Abortion Rights Coalition of Canada
Coalition pour le droit à l'avortement au Canada

Your Voice for Choice

Canada's only national political pro-choice advocacy group

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Position Paper #5

The Canadian Abortion Provider Shortage: Now and Tomorrow

Since the Morgentaler decision of 1988, no laws restrict the provision of abortion services in Canada, and in theory, abortion is treated as any other medically necessary procedure. Unfortunately for millions of women, access to abortion does not meet the standards of the Canada Health Act. Part of this deficiency is due to the shortage of trained medical professionals able to provide safe and legal abortions and abortion-related care in this country.

Geographical and Political Barriers

As the world's second-largest country, based on land-size, one of the defining characteristics of our nation is also one that creates one of the largest barriers for comprehensive medical care. While most Canadians live within 250 km of the US border, abortion services are mainly restricted to larger urban centres. Currently, first-trimester abortion services are available in all provinces and territories, but in rural and suburban parts of Canada, women and transgender people must travel easily 50 km or more to find an abortion provider and obtain services. In more remote areas, these distances quickly run into the hundreds of kilometres or more.[1] For example, in Yukon, the only abortion provider is the Whitehorse General Hospital.

Only 16% of hospitals in the country offer abortion services. The reasons for this small number are many, but a major factor is often a shortage of providers, especially in smaller communities and northern areas. In Canada, about 75% of abortion procedures are performed in abortion clinics[2], but clinics are located only in larger cities. Outside major cities, most people depend on hospitals. If a hospital is willing to provide abortions (many are not), they need to find a willing provider in their community. Smaller communities often have no doctors able or willing to perform abortions, because of the stigma still attached to abortion, fear of being known and targeted in a small community by local anti-choice activists, and the lack of abortion training offered at Canadian medical schools[3].

In addition, doctors at Catholic hospitals (outside Quebec at least) are not allowed to perform abortions, and, as hospitals amalgamate, the Catholic anti-choice doctrine usually dominates new hospital policies. About 12% of all Canadian hospitals are Catholic.

Lack of Mid-Trimester Providers

Mid-trimester procedures are available in only a handful of sites across the country. In 2015, only 9% of abortions in Canada took place between 12 and 20 weeks of gestation, with a mere 2% of abortions occurring after 20 weeks at hospitals[4] (0.59% percent total, including both clinics and hospitals.[5]) Most women who terminate their pregnancies after 12 weeks are doing so for various compelling reasons. Frequently, women have mid-trimester procedures because they did not have access to accurate pregnancy results, or access to first-trimester abortion services. Other women may be in desperate social circumstances, such as an abusive relationship, or they may be very young teenagers who have delayed abortion care because they were in denial about the pregnancy.

Some women may be faced with an unexpected fetal diagnosis, such as a serious birth defect, which may jeopardize the health of the mother or child should the pregnancy be carried to term. Abortions under these circumstances are termed “genetic terminations”. Given the nature of maternal screening, these defects are usually only found during the second trimester of pregnancy – often around 18-20 weeks gestation[6]. While the decision to terminate such a pregnancy can be difficult, this process is often compounded by the lack of trained and willing providers in this area. After about 14 weeks gestation, and especially after 20 weeks, mid-trimester procedures become more complicated surgical procedures. Because of the lack of providers, the need outstrips the supply in Canada—many women must travel to the United States to have abortions after 20 weeks gestation.

Family Physicians and Their Obligations

In Canada, most abortion providers are family physicians or obstetrician/gynaecologists. Abortion training is only considered routine in approximately half of programs and elective in the rest. The majority of residents (71%) in a study in 2006 participated in abortion training, and half planned to do elective abortions after residency (less than 40%).[7]

Most family physicians in Canada either do not perform abortions, or they perform only a handful a year for their regular patients. Again, this is a result not only of the ongoing safety fears for the physician and her family and lack of training, but also the lack of prestige, financial reward, and institutional support associated with being an “abortion doctor.” The major cause of abortion is unplanned pregnancy, so a major determinant of abortion rates is access to contraception.

Even though most physicians choose not to perform abortions, all primacy care physicians have the opportunity to provide women with effective contraceptive options, thus reducing the need for women to seek abortions. Unfortunately, some physicians restrict women’s access to both contraception and abortion under the guise of a “moral imperative”, often rooted in their religious beliefs. Such doctors not only refuse to perform abortion, they may even refuse to refer women for abortion[8].

ARCC believes that all women, transgender and non-binary people should have access to all aspects of reproductive health, including contraception, and accurate, unbiased referrals to legitimate abortion providers. We also assert that it is unprofessional for a physician to refuse an appropriate referral or request for fertility control.

The Future of Abortion Care

Canada is facing a health care crisis as the physician population ages, the demand of the health care system increases, and as the number of medical school and residency spots fails to adequately compensate for these changes. Abortion care is one area of medicine experiencing a similar crunch.

In 2013, a study suggested that 15% of family doctors and 12% of other specialists were going to retire by 2016, and an additional 30% of all physicians planned to reduce their hours or scope of practice.[9] Medication abortion, which is discussed in more detail in ARCC *Position Paper #28 – Medication Abortion*, has the potential to greatly ease the impending provider shortage, but it also goes without saying that family physicians have a role to play in ensuring barrier-free access to information about fertility control and contraceptives. ARCC will continue to work with other organizations, including Medical Students for Choice, to ensure that as abortion providers retire, there are enough trained professionals who are ready and willing to replace them, thus ensuring that future generations of women have access to safe, comprehensive medical care.

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1 https://globalnews.ca/news/2351133/where-in-canada-can-you-get-an-abortion-its-secret-for-security-reasons/ This article provides a "heat map" of the availability of abortion providers in Canada.

2 Statistics on Abortion in Canada, compiled by Abortion Rights Coalition of Canada. http://www.arcc-cdac.ca/backrounders/statistics-abortion-in-canada.pdf

3 http://www.chatelaine.com/living/features-living/abortion-education-canada-medical-schools-smarten-up/

4 In 2015, it was 9.2% for 9-20 weeks and 2.4% for 20+ weeks. https://www.cihi.ca/ "Induced Abortions Reported in Canada in 2015".

5 Statistics on Abortion in Canada, compiled by Abortion Rights Coalition of Canada. http://www.arcc-cdac.ca/backrounders/statistics-abortion-in-canada.pdf

6 The number of scans and screenings varies based on the province (though in provinces where it is not covered, a woman can pay a private company for the screening). In Ontario, for example, screening in the form of an Integrated prenatal screen (IPS) is a blood test and ultrasound between weeks 11-13, then another blood test between week 16-20, with results provided by 18 weeks. Other options are the non-invasive prenatal test (NIPT or Harmony). The 18-22 week ultrasound, which most people equate to as the "determination of sex" ultrasound, is in truth a morphology ultrasound that is a detailed look at a fetus' body and organs to determine Down Syndrome as well as cleft palate and heart defects. This ultrasound is not given until 18 weeks at the earliest, and for those that forgo the elective screening, this may be the first time they discover the fetus has a genetic defect – well into the second trimester.

7 https://www.ncbi.nlm.nih.gov/pubmed/16880300

8 In Ontario, the College of Physicians and Surgeons of Ontario requires doctors who have a moral objection to the treatment sought by a patient to refer them to another medical professional. It was challenged in 2015 but was held up by the courts. https://globalnews.ca/news/3998505/doctor-treatment-moral-grounds-referral/.
Also see ARCC's Position Paper #95 – The Refusal to Provide Health Care in Canada.

9 http://www.cmaj.ca/content/cmaj/189/49/E1517.full.pdf