# CFMS/FEMC Position Paper:
## Induced Abortion

### Introduction

Induced abortion is the active termination of a pregnancy before fetal viability, where viability is the ability to survive independently of the maternal environment.[1] In January 1988, the Supreme Court of Canada struck down section 251 of the Criminal Code of Canada, decriminalizing abortion. Since then, there has been no federal abortion law in Canada, so it remain a right protected under the Charter of Rights and Freedoms.[1, 2] The debate over abortion remains active in Canada.[2] Access to abortion remains a patchwork across the country with only one in every six hospital offering abortion services. In addition, most of the providing hospitals are located closest to the US border creating further geographical barriers in terms of access.[3] Many organizations, most notably the Canadian Medical Association (CMA), have published policies or position papers on the topic of abortion.[1] This includes other medical student federations such as the American Medical Student Association.[4]

### Rationale

The CFMS/FEMC relatively recently created a position within the Global Health Program called the National Officer of Reproductive and Sexual Health (NORSH). The role of the position initially began as a facilitator of awareness days but has grown to encompass, among other roles, advocacy. However, unlike other medical student federations, the CFMS/FEMC does not have a comprehensive body of position papers. With the expansion of the NORSH's role, the availability of a larger diverse set of position would allow the NORSH to perform political advocacy initiatives on local, regional, national and international levels with the full support of the CFMS/FEMC.

The CFMS/FEMC currently has no position paper on induced abortion which not only impedes the activities of the NORSH, but also provides no direction for its membership. A small working group was created during the 2013 CFMS/FEMC AGM in Quebec City, QC recognizing the importance of such a document.

### Principles

The Canadian Federation of Medical Students/Fédération des Étudiants et des Étudiantes en Médecine du Canada:

1. Regarding Medical School Curriculum
    a. Urges teaching in third or fourth year rotations in OB/GYN the procedure of abortion to medical students with exemption on the basis of personal principles, in the same manner as other surgical procedures within that field
    b. Urges the Committee on Accreditation of Canadian Medical Schools (CACMS) to only accredit those medical schools who offer didactic training in reproductive and sexual health including, but not limited to: abortion in OB/GYN clerkships and in preclinical years and experience in the surgical procedure of abortion including observation of the procedure itself and the pre- and post-abortion counseling; with exemptions for students based on personal principle

    c. Urges the Medical Council of Canada to include items regarding abortion in the MCCQE Part I and Part II exams
2. Regarding Family Medicine Residency Training Programs
    a. Urges the College of Family Physicians of Canada to encourage mandatory training in abortion and pregnancy options counseling in the design of family medicine residency education
    b. Encourages family medicine directors to coordinate abortion training at the teaching institution, a clinic, or office in the community; with exemptions based on personal principle
    c. Urges the College of Family Physicians of Canada to include questions on abortion procedures in exams
    d. Asks the College of Family Physicians of Canada to only recommend accreditation to programs that offer abortion training and management on and/or off site
    e. Encourages the College of Family Physicians of Canada to provide CME and CPD training and credits for abortion provision
3. Regarding OB/GYN Residency Training Programs
    a. Believes that abortion care should be a required component of OB/GYN residency training with exemption based on personal principles
    b. Urges the Royal College to encourage mandatory training in abortion and pregnancy counseling in OB/GYN residency education
    c. Encourages OB/GYN residency directors to coordinate abortion training at the teaching institution, a clinic, or office in the community; with exemptions based on personal principle
    d. Urges the Royal College to include questions on abortion procedures in exams
    e. Asks the Royal College to only accredit those programs that offer abortion training and management on and/or off site
    f. Encourages the Society of Obstetricians and Gynaecologists to provide CME and CPD training and credits for the provision of abortion
4. Regarding Options Counseling
    a. Believes the decision to perform an induced abortion is a medical one, made confidentially between the patient and her physician
    b. Believes no patient should be compelled to have a pregnancy terminated
    c. Believes patients should be provided with information about all clinical options available and information about the existence of a procedure or treatment not be withheld because providing that procedure or giving advice about it conflicts with the healthcare provider's moral beliefs
    d. Believes healthcare providers should communicate clearly and promptly about any treatments or procedures they choose not to provide because of his or her moral or religious beliefs
5. Regarding Conscientious Objection
    a. Believes healthcare providers should not be compelled to participate in the termination of a pregnancy
    b. Believes healthcare providers are required to inform the patient when personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants
6. Regarding Referral
    a. Believes that if a healthcare provider is uncomfortable providing abortion services (medical, surgical), they have the duty to refer the patient to another provider

    b. Believes there should be no delay in the provision of abortion services as it is a time sensitive procedure
7. Regarding Access
    a. Believes that all women, regardless of age, religion, SES or marital status have the right to obtain a legal, safe and voluntary abortion
    b. Believes as a secondary means, emergency contraception and/or abortion, with informed consent, should be fully accessible to all
    c. Believes that voluntary induced abortions should be available from all public hospitals on the same basis as any other medical or surgical procedure
    d. Opposes any policy at the local, provincial or federal level that causes delay and increased medical risk in the delivery of abortion services to women
    e. Opposes the use of explicit visual and/or verbal representation of the products of abortion that tend to produce emotional trauma rather than provide useful information to a woman considering an abortion
    f. Believes there should be no delay in accessing an abortion as it is a time sensitive procedure
    g. Believes induced abortion should be uniformly available to all women in Canada regardless of geographical location
    h. Believes healthcare insurance should cover all costs of providing all medically required services relating to abortion provision including counseling
    i. Supports the use of federal and provincial funds to provide abortions for women
    j. Supports the inclusion of abortion as part of the inter-provincial billing agreement
    k. Opposes restrictions on the availability of funds for family planning clinics that offer, counsel for, or refer for abortion
    l. Believes hospital staff should not discriminate against, prevent or delay women seeking abortions
8. Regarding Safety
    a. Supports a woman's right to an abortion performed in a safe and secure environment
    b. Condemns violence directed against abortion clinics and family planning centers as a violation of the right to access healthcare
    c. Condemns inflammatory rhetoric that encourages violence surrounding the abortion debate
    d. Strongly urges all health professional organizations/associations to publicly condemn violence directed against abortion providers, clinic workers and patients
    e. Condemns the discrimination of women seeking abortions by healthcare providers and staff
9. Regarding Stigma and Discrimination
    a. Believes that the stigma existing against abortion providers creates further barriers to care
    b. Believes students and healthcare providers should not be discriminated against or stigmatized based on their views or practice of abortion care
    c. Believes there should be no discrimination of students or healthcare providers who perform or assist in induced abortions
10. Regarding Personhood
    a. Believes that the question of when a conceptus acquires personhood is a complex, religious, moral and personal question that cannot be answered by medical science, and opposes all legislation attempting to define personhood of a conceptus
11. Regarding When An Abortion Is Performed

    a. Since the risks of complications of induced abortion are lowest in early pregnancy, early diagnosis of pregnancy and determination of appropriate management should be considered
    b. Elective termination of pregnancy after fetal viability may be indicated under certain circumstances
12. Regarding Contraception and Emergency Contraception
    a. Believes that unintended pregnancies can place an undue burden on women and their families
    b. Believes birth control to be a form of preventative medicine
    c. Believes primary forms of birth control methods that prevent conception should be encouraged through education and increasing availability
    d. Believes that as a secondary means to contraception, emergency contraception and/or abortion, with informed consent, should be fully accessible to all
    e. Supports the proposal that cost be no barrier in the availability of birth control information, devices and medications
    f. Supports contraceptive equity – insurance coverage for contraceptive devices and medications including emergency contraception, at the same rate as other covered medications – for both private and public insurance, to achieve fair access and lower costs to patients
    g. Supports over-the-counter availability of emergency contraception and other contraceptive methods as safe and effective for over-the-counter use, to all women regardless of age
    h. Condemns age-based restrictions on over-the-counter access to emergency contraception
    i. Urges counseling about and access to emergency contraception as the standard of care for victims of sexual violence

**References**


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**Supplementary Material**

Sections 1-3: Medical Education and Residency Programs

These sections of the principles were adapted from the AMSA Preamble, Purposes and Principles document.[4] Additionally, organizations like the American Academy of Family Physicians (AAFP) support the inclusion of abortion within Family Medicine Residency curriculum.[5] The College of Family Physicians of Canada has included the topic of abortion within their family medicine bioethics curriculum.[6]

Section 4: Options Counseling

Sections 4a-b were adopted from the CMA policy on induced abortion.[1] Sections 4c-d were adopted from the College of Physicians and Surgeons of Ontario policy statement on physicians and the human rights code.[7] Section 4d is also found within the CMA Code of Ethics.[8]

Section 5: Conscientious Objection

Section 5a was adopted from the CMA policy on induced abortion.[1] Section 5b was adopted from the CMA code of ethics.[8]

Section 6: Referral

The issue of referral is based upon various sections within the CMA policy on induced abortion: "The patient should be provided with the option of full and immediate counseling services in the event of unwanted pregnancy;" "Early diagnosis of pregnancy and determination of appropriate management should be encouraged;" and "There should be no delay in the provision of abortion services." These statements recognize the need for timely referral and the importance of physicians not to create additional barriers preventing women from accessing abortions elsewhere.

Section 7: Regarding Access

This section was adopted from the AMSA principles document.[4] Specifically section J refers to the fact that women not living in their home province/territory face additional challenges because abortion is not part of the inter-provincial billing agreement. In fact, abortion is the only time-sensitive and medically necessary procedure excluded from the list of services on the inter-provincial billing agreement. This creates an issue for students attending school in another province/territory or women who have recently moved and are in the process of transitioning their health care benefits.[9] Section 7l was based upon a study called Reality Check which looked at barriers women face in accessing abortion across Canada. The study found that in addition to the physical barriers of geography, women can face anti-choice healthcare workers who mislead or misinform women. Alternately, some healthcare workers may be misinformed or not know whether their hospital provides abortions.[3]

Section 8: Regarding Safety
This section was adopted from the AMSA principles document.[4]

Section 9: Regarding Stigma and Discrimination
Section 9 was inspired by a recent study in the journal Contraception which looked at abortion stigma amongst health workers of all types working at reproductive health clinics in the U.S. They found that all workers felt the effects of doing stigmatized work through public discourse, in institutions and amongst family and friends. They found the workers were forced to make choices about whether and how to disclose their abortion work. One abortion provider said he felt other doctors judged him as if they were on a higher moral plane. Dr. Lisa Harris states "When abortion providers do not disclose their work in everyday encounters, their silence perpetuates a stereotype that abortion work is unusual or deviant, or that legitimate, mainstream doctors do not perform abortions. This contributes to marginalization of abortion providers within medicine and the ongoing targeting of providers for harassment and violence. This reinforces the reluctance to disclose abortion work, and the cycle continues." [10]

Section 10: Regarding Personhood
This section was adopted from the AMSA principles document.[4]

Section 11: Regarding When An Abortion Is Performed
This section was adopted from the CMA policy on induced abortions.[1]

Section 12: Regarding Contraception and Emergency Contraception
This section was adopted from the AMSA principles document.[4]