Therapeutic abortion counseling and provision

Are Canadian family physicians opting out?

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A pregnant 22-year-old woman is offered an abortion when prenatal screening suggests the fetus has Down syndrome. Another pregnant 22-year-old woman requests a therapeutic abortion (TA) for personal rather than medical reasons. Both make a choice based on what is best for themselves, the fetuses, and society. The first woman easily obtains this procedure; access to an abortion for the second woman might be constrained by lack of information or provider, or by the woman’s location or finances. What has happened to the accessibility, universality, and comprehensiveness guaranteed in the Canada Health Act?

In 1974, author 1 (S.P.) entered medical school. Contraception had been legal in Canada for a mere 5 years, and abortion was only available after a 3-doctor committee determined that continuing the pregnancy presented a risk to the pregnant woman’s health. Nevertheless, medical students were expected to present abortion as a choice when pregnancy was accidental or unwanted, and to know how first- and second-trimester abortions were performed. During their gynecology rotations, family medicine residents attended TA clinics, assessed uterine size, and completed the paperwork required for abortion approval. Participation was expected. The author’s recollection is that none of her residency colleagues opted out.

In 2014, when author 2 (S.S.) entered medical school, the era of illegal contraception and abortion seemed like ancient history. A 1988 Supreme Court ruling had removed the legal framework for abortion and recognized it solely as a medical procedure. Nevertheless, constraints on access remain, perhaps embedded in the values and religious beliefs of some practitioners and regulators.

From illegal to invisible

The “voices” of organized medicine view terminating a pregnancy as a personal decision. Following the decriminalization of abortion, the Canadian Medical Association adopted the following policy:

The decision to perform an induced abortion is a medical one, made confidentially between the patient and her physician within the confines of existing Canadian law. The decision is made after conscientious examination of all other options.

Induced abortion requires medical and surgical expertise and is a medical act. It should be performed only in a facility that meets approved medical standards, not necessarily a hospital.

Similarly, the Society of Obstetricians and Gynaecologists of Canada states,

Every woman seeking abortion should receive supportive and compassionate counselling on all the options available, including continuing the pregnancy and having the child adopted or seeking assistance should she wish to parent. Counselling should take place early enough to avoid any delays in the event the woman chooses to terminate the pregnancy. The counsellor should be free of personal bias and responsive to the woman’s circumstances.

And yet, medical education, practice, and policy have steadily rendered abortion invisible and unavailable in parts of Canada. All medical students must write examinations set by the Medical Council of Canada (MCC) to obtain licences to practise. Questions are linked to the MCC’s objectives. Section 082 of the 1999 objectives, titled “Contraception/Pregnancy Prevention/Termination,” stated that knowledge of termination was necessary and that students should be able to present contraceptive and termination alternatives while respecting the individual’s moral, ethical, and religious beliefs—not the doctor’s beliefs, but the patient’s. The current version of those MCC objectives (updated in November 2012) is quite different. Termination has disappeared completely. Abortion is addressed under professionalism and referred to as a “complex ethical issue” (section 6.7). Therapeutic abortion has been redefined as (and limited to) a necessary referral following a clinical finding (implying a fetal genetic abnormality) (sections 80 to 81).

Aligning education with provision of care

In Canada there are 28 abortions for every 100 live births. Women seeking a termination will often consult with a family physician for referral. Approximately 61% of abortion providers are family physicians. How well does physician education align with provision
of care? Family medicine residents are more likely to view abortion as an option and provide this service if they receive training.9 However, there is no mention of options counseling or abortion training in the 99 “priority topics,” the essential competencies the College of Family Physicians of Canada expects of those entering family practice.10 The Royal College of Physicians and Surgeons of Canada’s competencies for gynecology trainees are also silent on abortion as a choice. Therapeutic abortion is mentioned tangentially but not directly and is not among the detailed list of expected procedural competencies. By explicitly addressing only second-trimester abortions, the document implies (although does not state) that the indication for termination is an abnormal prenatal genetic screening result.11 Among the Royal College of Physicians and Surgeons of Canada’s enabling competencies for obstetricians and gynecologists is a statement that seems to remove direct responsibility for provision of care, suggesting that the specialist need only “facilitate medical care for patients even when that care is not provided personally or locally or when that care is not readily accessible (e.g., therapeutic abortion).”11

Put simply, the national organizations that guide the education of physicians have enabled TA to essentially disappear from training.

Family medicine residency programs across the country generally do not include abortion training and residents anecdotaly report difficulty arranging elective instruction in provision of abortions. Canadian medical schools set their own curricula and, therefore, the nature and content of undergraduate teaching surrounding pregnancy termination will vary. Schools might very well be addressing counseling, assessment, procedural skills, etc. However, they, too, are subject to implicit or explicit pressure to make abortion invisible. One school refuses to allow their very clear teaching on reproductivechoice to be recorded, as all other lectures are, stating that the content is overly sensitive. This is a decision made by the school rather than the lecturer. By recording lectures, the school ensures long-term student access to the knowledge being disseminated. Not recording this lecture limits information for future physicians.

### Conclusion

Abortion is safe, available, and accepted as the most humane option for the woman, the fetus, and society when medicine-centred reasons (eg, fetal genetic anomalies) are identified. But, it would seem we are reverting to silence with respect to education, provision, and access when the reason for an abortion request is patient-centred rather than medicine-centred.

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### Competing interests

None declared

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### References