Reflections on Canadian abortion care in a post-Roe world

"Every mother a willing mother. Every child a wanted child."

—Dr Henry Morgentaler

The legal framework for abortion in Canada dates back to 1892, when abortion, as well as the sale, distribution, and advertising of contraceptives, was banned under the Criminal Code.[1] It was not until 1969[2] that the government decriminalized contraception and provided allowances for abortion, when performed in hospital, for circumstances in which the health of the mother was in danger. That same year, abortion activist Dr Henry Morgentaler[1] opened an outpatient abortion clinic in Montreal. He endured years of persecution and legal battles, including serving 10 months in jail in 1975–76 and the 1992 firebombing[3] of his Toronto clinic.

It was in 1988 that Canada's Supreme Court struck down the abortion law because it was in violation of the Canadian Charter of Rights and Freedoms, specifically a woman's right to "life, liberty and security of person."[1] As UBC's Dr Dorothy Shaw wrote on the 30-year anniversary of the Morgentaler decision: "Dr Henry Morgentaler was a leader who risked his life to provide women access to safe abortions. He was integral in the Supreme Court of Canada's decision to overturn the abortion law. . . . That was a landmark decision for reproductive rights for women."[2]

However, the battle for access to a safe abortion did not end peacefully after the Supreme Court ruling. Abortion was thereafter controlled by the provinces and medical regulations. Threats of legislation continued, such as an attempt in 1990 to pass a bill that would imprison doctors who performed elective abortions.[1] There were also numerous attempts at provincial restrictions throughout the 1990s and 2000s, some of which were successful at targeting the abortion procedure or its funding. Reading a CBC article[1] detailing a timeline of abortion in Canada, I was surprised to see so many contemporary challenges to a procedure that, throughout my medical career, I have taken for granted as a treatment available to anybody in Canada with a uterus. The article educated me about some of the hard-fought battles brought forth by activists and doctors long before I graduated medical school. There have been many violent incidents, including in 1994 when Dr Gary (Garson) Romalis was the first Canadian abortion doctor to be shot. I had the privilege of working with Dr Romalis during my obstetrics-gynecology residency, and I would encourage anyone to read more about him in the recent *BCMJ* blog post by Dr George Szasz.[4]

Although abortion is not a component of my practice, I regularly prescribe Mifegymiso (mifepristone plus misoprostol) for medical management of miscarriage, and I also use assisted reproductive technologies like in vitro fertilization (IVF). I continue to ponder how I would feel if these essential tools of gynecological care were not available to my patients in a post-Roe America. It could be devastating. Take IVF,[5] for example. If state laws recognize an embryo as a person, it might prevent the discarding of genetically abnormal embryos, or limit how many eggs can be fertilized during IVF. I have read several articles[6] that point out the irony that laws aimed at "saving lives" by stopping abortion could also reduce fertility for many people. Furthermore, abortion laws that directly or indirectly restrict fertility treatments in America may also disproportionately impact people of color, who experience infertility at higher rates, and people of lower socioeconomic status, who may not be able to travel to access treatment, which can be expensive to begin with. Thankfully, most of my colleagues to the south do not appear to be facing an imminent threat to fertility care, but there are signs of an ongoing debate.[7] According to an opinion piece in the *Los Angeles Times*,[8] "a now-dead bill[9] introduced in the Louisiana [State] Legislature this year sought to 'ensure the right to life and equal protection of the laws to all unborn children from the moment of fertilization by protecting them by the same laws protecting other human beings.' The bill spoke of 'prenatal homicide,' assault and battery."

Doing research for this editorial made me even more grateful to the generations of physicians and advocates who shaped the practice of modern gynecology in Canada. It is because of this groundwork that I may help patients however and whenever they choose to grow their families. ■

—Caitlin Dunne, MD, FRCSC

References

1. CBC News. Abortion rights: Significant moments in Canadian history. Last updated 27 March 2017. Accessed 6 September 2022. www.cbc.ca/news/canada/abortion-rights-significant-moments-in-canadian-history-1.787212.
2. Shaw D. 30 years post-Morgentaler decision: The journey remembered. BC Women's Hospital and Health Centre. 27 January 2018. Accessed 6 September 2022. www.bcwomens.ca/about/news-stories/stories/30-years-post-morgentaler-decision-the-journey-remembered.
3. Claiborne W. Clinic bombing rekindles Canadian abortion debate. The Washington Post. 21 May 1992. Accessed 6 September 2022. www.washingtonpost.com/archive/politics/1992/05/21/clinic-bombing-rekindles-canadian-abortion-debate/f1f99d42-e58b-4fab-9721-dceb505be896.
4. Szasz G. Access to safe abortion services: Remembering the life and work of Dr Gary (Garson) Romalis. BCMJ. 5 August 2022. Accessed 6 September 2022. https://bcmj.org/blog/access-safe-abortion-services-remembering-life-and-work-dr-gary-garson-romalis.

References continued on page 338

Protecting reproductive rights and freedoms

As our neighbors to the south face the devastating effects of the US Supreme Court's decision to overturn *Roe v. Wade,* we must consider how this landmark decision may affect abortion care in Canada as well. Shortly after this decision, Prime Minister Justin Trudeau called the overturn "horrific," reiterating his support for women in Canada's right to choose. It is reassuring to know that safe abortion care remains an essential medical service in Canada. However, up to 26 US states may ban or nearly ban abortion, and many of those states share a border with Canada. This may lead to an uptick of women traveling to Canada to get a safe abortion.

As a country, we have long had the obligation to provide this essential medical service to patients who live in Canada, and it would be prudent for us to maintain the infrastructure and capability to continue to do so. What does it mean for patients living in Canada who are looking for abortion care if we begin to see an influx of patients coming from the US looking for the same care? We need to ensure we maintain equal standards across provinces as well as safe access.

Women of lower socioeconomic status and women of marginalized races and ethnicities will be disproportionately affected by the decision to overturn *Roe v. Wade*. Unfortunately, in Canada, access to abortion care is similarly more difficult for certain populations. A 2013 Canadian study found that 18.1% of women living in Canada had to travel more than 100 km to access abortion services.[1] The uneven distribution of clinics across provinces also makes access to care variable, depending on which province one lives in. Currently, each province's delivery of abortion care varies widely in terms of the number of clinics and providers available, as well as the legally allowed gestational limit.[2] Clinics that provide abortion services do not advertise their services for obvious reasons, and many patients may not be aware that the majority of clinics accept self-referrals. This could result in patients relying solely on their primary care providers for information and could lead to differences in how patients access abortion care.

Additionally, abortion care providers in Canada continue to face challenges regarding their anonymity and safety. It is crucial that the essential work they do continues to be supported by the government. There are still many areas of uncertainty as we navigate through the effects of the US Supreme Court's decision to overturn *Roe v. Wade*.

Reflecting further on women's health and rights, it has also been discouraging to hear about the recent severe formula shortage in the US, which left many mothers and babies scrambling to find a basic life necessity for the many babies who may not be able to breastfeed. The shortage impacted Canada's formula supply as well, given our close proximity and many people crossing the border to look for formula. The lack of formula particularly impacts low-income mothers who may not have the ability to maintain a breastfeeding relationship due to inadequate maternity leave policies or lack of support from employers to allow pumping at work. Although breastfeeding is protected by the Canadian Charter of Rights and Freedoms, the reality is that many workplaces and institutions still do not provide adequate support for working mothers to breastfeed. As health care providers, we can normalize breastfeeding and support mothers who choose to breastfeed. There should also be increased awareness around breastfeeding in the medical school and residency curriculum.

Given what has happened to abortion care in the US, this is an important opportunity to reflect on what we currently have in Canada. We are fortunate enough to have this fundamental right protected here, but access is an ongoing issue. Access to abortion services must be made consistently available to those in need, and as a society, we must continue to raise awareness about the challenges women face with regard to their reproductive rights and freedoms. ■

—Yvonne Sin, MD

References

1. Sethna C, Doull M. Spatial disparities and travel to free-standing abortion clinics in Canada. Womens Stud Int Forum 2013;38:52-62.
2. Action Canada for Sexual Health and Rights. Access at a glance: Abortion services in Canada. 19 September 2019. Accessed 23 August 2022. www.actioncanadashr.org/resources/factsheets-guidelines/2019-09-19-access-glance-abortion-services-canada.

Reflections on Canadian abortion care in a post-Roe world

Continued from page 337

5. ASRM Center for Policy and Leadership. State abortion trigger laws' potential implications for reproductive medicine. Last updated 1 July 2022. Accessed 6 September 2022. www.asrm.org/news-and-publications/asrms-response-to-the-dobbs-v-jackson-ruling/dobbs/state-law-summaries.
6. Jokisch Polo M. Infertility patients fear abortion bans could affect access to IVF treatment. NPR. 21 July 2022. Accessed 6 September 2022. www.npr.org/sections/health-shots/2022/07/21/1112127457/infertility-patients-fear-abortion-bans-could-affect-access-to-ivf-treatment.
7. Gerson J. How overturning Roe v. Wade could affect IVF. PBS News Hour. Last updated 24 June 2022. Accessed 6 September 2022. www.pbs.org/newshour/health/how-overturning-roe-v-wade-could-affect-ivf.
8. Ikemoto LC. Op-Ed: How IVF could be derailed by abortion restrictions. 7 July 2022. Accessed 6 September 2022. www.latimes.com/opinion/story/2022-07-07/ivf-roe-vs-wade-abortion.
9. Abortion: Enacts the Abolition of Abortion in Louisiana Act of 2022. Louisiana House Bill 813. Accessed 6 September 2022. https://legis.la.gov/legis/ViewDocument.aspx?d=1259299.