most significant barriers to abortion access can be addressed using legal tools. In many cases, the nature of these obstacles is legal and changing law will break down barriers and make real access available to more Canadian women. Legal tools can also be used to counter non-legal barriers to abortion access, challenging the administrative and social factors which hinder Canadian women's ability to access abortion. In this section, we seek to make the links between the barriers described above and the legal tools that could be used to address them.⁹³ Of necessity, the explanations of the tools are limited. The goal is to show that there are many promising legal avenues that could be pursued and to motivate ourselves and others to take up specific avenues and between us all to develop the arguments in depth that would be required to make change.

93 We do not explore non-legal tools in this paper. However, for illustrative purposes, we provide here one example of a non-legal tool. Health Canada's Women's Health Strategy was adopted in 1999 in an effort to meet Canada's international commitments to women's health and gender equality, such as those expressed in the Platform for Action tabled at the Fourth World Conference on Women in Beijing, China. (<<http://www.un.org.womenwatch/daw/beijing/platform/health.htm>>). The strategy articulates a mandate for the Bureau to ensure that Health Canada's policies are responsive to gender difference and to provide effective health care services to women, including the development of best practices for addressing abortion issues (<http://www.hc-sc.gc.ca/ahc-asc/pubs/stateg-women-femmes/strateg_e.html#objective%203> at s. 3.18). The many barriers Canadian women face in accessing abortion indicate that this strategy is not being effectively pursued, and pro-choice advocates could press Health Canada and the Bureau of Women's Health and Gender Analysis to live up to their commitments and responsibilities to address women's decision-making capacity and general access to quality reproductive health care and abortion services.

a. Referral policies

Provincial/territorial policies requiring a physician referral to access abortion services could be challenged under the *Canada Health Act*⁹⁴ as a breach of the principle of accessibility – the argument would be that there should not be barriers to access to abortion services (as they are medically necessary services) and therefore abortion services should be available without a physician referral unless there is demonstrably free and timely access to referring physicians.⁹⁵ Of course, there is a significant limit on the usefulness of this approach as the only remedy for a breach of the *Canada Health Act* is the withholding of transfer funds.

A *Charter*⁹⁶ challenge could also be brought against provincial/territorial or hospital referral policies. It could be argued that requiring a physician's referral to access abortion services violates the s.7 and s.15 *Charter* rights of women who, geographically or circumstantially, cannot access a pro-choice physician in a free and timely fashion. Given the evidence that is already available and could be gathered re: the access delays and denials caused by the referral policies, these policies are likely to be vulnerable to the very arguments that resulted in the prohibitive sections of the *Criminal Code*⁹⁷ being struck down by the Supreme Court of Canada in *Morgentaler*. The increased risks associated with delays are well documented in the scientific literature.⁹⁸ Justices Beetz and Estey recognized this in *Morgentaler*:

The risk of post-operative complications increases with each passing week of delay. There is a heightened physical and psychological risk associated with later stage pregnancy techniques for abortion. Finally, psychological trauma increases with delay. The delays mean therefore that the state has intervened in such a manner as to create an additional risk to health, and consequently this intervention constitutes a violation of the woman's security of the person.⁹⁹

94 *Canada Health Act*, R.S.C. 1985, c. C-6 [*Canada Health Act*].

95 *Ibid.*

96 *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982*, (U.K.), 1982, c. 11 [*Charter*].

97 *Criminal Code*, R.S.C. 1985, c. C-46 [*Criminal Code*].

98 See Bartlett et al., "Risk Factors for Legal Induced Abortion-Related Mortality in the United States" (2004) 103(4) *Obstetrics and Gynecology* 729.

99 *Morgentaler*, *supra* note 2 at para 121.

Similarly, Chief Justice Dickson noted: "...the increasing risks caused by delay are so clearly established that I have no difficulty in concluding that the delay in obtaining therapeutic abortions ...is an infringement of the purely physical aspect of the individual's right to security of the person".¹⁰⁰

b. Physician approval policies

Provincial/territorial policies requiring one or more physicians to declare that an abortion is medically necessary before access to abortion services is granted could be challenged under the *Canada Health Act* as a breach of the principle of accessibility – again, the argument would be that there should not be barriers to access to abortion services (as they are medically necessary services) and therefore abortion services should be available without a physician referral unless there is demonstrably free and timely access to approving physicians.¹⁰¹ Again, the limited remedies limit the usefulness of this approach.

A *Charter* challenge could also be brought against provincial/territorial or hospital approval policies. It could be argued that requiring one or more physicians' approval to access abortion services violates the s.7 *Charter* rights of women who, geographically or circumstantially, cannot access approving physicians and violates the s.15 rights of women who face a barrier to access to a medically necessary procedure not faced by men (there are no analogous policies outside the pregnancy context and, as has already been established by the Supreme Court of Canada, discrimination on the basis of pregnancy is discrimination on the basis of sex).¹⁰² Given the evidence that could be presented to the courts re: the access delays and denials caused by the approval policies, these policies are also likely to be vulnerable to the very arguments (noted above) that resulted in the prohibitive sections of the *Criminal Code* being struck down by the Supreme Court of Canada in *Morgentaler*.

c. Multiple-visit requirements

The requirement for multiple appointments or consultations with physicians before obtaining an abortion could be argued to violate s. 7 and s.15 provisions of the *Charter*. For instance, the New Brunswick government will only

100 *Ibid.* at para 29.

101 *Supra* note 94.

102 *Brooks v. Canada Safeway Ltd.*, [1989] 1 S.C.R.1219.

fund abortions provided in a hospital, performed by a specialist in obstetrics and gynecology, and approved by two physicians.¹⁰³ These requirements are likely to delay access to abortion and, as previously discussed, thereby increase the risks of harm to the women.

Multiple-visit requirements are particularly onerous for women living in rural areas and women who do not have the money or time to make multiple trips to the hospital, and discriminate against women. They would be vulnerable to similar arguments as led to the striking down of the *Criminal Code* abortion provisions in *Morgentaler*, as well as an equality argument grounded in evidence that men do not face such medically unnecessary hurdles in accessing medically necessary services.

d. Gestational limits policies

Where gestational limits are demonstrably justifiable in relation to medical concerns (e.g., a physician is not trained to safely perform abortions past a certain date), then a legal challenge to these policies will be difficult to mount. However, limits might be the result of provincial regulations or hospital policies that are grounded in moral or political concerns, not safety concerns. In the 1993 *Morgentaler*¹⁰⁴ case, the Court emphasized the necessity of looking beyond the stated purpose of the legislation to its actual effects. These challenges could best be mounted at hospitals where the necessary equipment and medical expertise for later term abortions are available, but gestational limits remain in place. In the same manner, policies concerning gestational limits could be challenged with respect to whether the purposes articulated are the real purposes for which the limits are imposed. Security of person arguments, similar to those in the 1988 *Morgentaler* decision, might also be made about gestational limits. These arguments might be particularly effective in New Brunswick, where the twelve-week gestational limit¹⁰⁵ and the requirements regarding physician consent¹⁰⁶ effectively prevent many women from obtaining medically necessary abortions.

103 *Supra* note 12.

104 *R. v. Morgentaler*, [1993] 3 S.C.R. 463, 125 N.S.R. (2d) 81.

105 Donalee Moulton, "New Brunswick assailed over 'sexist' abortion laws" (2003) 169(7) C.M.A.J. 700.

106 *Supra* note 12.

e. Parental consent

Wherever it exists, the requirement of parental consent could be removed by altering provincial/territorial consent legislation to mirror the unlimited mature minor rule found in the common law,¹⁰⁷ recognizing the decision-making authority of minors where they have the capacity to understand the nature and consequences of the abortion decision. Pro-choice groups could lobby provincial/territorial governments for such law reform. The best strategy would probably be to watch for the opportunity for reform that arises when the legislatures decide to revisit their consent legislation – they are unlikely to reopen their consent legislation for the mature minor issue but might be receptive to addressing it in the context of wider consent law reform.

If legislative reform cannot be achieved, then pro-choice groups could try to find cases to take to court to get the courts in each province or territory to embrace the common law mature minor rule and, in the face of a rejection of the common law rule or the adoption of a limited mature minor rule (i.e., one limited by the welfare principle), seek to take appeals to the Supreme Court of Canada to get an unlimited mature minor rule explicitly endorsed for the entire country. Given the conflicting cases in different provinces,¹⁰⁸ the splits in the Courts of Appeal,¹⁰⁹ and the importance of the issue of the authority for consent to treatment for mature minors, it is reasonable to assume that, with the right set of facts, the Supreme Court of Canada would grant leave to appeal a mature minor case.¹¹⁰

Where an unlimited mature minor rule has already been adopted by a provincial/territorial court of appeal or written into the legislation, pro-choice groups could seek to educate health care providers, minors, and their

107 *C. (J.S.) v. Wren*, [1987] 2 W.W.R. 669 (Alta. C.A.); see also Gilmour, *supra* note 85; and Jocelyn Downie, *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada* (Toronto: University of Toronto Press, 2004) at 80-84 (discussion of mature minor rule).

108 *U. (C.) (Next Friend of) v. Alberta (Director of Child Welfare)* 2003 ABCA 66, 34 R.F.L. (5th) 181.

109 *Van Mol (Guardian ad litem of) v. Ashmore*, [1999] B.C.J. No. 31 (C.A.).

110 See *R. v. Chaulk (Application)*, [1989] 1 S.C.R. 369 (Leave to appeal will be granted if the Court "is of the opinion that any question involved therein is, by reason of its public importance or the importance of any issue of law or any issue of mixed law and fact involved in such question, one that ought to be decided by the Supreme Court").

families about the law so that everyone understands that mature minors have the right to access abortion services without parental consent.

Finally, pro-choice groups should lobby parliamentarians to craft regulations under Bill C-2 such that it protects minors from sexual exploitation but does so without driving minors away from legal abortions. For example, they could argue that the regulations should exempt abortion providers from the duty to report.

f. Failure to fund abortions

One legal instrument which can be used to counter funding barriers is the withholding of federal health care payments to provinces who do not comply with the *Canada Health Act*. Regarding abortion, this has been done in Nova Scotia and PEI. Withholding funds under the *Canada Health Act* can be an effective tool - for instance, Newfoundland and Labrador eliminated user fees for abortion clinics in the face of federal deductions.¹¹¹ However, other provincial governments, such as Nova Scotia, have historically been willing to take a financial hit for political gain. Nova Scotia accepted over \$372,000 in deductions for failing to properly provide and fund abortions¹¹² (they were deemed to be compliant by default and ceased having funds withheld when the province's only abortion clinic closed in 2003). Pro-choice activists could lobby the federal Minister of Health to withhold transfer payments in all jurisdictions in which abortion services are not adequately funded.

Another tool which can be used to encourage provinces/territories to comply with the *Canada Health Act* is the Dispute Avoidance-Resolution system. This was first introduced by Anne McLellan in 2002 and was used by Ujjal Dosanjh to address issues such as non-payment for abortion services and private clinics.¹¹³ This process involves appointing a three member panel, with representation from provincial/territorial and federal governments, to research provincial compliance with the *Canada Health Act*, and to attempt to negotiate a resolution. However, this process has not been used

111 Health Canada, "Canada Health Act Federal Transfers and Deductions," online: Health Canada
<http://www.hc-sc.gc.ca/hcs-sss/medi-assur/transfer/index_e.html>.

112 *Ibid.*

113 Minister of Health, *Canada Health Act Annual Report 2003-2004* (Ottawa: 2004), online: <http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/cha-lcs-ar-ra/2003-04-fed_e.pdf>.

by the current Conservative government; shortly after the January 23, 2005 election, Health Minister Tony Clement froze any pursuit of DAR regarding abortion funding.¹¹⁴ However, he later pledged to revisit the issue in relation to New Brunswick following the provincial election held September 2006. Given that there was a change in governing party (from Conservative to Liberal) it will be interesting to see whether the process begun in 2002 will be revived.

Individual legal action can also be used to deconstruct this barrier. In the recent successful class action against the province of Quebec it was held that allowing private clinics to charge additional fees for services, which was necessary for their financial viability, was prohibited by law.¹¹⁵ As a result, Quebec will reimburse over 45,000 women for the clinic fees they were forced to pay.¹¹⁶ In New Brunswick, Dr. Morgentaler is presently pursuing a suit against the provincial government for its failure to fund clinic abortions.¹¹⁷ Other groups are also considering launching a suit against New Brunswick for its failure to adequately fund abortion services in the province.¹¹⁸

g. Centralization of clinics and hospitals

The British Columbia *Hospital Act*¹¹⁹ mandates that all listed hospitals must provide abortion services. Pro-choice advocates could lobby all provincial/territorial legislatures to amend their Hospitals Acts (or equivalent legislation) to mirror the British Columbia statute. This could help to ensure that a large number of hospitals in both urban and rural areas throughout each province/territory would provide abortion services and would not leave the choice about whether to provide abortion to individual hospital policymakers.

114 Peter O'Neil, "Federal Tories ignore alleged health violations outside Alberta" *Regina Leader-Post* (4 July 2006).

115 *Assoc. pour l'accès à l'avortement c. Québec (Procureur général)* 2006 Carswell Que 7943.

116 "Quebec to pay back \$13M in abortion extra-billing" *CBC News* (18 August 2006), online: CBC News <<http://www.cbc.ca/news/story/2006/08/18/abortion-overbilled.html>>.

117 *Morgentaler v. New Brunswick*, 2004 NBQB 139, 49 C.P.C. (5th) 134.

118 "Lawyers plan suit over N.B.'s abortion access" *CBC News* (15 January 2007), online: CBC News <<http://www.cbc.ca/canada/new-brunswick/story/2007/01/15/nb-abortion-suit.html>>.

119 *Hospital Act*, R.S.B.C. 1996, c. 200, s. 24.1.

h. RU-486

Several advocacy groups and medical associations have petitioned the Canadian government to approve RU-486 (mifepristone).¹²⁰ Independent trials were being conducted in Canada in 2001,¹²¹ but were stopped when one participant died due to a rare infection that was not related to the drug.¹²² However, support for making RU-486 available in Canada indicates that independent groups would likely be willing to support further trials if, relieved of the burden of conducting the testing and application for approval, manufacturers would be willing to make mifepristone available to Canadian physicians and Health Canada would accept an application for approval from individuals or groups other than the manufacturers.

An argument could therefore be made that the process by which drugs are approved in Canada should be changed. Specifically, applications to begin trials of mifepristone should be accepted not only from manufacturers, but also from public interest groups or medical groups.¹²³ This way, independent trials could be conducted and the drug approved despite the industry fears of anti-abortion backlash against them or insufficient potential profits from the drug. Pro-choice advocates could lobby the federal government for changes to the *Food and Drugs Act*¹²⁴ and *Food and Drugs Regulations*.¹²⁵

i. Lack of training in medical schools

Accreditation schemes could be used to address informational and training problems within the medical community. That is, at the very least, the provision of a meaningful opportunity to all students who wish to take the opportunity to receive training and experience in abortion techniques should be a condition of accreditation. In addition, training for all students in abortion techniques such that they would be properly trained to provide abortion ser-

120 LaLiberte, *supra* note 51.

121 Wiebe et al., "Comparison of Abortions Induced by Methotrexate or Mifepristone Followed by Misoprostol" (2002) 99 *Obstetrics and Gynecology* 813; see also "Clinical trial of 'abortion pill' begins in Canada" *CBC News* (7 July 2000), online: *CBC News* <<http://www.cbc.ca/canada/story/2000/07/06/pill000706.html>>.

122 Sally Murray & Eric Woollorton, "Septic shock after medical abortions with mifepristone (Mifeprex, RU 486) and misoprostol" (2005) 173 *C.M.A.J.* 485.

123 Sibbald, *supra* note 49.

124 *Food and Drug Act*, R.S.C. 1985, c. F-27.

125 *Food and Drug Regulations*, C.R.C., c. 870.

VICES that they would be required under the law to provide (no matter their personal convictions) should be a condition of accreditation. Accreditation is the responsibility of the Committee on Accreditation of Canadian Medical Schools which uses the standards developed by the American Liaison Committee on Medical Education.¹²⁶ Pro-choice advocates could lobby these organizations to include these two conditions.

j. Doctors who withhold accurate information or provide false or misleading information and doctors who fail to provide referrals

Doctors who withhold accurate information or provide false or misleading information about abortions could be sued for malpractice – failing to provide adequate information about treatment options clearly falls well below the standard of care required of physicians by the common law in Canada.¹²⁷ Furthermore, they could be reported to their College of Physicians and Surgeons – withholding accurate information or providing false or misleading information to patients is contrary to the Code of Ethics and therefore cause for disciplinary action. Section 21 of the Code of Ethics establishes the following as a responsibility to patients: “Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.”¹²⁸

Doctors who fail to provide referrals are also arguably in breach of Canadian Medical Association (CMA) policy and vulnerable to possible disciplinary action and lawsuits.¹²⁹ The CMA Policy on Induced Abortion states the following:

- A physician whose moral or religious beliefs prevent him or her from recommending or performing an abortion should inform the patient of this so that she may consult another physician.

126 The Association of Faculties of Medicine of Canada, “Medical Education Accreditation,” online: The Association of Faculties of Medicine of Canada <<http://www.afmc.ca>>.

127 *Hopp v. Lepp* (1980), 4 W.W.R. 645, 13 C.C.L.T. 66; *Reibl v. Hughes*, [1980] 2 S.C.R. 880, 33 N.R. 361.

128 Canadian Medical Association, *CMA Code of Ethics* (Ottawa: 2004), online: Canadian Medical Association <<http://policybase.cma.ca/PolicyPDF/PD04-06.pdf>>.

129 Sanda Rodgers & Jocelyn Downie, “Abortion: Ensuring Access” (2006) 175(1) C.M.A.J. 9.

- The patient should be provided with the option of full and immediate counselling services in the event of unwanted pregnancy.
- Since the risks of complications of induced abortion are lowest in early pregnancy, early diagnosis of pregnancy and determination of appropriate management should be encouraged
- There should be no delay in the provision of abortion services.¹³⁰

As noted by Rodgers and Downie:

[t]hese statements recognize the need for timely referral. A physician who does not participate in abortion does not violate CMA policy. A physician who sets up barriers to prevent women from accessing abortion elsewhere does violate CMA policy. The Policy on Induced Abortion allows conscientious objection by a physician who need not 'recommend' or 'perform' or 'assist at' an abortion. It does not allow a right of conscientious objection in relation to referrals.¹³¹

Jeff Blackmer, Executive Director of the Office of Ethics at the CMA, has asserted that Rodgers and Downie misrepresented the CMA's position on access to abortion and were wrong to claim that "all physicians are under an obligation to refer."¹³² However, as Blackmer himself states, "CMA policy does not state or imply a moral obligation for physicians to refer patients for services to which they are opposed for personal or moral reasons, [but] *they should not prevent or delay patients from accessing those services*"¹³³ and

You should therefore advise the patient that you do not provide abortion services. You should also indicate that because of your moral beliefs, you will not initiate a referral to another physician who is willing to provide this service (unless there is an emergency). However, you should not interfere in any way with this patient's

130 Canadian Medical Association, *CMA Policy: Induced Abortion* (Ottawa: 1988), online: Canadian Medical Association <<http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD88-06.pdf>>.

131 Sanda Rodgers & Jocelyn Downie, "Authors' Response to Letters on 'Access to Abortion'" (2007) 176(4) C.M.A.J. 494.

132 Jeff Blackmer, Letter to the Editor, *C.M.A.J.* (19 February 2007) online: CMAJ <<http://www.cmaj.ca/cgi/eletters/176/4/494>>.

133 *Ibid.* [emphasis added].

right to obtain the abortion. At the patient's request, you should also indicate alternative sources where she might obtain a referral. *This is in keeping with the obligation spelled out in the CMA policy: 'There should be no delay in the provision of abortion services.'*¹³⁴

The failure of logic in Blackmer's rejection of Rodgers and Downie's position rests on his twin assumptions that a physician's refusal to provide a referral will not prevent or delay women from accessing abortion, and that women have access to alternative sources for referrals. Given the lack of access to physicians documented earlier in this paper, these are unreasonable assumptions. Unless a physician is certain that a woman has rapid access to an alternative source for a referral, that physician has an obligation under CMA policy to provide the referral him or herself.

Advocates could also lobby the CMA and medical regulatory bodies to clearly take and communicate with their members the position that while physicians are free to not perform abortions, they are not free to withhold information or to provide false or misleading information to women. In addition, a recent disciplinary action in Ontario concerned a doctor who refused to provide contraceptives and related information to unmarried women. The doctor was ordered to distribute information about his personal beliefs to prospective patients, who could then choose to seek medical care elsewhere.¹³⁵ Medical regulatory bodies could also require physicians to warn prospective patients in a similar manner, and physicians who fail to do so could be subject to disciplinary action.

k. Failure to provide appropriate information by staff

Systems of accreditation could also be applied to support staff working in public hospitals. Administrative or "gatekeeper" staff often do not have adequate information about abortion services, are unwilling to yield such information, or worse, deliberately provide misleading information. Systems of training and certification could be implemented to ensure that support staff have accurate information and are capable of delivering it.¹³⁶ This would remove the excuse of ignorance and make it obvious that individuals are de-

134 Jeff Blackmer, "Clarification of the CMA's position concerning induced abortion" (2007) 176(9) C.M.A.J. 1310 [emphasis added].

135 Brad. J MacKay, "Sign in office ends clash between MD's beliefs, patients' requests" (2003) 168(1) C.M.A.J. 78 at 78.

136 Linette MacNamara, Erin Nelson & Brent Windwick, "Regulation of Health

liberately providing misleading information about abortion. Pro-choice advocates could lobby the Canadian Council on Health Services Accreditation (CCHSA) to include abortion services in its list of health services subject to their accreditation process in a fashion that would require implementation of a policy prohibiting the delivery of incomplete, misleading, or false information and providing a mechanism for disciplinary action to be taken against those who provide such information. Then, if a hospital fails to implement policy regarding the delivery of accurate and complete information or fails to discipline those who breach the policy, pro-choice advocates could report the failure to the CCHSA.¹³⁷ While accreditation by the CCHSA is technically a voluntary process, the program has a high degree of recognition in the health care community and failure to comply with CCHSA standards can have negative consequences. For instance, the Royal College of Physicians and Surgeons stipulates that residency programs may only operate in CCHSA accredited facilities.¹³⁸ Accreditation also serves as a type of peer-review process among administrators and professionals, reflecting community standards for acceptable practice, and functions as a measure of a facility's public accountability. Evolving CCHSA standards are likely to have a strong impact on the practices of Canadian hospitals, because the viability of the hospital is directly affected by the opinions of the professional and public communities, and the hospital's ability to meet human resource needs.

I. Harassment/violence against providers/anti-choice intimidation

Criminal laws regarding harassment of abortion providers must be enforced more consistently and rigorously. The *Criminal Code* makes provision for prosecution of criminal harassment, which includes harassing individuals because of the nature of their profession.¹³⁹ In British Columbia, the Attorney General formed the criminal harassment unit in response to anti-abor-

Care Professionals" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 2nd ed. (Toronto: Butterworths, 2002) .

137 CCHSA, "Home," online: CCHSA <<http://www.cchsa.ca/Default.aspx>>.

138 CCHSA, "Benefits of Accreditation," online: CCHSA <<http://www.cchsa.ca/default.aspx?page=134&cat=27>>.

139 *Criminal Code*, s. 264; Department of Justice, *Working Document: A review of Section 264 (Criminal harassment) of the Criminal Code of Canada* (Ottawa: 1996), online: Media Awareness Network <http://www.media-awareness.ca/english/resources/legislation/canadian_law/federal/criminal_code/criminal_code_hate.cfm>.

tion intimidation, and gave funding for increased security measures at clinics and providers' residences.¹⁴⁰ Other Canadian provinces must also seriously address harassment of abortion providers by lobbying for enforcement of the *Criminal Code*. It has also been suggested that hate crime laws should be amended to include the harassment of abortion providers and advocating violence against providers and clinic workers.¹⁴¹

The problem of anti-choice intimidation could be addressed through "bubble-zone" legislation. The only province that currently has any such legislation is British Columbia, where the *Access to Abortion Services Act*¹⁴² was enacted in 1996. This Act makes it illegal to harass abortion providers, photograph abortion providers, and to protest within certain distance of clinics, hospitals and residences of doctors. The *Access to Abortion Services Act* allows for pecuniary damages to doctors and clinics for any harassment.¹⁴³

In Ontario, the *Dieleman*¹⁴⁴ case in 1994 provided a temporary injunction against protesting within a certain distance of clinics and doctors' homes, and from circulating information about abortion providers. This injunction remains in place, but only in the cities of Toronto, London, Brantford, Kitchener and North Bay.¹⁴⁵ There is no permanent legislated "bubble-zone" protecting abortion clinics or providers. As in Ontario, several provinces have injunctions protecting specific clinics and residences, such as the Kensington clinic in Alberta.¹⁴⁶ In New Brunswick, obscenity charges have been used to stop protesters from displaying graphic images of fetuses outside a Fredericton clinic.¹⁴⁷

Pro-choice advocates could lobby all provinces to emulate British Columbia and legislate to create "bubble-zones" and protections for abortion providers and those seeking abortion. Lack of abortion providers is one of

140 Canadian Federation, *supra* note 62.

141 CARAL, *supra* note 4.

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

143 *Ibid.*

144 *Ontario (Attorney General) v. Dieleman*, 1993 CarswellOnt 1832; 110 D.L.R. (4th) 349.

145 Canadian Federation, *supra* note 62.

146 *Ibid.*

147 Interview of Valerie Kilfoil, Office of the New Brunswick Attorney General; "Anti-abortion protester's court date delayed" *CBC News* (17 November 2006) online: CBC News <<http://www.cbc.ca/canada/new-brunswick/story/2006/11/17/nb-signcharge.html>>.

the most significant barriers to abortion access in Canada. If anti-choice intimidation is a deterrent to would-be providers, then providing legal protection against harassment and intimidation will serve to encourage more doctors to become providers, and improve access for all Canadian women.

3. Conclusion

In the end, it is clear that there are many barriers to access to abortion. However, it is also clear that there are many ways in which pro-choice advocates could seek to use the law to deconstruct these barriers. We must recognize the problem, educate a complacent population about the challenges faced by many women (particularly the disadvantaged), and mobilize. *Morgentaler 1988* was an important first step but we clearly have miles yet to go.

