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**THE STATUS OF ABORTION EDUCATION IN
ONTARIO MEDICAL SCHOOLS?**

by

Erin Connell, Hons.B.A.

A thesis submitted to the Faculty of Graduate Studies and Research in partial
fulfillment of the requirement for the degree of
Masters of Arts
in Canadian Studies

Carleton University

Ottawa, Ontario

January 8, 2001

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**The undersigned recommend to the Faculty
of Graduate Studies and Research acceptance of the thesis**

**“The Status of Abortion Education
in Ontario Medical Schools”**

submitted by Erin Connell, Hons. B.A.

**in partial fulfillment of the requirements for
the degree of Master of Arts**

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January 2001

ABSTRACT

The goal of this study is to explore the status of abortion education in Ontario medical schools. Survey research supported my first hypothesis that undergraduate medical students are receiving little education on abortion issues. The data do not support my second hypothesis that because of this lack of training, few medical students are planning to offer abortion services as a part of their future medical practices. This lack of training is due to the process of absorption, where the abortion issue was extracted from its political context and absorbed into institutional structures, resulting in the medicalization and institutionalization of abortion. The controversial nature of abortion itself, as well as the slow emergence of women's health issues into medical school curricula, further explain this lack of training. These results are a call to the women's movement to reexamine its strategies in order to prevent the depoliticization and absorption of feminist concerns into institutional structures.

ACKNOWLEDGEMENTS

There are several people who contributed to the completion of this project that I would like to take this opportunity to thank. First, I would like to thank my advisor, Pat Armstrong. Amidst a very hectic schedule, she was always very supportive and patient and her guidance and intelligence truly inspirational. I would also like to thank my mom for her on-going encouragement and support. Many thanks to my Aunt Jane, Alia, and especially Dr. Jo-Anne Lefevre for helping me with my statistics. Thanks also to all of my friends and, in particular, Heidi, Duane, Melissa and Cathy, for always lending an ear during the often intimidating process of completing this project. Lastly, many thanks to Karen, without whom this project would never have come to fruition.

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INTRODUCTION

On January 28, 1988, the Supreme Court of Canada struck down Canada's abortion law, declaring it unconstitutional and in violation of a woman's right to life, liberty and security of the person. The day was hailed as a major victory for Canadian women: the fate of women faced with unintended pregnancies was no longer left in the hands of Therapeutic Abortion Committees or hard-to-access, and sometimes expensive and/or unsafe, illegal abortionists. When a new abortion law was defeated in Senate in 1991, women's groups uttered a sigh of relief. Abortion would not be recriminalized – it would become a private medical matter to be decided upon by a woman in consultation with her doctor.

The assumption made by women's groups at the time was that the decriminalization of abortion would result in automatic access to abortion services facilitated by a sympathetic medical profession. Physicians could offer abortion services free of reprimand and women would have access to insured services through clinic and hospital-based facilities in all communities. What became clear, however, is that there are not enough abortion providers and facilities to accommodate what Statistics Canada has deemed the most common surgical procedure women undergo in Canada (Powell, 1997).

To celebrate the tenth anniversary of the decision of the Supreme Court of Canada, the Canadian Abortion Rights Action League (CARAL) issued a report entitled *Access Granted: Too Often Denied*. As Canada's only national, pro-choice organization working full-time to keep abortion legal and accessible to all women, CARAL offered a detailed review of the status of abortion in Canada over the last ten years. Their report

illustrates how Canadian women have been “robbed” of the full promise of the Supreme Court decision because the 1988 decision “defined abortion in terms of women’s right to health care” (Studler and Tatalovich, 1996: 81). Because the allocation of health care dollars and the development of health care programs are left to the discretion of the provinces, abortion services are not uniform and accessibility varies province to province. In all provinces, there is a strong urban bias to the availability of hospital and clinic based abortion services (ibid) and this situation is further exacerbated by health care downsizing, cutbacks, and amalgamation. In fact, some provinces (particularly the Atlantic provinces) still require that a woman obtain the approval of more than one physician before obtaining an abortion. Further, provincial funding is extremely uneven. Abortion is excluded from provincial reciprocal billing lists meaning a woman moving to or living outside her home province cannot access medicare dollars for abortion services.

The CARAL report also outlines how we are experiencing a shrinking pool of abortion providers, which not only poses a serious threat to abortion access, but perpetuates abortion as a discretionary procedure subject to the choice of physicians. The report describes this decline as attributable to three main causes. The first is the “graying” of providers, where most abortion providers, who were motivated to provide this service by the tragedy of unsafe, “back alley” abortions, are nearing retirement and few physicians are stepping forward to take their place. The second involves the harassment and violence perpetrated against abortion providers and facilities, such as picketing, acid attacks, bombings and even shootings. The last is a lack of abortion training provided in medical schools at the undergraduate and residency levels.

This study is concerned with the latter point: the status of abortion education in medical schools. Data on this subject are not available in the Canadian context, although anecdotal and preliminary data seem to indicate that a lack of training may be an issue. The CARAL report describes how almost no medical schools “formally include abortion as any part of the undergraduate curriculum on women’s reproductive health” (Bowes et al, 1998: 53). Ferris et al. (1997), in their study *A Descriptive Report on the Availability of Abortion Services in Ontario General Hospitals*, found that 15% of physicians interviewed did not perform abortion because they never received the necessary training as part of their medical education. Data collected in the U.S. indicate that the majority of medical schools do not provide abortion training at the residency level (Burkman et al., 1974; Lindheim and Cotterill, 1978; Darney et al., 1987; MacKay and MacKay, 1995; Talley and Bergus, 1996; Steinauer et al., 1997). While there are of course some fundamental medico-legal differences between the U.S. and Canada, these results, in combination with the research of Bowes et al. and Ferris et al., may suggest a pattern.

This study will explore the status of abortion education in Ontario’s five medical schools by way of survey research. Specifically, it will examine what procedures, communication techniques and ethical issues, as they pertain to abortion, are included in the curricula, how they are integrated and in what forum they are taught. It will also explore the necessity (or lack thereof) for abortion education, climate issues and student willingness to facilitate (or not) women’s access to abortion services. Ontario was chosen because there are more medical schools in Ontario than any other Canadian province, Ontario is the most populous province in Canada and is also most geographically convenient. The scope of this study is also limited to undergraduate medical education.

All medical students need a certain level of knowledge and awareness regarding abortion issues as most future physicians will encounter women patients who have had or will need an abortion. Undergraduate education is also a critical time where students determine their specialty and therefore what services they will provide as part of their future medical practices. If undergraduate students are not exposed to abortion issues, how will students become motivated to provide abortion services?

However, my hypothesis is that students receive little education and training in abortion issues. Given this context, I also hypothesize that few medical students are planning to offer abortion services as part of their future medical practice.

The following chapter will provide a theoretical basis to support these hypotheses. Specifically, it will borrow from Gillian Walker's work on the transformation and absorption of feminist concerns into existing institutional structures to explain how abortion has been extracted from its political context and subsequently medicalized and institutionalized. In the absence of an adequate structural analysis, women's groups are forced to defend past gains. In addition, the controversial nature of abortion, which includes the moral and religious arguments against abortion, the marginalization of abortion providers by the medical profession and the violence and harassment perpetrated against abortion providers, will also be explored. Likewise, the slow and fragmented emergence of women's health issues, in general, into a medical school curricula which still views the male as normative in research, treatment, social constructs and health care provision will also be examined. All of these factors: absorption, the controversial nature of abortion and the slow emergence of women's health issues into medical school

curricula will provide a way of understanding why medical students may be receiving little education in abortion issues.

Chapter Three will describe the study's methodology. It will outline the development of the survey tool, the pilot testing process and entry into the medical schools. I will also describe the various barriers, obstacles and restrictions experienced in conducting the research: the controversial and sensitive nature of abortion; my own lack of control as to how, when and where my research would be conducted; resistance from administrators and, consequently, a lower than anticipated response rate.

In Chapter Four, I will analyze and describe the survey results. Data will be analyzed for statistical significance and will not only explore the availability of abortion education and training but also student opinion on abortion education.

The final chapter will reiterate the major findings of the study. It examines how they complement the literature as well as implications for future research and policy strategies.

EXPLAINING A LACK OF TRAINING IN ABORTION ISSUES: WHAT THE LITERATURE TELLS US

When, in 1988, the Supreme Court of Canada decriminalized abortion, declaring it contrary to a woman's right to life, liberty and security of the person, women's groups across the country cheered. With one swift strike of the gavel, abortion was removed from the *Criminal Code of Canada* and its regulation mandated to the medical profession. Abortion would be a private decision to be made by a woman in consultation with her doctor, a procedure only to be performed by licensed medical practitioners in accredited medical facilities and available to women up to twenty weeks gestational age. While the decriminalization of abortion was certainly positive for women, I will argue that the medicalization and institutionalization of abortion has negative consequences for women. Indeed, the 1988 decision "...defined abortion in terms of women's right to health care" (Studlar and Tatalovich, 1996: 81). Women certainly won the right to choose, but without the corresponding right of access.

The medicalization and institutionalization of abortion resulted from a gradual regulatory shift from law to medicine, coinciding with the second wave of feminism in Canada during the late 1960s, until the Supreme Court decision in 1988.¹ Although parliament attempted to create a new abortion law in 1991, all efforts were defeated by a tie vote in the Senate. Since 1991, no federal government has broached the abortion

¹ The medicalization of abortion actually occurred in two phases. The first involved a regulatory shift from midwives and lay-healers to medicine (much like the rest of women's reproductive health) and the second involved a regulatory shift from law to medicine. The former is beyond the scope of this project; therefore, the medicalization of abortion will, for the purposes of this paper, focus on the regulatory shift from law to medicine.

issue² and abortion policy has been left with the medical profession and the provincial ministries of health. The result has not been entirely positive for the women of Canada. While there have been important short-term implications, most notably the protection of individual women, this shift is part of a larger process of absorption.

This process of absorption is best described in Gillian Walker's analysis of the battered women's movement. Walker describes how the efforts of feminist activists concerned with wife beating have been transformed and absorbed into existing institutional structures, leaving the sites of feminist struggles dispersed, disconnected and depoliticized. Specifically, she describes a political process of control where wife battering was absorbed into a social problem apparatus: in making public and naming a private issue, women's groups opened the door to state remedy where the issue is extracted from its political context. Indeed:

Naming the experience is a double-edged sword. It coordinates our mobilization and identifies our difficulties to ourselves and each other... At the same time, it [directs] such action into particular channels: seeking "help" in the form of social services or legal redress. Neither of these mobilize women unless they are put in a feminist context; nor do they address the totality of women's lives (Walker, 1990: 80).

In Walker's analysis, the process of absorption is largely influenced by who defines and controls the issue as well as how these definitions and control mechanisms manifest themselves in institutional structures. Problems are defined in ways that link to institutions, agencies, government and others who have the power to make decisions. As a result, wife battering is defined primarily as a problem of assault under the criminal code and a private matter concerned with the interpersonal relations of individuals. Any

² This particular situation may, however, change, with the emergence of New Right groups such as the Canadian Alliance.

analysis of women's oppression in broader society is secondary to a strategy of invoking women's rights as individuals under the law.

Once defined, the issues are lodged, or owned, in specific categories and within professional discourse. Categories such as "battered wife" are constructed through which professional intervention (e.g. conferences, a literature, professional practice) operates. A professional discourse of "family violence" prevails as opposed to a feminist discourse on "male violence" (the definition of the problem as male violence, however, did make visible the gender and power relations in "family" violence and helped advance the struggle for definitional control and action). And it made the professional discourse accommodate women's experience. Certain groups in society assume power to regulate, control, and innovate solutions. As the authority of women's groups was dispossessed, government and professional adoption of the issue directed the movement in ways which suited the interests of these government and professional groups. As a result:

... the very issues which necessitated the recognition of wife beating as a social problem have been refined and even reversed through government cooption of the problem... maintenance of the problem on the public agenda was ensured only by the government's ownership of the problem... once the government accepted ownership of the problem, it was able to limit the response it made (Hinton, 1989: 314, 325).

Other effects of absorption include a progressive weakening of active dialogue, as active dialogue is withdrawn from the general struggle. The process of professionalization eliminates the possibility of a more radical critique since ways of understanding the problem are policy-oriented and the role of patriarchy remains unrecognized. The failure to address the role of patriarchy and the structural features of oppression not only lead to inadequate public response against the problem but also "leaves the justice system free to manage violence in ways which bolster and reassert the status quo." (Walker, 1990: 84)

Moreover,

Each new way of absorbing women's movement initiatives into the institutional structure isolates them from the movement and depoliticizes them. Each is reassembled as a technical or otherwise limited problem. It is relocated in its professional or other institutional setting. It is given a new terminology tying it into the controlled institutional communication and action system. How it becomes visible, can be thought and acted upon, gets restricted to that frame. The problem becomes specific, contained, cut off from its general relation to the whole question of women's oppression in contemporary capitalist society (Smith, 1979: 13-14).

This analysis is particularly helpful when examining the issue of abortion. Women had to create alliances with different aspects of the state, or more specifically the criminal justice system and the medical profession, to alter oppressive conditions and make public the private issue of abortion. While Walker warns us that it is not adequate to hold one-dimensional views of the state as a monolith, with either benign or hostile intentions toward women, women's groups often find themselves in opposition to approaches put forward by professionals and institutions.

There are important parallels with the abortion issue. The legal right to abortion was won in 1988; however, the issue became medicalized and institutionalized by the medical profession. While individual women have benefited from this shift, the way the issue has been defined and controlled has been to the benefit of the medical profession. Many Canadian women continue to struggle in order to access abortion services. This has led to a situation where women's groups are defending past gains, in part at least because the medical and legal institutions failed to develop an adequate structural analysis.

Using this as a theoretical approach, I will analyze, in the following pages, how abortion has not only been medicalized and institutionalized, but how it has also been absorbed. This process, in combination with the controversial nature of abortion and the

slow and fragmented integration of women's health issues, in general, into medical school curricula, will provide a way of understanding why abortion issues have not been successfully integrated into undergraduate medical school curricula. As a consequence, women's access to abortion continues to be severely restricted.

Medicalization, Institutionalization and Absorption

Up until the first half of the nineteenth century, information about abortion methods was tolerated and the use of this information largely unregulated and not publicly challenged. In fact, British common law established that prior to "quickening," when the fetus moved in the womb, women could legally terminate their pregnancy.

However, by 1869 the *Offences Against the Persons Act* was established which defined abortion as an indictable offence. The *Act* was incorporated into the *Criminal Code of Canada* in 1892 and went virtually unaltered until 1969. Abortion providers who were convicted were liable to a maximum of seven years imprisonment. There was, however, a provision in the *Act* that absolved physicians who, while acting to preserve a woman's life, caused an abortion.

Women continued to require abortion services and some physicians operated outside of the law to offer them. Fear of physician prosecution provided the impetus for the Canadian Medical Association (CMA) to begin to question the *Criminal Code* regulation of abortion and when abortion reform was examined by the federal government in 1967, the CMA presented its resolution to the Standing Committee on Health and Welfare. The CMA proposed that, with the use of a Therapeutic Abortion Committee (TAC), a woman

should be able to receive an abortion if her life or health was threatened, if the fetus was defective or if the pregnancy resulted from a sexual crime.

The omnibus bill, Bill C-150, essentially reflected the CMA's recommendation. The new abortion law prohibited abortion unless performed by a qualified medical practitioner in an accredited and approved hospital with the consent of a hospital-based Therapeutic Abortion Committee comprised of at least three medical practitioners. Although some women, particularly urban women, were better served by better access and protected by safer conditions, the new law provided a medicalized and institutionalized definition of abortion. Here, "choice became a right won by physicians" (Kellough, 1996: 81) and access to abortion services was controlled by the medical profession.

This is exemplified in two studies. Smith and Wineberg (1970) found in their review of TAC rulings that the law institutionalized subjective decision-making where doctors controlled access to abortion services: doctors, not women, presented the case to the TAC and doctors only presented cases that would be accepted by the committee. Clearly, women were dependent on not only having access to a doctor, but also on the benevolence of their doctors who determined whether women were entitled to health care.

The second study, the Badgley Report, highlighted similar findings. Hospitals could choose not to provide abortion services by not establishing TACs, which meant "the possibility of 'legal' abortion had no meaning if no doctor agreed to perform them or if no TAC existed" (Brodie et al., 1992: 51). Further, because TACs had no criteria or procedure for due process for deciding what was 'legal' or 'illegal', "doctors,

individually and as a group, were legally obligated to make judgements about the morality of abortion decisions”(Kellough, 1996: 108). Also, a number of committees had established strict quotas to avoid gaining a reputation of being overly “permissive.”

Clearly, both studies indicate that “the legal “recognition” of the therapeutic abortion [had] medicalized the issue and legitimized the ‘moral arbitration of doctors’” (Gavigan, 1986: 265).

In 1969, abortion provider Henry Morgentaler defied the law’s requirement of hospital approval and established a free-standing clinic in Montreal and by 1983 had established additional clinics in Winnipeg and Toronto. From his first criminal trial in 1973 until his final acquittal in 1988, Morgentaler faced numerous charges in Quebec, Manitoba and Ontario. Finally, on January 28, 1988, the Supreme Court of Canada acquitted the charges against Morgentaler and two other abortion providers and struck down the abortion law declaring it unconstitutional and in violation of a woman’s right to life, liberty and security of the person. While many women and women’s groups are indebted to and grateful of Dr. Morgentaler’s efforts, it is no coincidence that it was the medical profession that played a major role in the decriminalization of abortion. In the absence of any abortion law, abortion policy is left entirely to the medical profession. The CMA (1988) indicates that “abortion requires medical and surgical expertise”, “abortion is a medical act” and the decision to perform an abortion “is a medical one, made confidentially between the patient and her physician.” Since physicians are the only health care professionals regulated to provide abortion services, abortion is, in many ways, a physician’s issue.

From this brief medico-legal history of abortion, "...it is possible to recount the history of abortion politics in Canada without making much reference to the actions of the women's movement; state actions regulating the termination of pregnancy have been constituted by a variety of other actors"³ (Brodie et al., 1992: 43). However, feminists were immediately critical of the 1969 law and organized the Abortion Caravan in 1970. Women from across the country joined the Caravan, which departed from Vancouver and visited many cities before arriving in Ottawa. Transforming abortion from an individual concern shrouded in isolation, vulnerability, responsibility and blame to a social issue, women travelling with the Caravan offered personal stories of the need for abortion, and the horrors of obtaining it illegally to illustrate the need for change (Adamson, et al., 1988: 202). Further to making the personal political, a pro-choice discourse developed out of the women's movement. In sum, feminists advocated for the legalization of abortion in order to protect the health of women and protect the integrity of the law. Further, feminists noted that abortion should be integrated into a comprehensive system of reproductive education and control. Moreover, feminists asserted that abortion is fundamentally a woman's right: citizens have the right to make decisions about their bodies free from state interference (bodily integrity) and women are autonomous, rational and moral agents capable of expressing choice (individual conscience).

The controversy leading up to the 1988 Supreme Court decision was, however, mostly about the rights and responsibilities of doctors. In fact, "...the voices raised were often those of humanists, doctors, social reformers, judges, religious leaders and state

³ This is not to say that women have been passive in the abortion debate. Indeed, women have always found ways to abort themselves within the constraints of law.

officials. Feminist voices, expressing a clear, pro-choice position, had a much harder time being heard” (Brodie et al., 1992: 16). The reasons for this are two-fold. The first has to do with divisions within the women’s movement and the second has to do with the process of absorption.

Not long after the Abortion Caravan, some feminists deemed abortion as “...the forgotten issue of the women’s movement in Canada” (McDonnell, 1982: 33). Brodie et al. (1992) attribute this to two causes: a split within the movement as to how to pursue reform and the liberalism of the Canadian women’s movement. On the issue of abortion, the women’s movement was split: some feminists believed that abortion, as a single-issue focus, had great mobilization potential as it was an issue women could identify with. Others perceived abortion as one of many changes that needed to occur and that women should be mobilized on other issues as well. Around the same time, women were mobilizing around workplace issues, such as equal pay and sexual harassment as well as issues related to violence against women. Further, because the Canadian women’s movement is heavily weighted toward liberal feminism, the authors describe the movement as one largely concerned with equalizing opportunity and moving women into the mainstream of economic, social and political life. Within this analysis, there is very little room to speak of women’s (reproductive) difference. Although the mainstream women’s movement always supported abortion reform, the issue did not dominate the agenda and it was left to Morgentaler defense committees or single-issue organizations like the Canadian Abortion Rights Action League (CARAL).

CARAL lobbied at the national level while organizations like the Ontario Coalition of Abortion Clinics (OCAC) lobbied at the provincial level to first decriminalize abortion

and then keep it legal. However, CARAL and OCAC, in their attempts to first decriminalize abortion and then keep abortion legal, rallied behind the medical profession unknowingly contributing to the process of absorption. Kellough (1990) describes Morgentaler, for example, as the movement's greatest asset and its greatest liability. On the one hand, he provided great medical expertise and a willingness to challenge the system. On the other hand, "...the image of Morgentaler as a benefactor of "the women of Canada" reinforced social-code assumptions about men and doctors dispensing welfare to women" (Kellough, 1990: 195). In seeking remedy and aligning themselves with different aspects of the state, the strategy of defining abortion as a medical issue, in order to first challenge and then avoid a new abortion law, contributed to the medicalization and absorption of abortion. While I am not trying to pass judgement on the success or failure of any particular strategy, in seeking medical recourse, the issue quickly became a physician's issue and not a woman's right. In the courts, the abortion law was described as undue interference with a doctor's right as it encroached upon normal medical liberty. Doctors were the primary legal subjects and women were secondary ones.

State remedy was sought through extracting abortion, as a medical issue, from its political context where it was deemed part of the demand for women's full sexual and reproductive freedom. Further, such remedy converted a social problem into a private matter involving individual women and "the morality of the system itself could not be addressed at this level, only the morality of the pregnant woman" (ibid: 117). By not addressing structural oppression and the role of patriarchy, abortion became an individual and medical matter rather than a matter of women's rights. As a result, it becomes clear

that “the ‘right to choose’ means little when women are powerless” (Petchesky, 1990: 11).

This is not to say that the legalization of abortion is not positive for women. It is the medicalization and institutionalization of abortion that is negative since “...women won a symbolic right of access but without the corresponding right to choose” (Kellough, 1996: 82). This failure to address the role of patriarchy and structural features of oppression results in an inadequate response that serves to bolster and reassert the status quo. The medical establishment, in the absence of a law, maintained its monopoly over the delivery of abortion services and continue to act as gatekeepers to protect public morality (McDaniel, 1985). As a result, there are few policies in place to ensure women’s access to abortion services particularly in a health care system that attempts to provide collective medical services within the larger negative rights model of the marketplace. Not all provinces and territories insure abortion through medicare and not all communities provide abortion services in hospitals or free-standing clinics. This is further exacerbated by hospital closures, downsizing of staff and delisting of certain services and procedures (Powell, 1997) as well as by the presence of religious hospitals opposed to abortion. There are no guarantees that there will be a sufficient number of abortion providers to meet demand nor are there any established models for educating physicians in training – the subject of this paper. Clearly, the delivery of abortion services is fragmented and inequitable. But this does not appear to be a priority for the medical profession which is problematic as they control medical education as well as access. While this illustrates the complexity of public policy, it also indicates a constant need to defend women’s rights, possibly because the right to abortion was won for doctors and not for women. Indeed,

“...we have been released for the moment from the “criminal” frying pan only to be burned by the ‘health care’ fire” (Brodie et al., 1992: 145).

The bottom-line result of the absorption of abortion by medical institutions is that women may have won the right to choose but without the corresponding right of access. Part of this lack of access is attributable to the lack of training of medical school students in abortion issues, thus perpetuating the shrinking pool of abortion providers we are currently experiencing. Because abortion was narrowly defined as a private medical procedure, moral and religious arguments against abortion, the marginalization of abortion providers by the medical profession and violence perpetrated against abortion providers continue to shape and inform public discourse. All of these factors contribute to a lack of abortion education in medical schools as will be explored in the following section.

The Controversial Nature of Abortion

Abortion is one of the most controversial issues facing our society today given the strong emotions the issue evokes. Abortion provides a meeting place of some of our most basic and contentious views of sexuality and reproduction (McDonnell, 1984) as it challenges assumptions surrounding individual rights and collective responsibilities.

Indeed:

... the abortion issue slices into the heart of how this society makes (or refuses to make) decisions on social policy, how it views motherhood and childbearing, how it views the individual's relation first to family and then to society (Collins, 1985: xiii).

This section will explore the moral and religious arguments against abortion, the marginalization of abortion providers by the medical profession and the violence and

harassment perpetrated against abortion providers to explain the possible lack of training of medical students in abortion education. Because much of this section is concerned with deconstructing anti-choice discourse, this necessity in itself indicates a lack of resolution on women's sexual and reproductive rights as a result of absorption. If our policies and institutions reflected the sentiments of a pro-choice majority Canadian population (Bowes et al., 1998) abortion would be deemed a medically necessary service in the context of a woman's right to choose and feminists would not be forced to defend past gains.

Opposition would be neither overt (e.g. violence and harassment) or covert (e.g. a lack of medical training).

The Moral and Religious Arguments Against Abortion

Perhaps one reason medical schools are hesitant to broach the subject of abortion with medical students lies in the moral and religious arguments the issue evokes. The anti-choice movement has made it abundantly clear that abortion threatens the sanctity of life as well as the roles and duties of women.

At the heart of the abortion controversy is the belief that life begins at conception. Although the Medieval Catholic Church had a 40 and 80 day rule (the soul entered a male fetus 40 days after conception and entered a female fetus 80 days after conception), this position was abandoned in 1869 and the Church adopted the view that the soul infused at conception. Christianity endowed the embryo with a soul and abortion became not only a crime against the fetus but murder. Today, although the Canadian Catholic Church believes abortion to be an unspeakable crime against humanity, organized opposition is not found so much in the Church hierarchy, but amongst lay people, like fetal rights

crusader Joe Borowski (Collins, 1985). Such activists insist that the fetus is fully human from the moment of conception, able to feel pain and, given these facts, the life of the fetus takes legal and moral precedence over women's rights and self-determination. Further, the anti-choice movement has made ideological links with the anti-euthenasia, disability, peace and anti-genetics movements. They hold a genuine fear that the value of human life is being eroded because people who drain resources and productivity in our capitalist/consumer society are disposable (McDonald, 1984). In a desire for social justice, abortion is likened to the Holocaust (because of the mass murder of babies) and the pro-life movement to a human rights movement (such as the civil rights movement).

The role of women in society is also central to religious and moral arguments against abortion. The "traditional" view of women describes them as vessels, mothers and nurturers and idealizes female passivity and self-sacrifice. The aborting woman is, therefore, selfish, morally bankrupt, self-centered and hedonistic. Abortion is an issue of innocence (the fetus) and evil (the aborting mother). Abortion is deemed a symbol of uncontrolled female sexuality and women are moral children unfit to handle the freedom and responsibility thrust upon them by the contraceptive revolution (Collins, 1985). Clearly, sexual pleasure is inappropriate for women. And women who indulge have to "pay the price" (Petchesky, 1990). This attitude of blame attached to abortion-seeking women springs from a number of sources: their sexual activity; their "irresponsibility" about birth control; and their rejection of their childbearing and nurturing role (McDonnell, 1984).

Abortion opens the door to the possibility of sex without procreation and not only decreases and undermines male responsibility but allows women to ignore their natural

motherly inclinations. From this perspective, women are deemed the preservers of the family and of a humane society and "...female nurturance within heterosexual relations is the bedrock of a moral society" (Kellough, 1996: 133). In "defending the family," proponents of this position fear a decrease in social and economic security and want a return to the simple solutions of the past. "Choice," in this context, is a lack of care for others and choosing self-interest over traditional nurturing values. Further, in their concern with the destruction of the nuclear family, anti-choice individuals and organizations often also oppose feminism, gay rights and daycare.

Lastly, within a religious and moral framework, anti-choice discourse aims to express concern for women because women are to be protected. In this case, abortion is presented as the ultimate example of male exploitation of women whereby patriarchal capitalist society is destroying the values of motherhood and childbearing. Abortion is "...a male cop-out in this male-dominated world and abortion is not a right for women but, like wife abuse and rape, is a wrong against women" (Landolt in Collins, 1985: 204). The penalty for women who choose abortion includes post-abortion syndrome (intense grief, regret, depression, suicidal ideation) and an increased risk of breast cancer.

These positions, however, are not reflected in law given that the fetus is not recognized as a person. Nor are they recognized in medicine given that post-abortion syndrome and increased risk of breast cancer as a result of abortion are not recognized in scientific studies nor by professional medical associations. Further, such "life at any cost" positions overlook quality of life issues (McDonnell, 1984) and "the equation of caring work with the essence of women – rather than with the essence of humanity, where it properly belongs – is part of a discourse disempowerment" (Kellough, 1996:

301). But what is most problematic about these arguments is their moral absolutism which clearly denies a feminist morality of abortion as articulated by a number of pro-choice feminists such as Kathleen McDonnell, Rosalind Petchesky and others.

Abortion is a difficult decision; abortion does involve ending a potential life; and abortion, while giving many women a sense of relief, may also cause feelings of grief and even regret. In fact, some feminists argue that a woman's right to choose is not absolute. In the context of sex selection, for example, abortion is often rejected by feminists. And some feminists recognize a philosophical contradiction: women want men and society at large to increase their role in childrearing but at the same time, women also want to control their bodies (Petchesky, 1990). However, this kind of a dialogue rarely occurs since "acknowledging women's contradictory attitudes about abortion [runs] the risk of fueling anti-choice arguments" (McDonnell, 1982: 35). In the public forum, the issue is either "yes" or "no": you're either pro-choice or anti-choice. Given this context, and the heated debate that results, it is not surprising that medical schools may choose to avoid the issue entirely.

The Marginalization of Abortion Providers

Another reason medical schools might avoid the issue of abortion is a result of the professional marginalization of abortion providers by the medical profession. This marginalization is a direct consequence of the absorption of abortion.

In fact, Carole Joffe (1995) notes that this marginalization partially stems from the silence and/or contradictory and ambivalent role of the medical profession. When abortion was illegal, the medical profession denounced "filthy" abortionists but at the

same time, many individual physicians sought out reliable providers of illegal abortion for their patients. Further, while the fight for legalization by the medical profession indicated a genuine sympathy for women, it cannot be denied that it also stemmed from professional self-interest. Once legal, the medical profession could have taken the opportunity to conduct massive educational and awareness campaigns regarding abortion issues at the local, provincial, and national level. However, while some individuals did, for the most part, the medical leadership remained silent (ibid).

As a result, some abortion providers experience a certain amount of stigma. This is not surprising since, only a short time ago, an abortion provider was referred to as an illegal abortionist, money-maker, quack, butcher and as “both incompetent and exploitative and presumably engaged in abortion work because he cannot make a living in mainstream medicine” (Hunt and Joffe, 1994: 165). Today, abortion providers may experience some stigma because of the low rate of remuneration they receive, especially when compared to other medical specializations. Further, the abortion procedure itself is technically unchallenging, as it can become tedious and devoid of intellectual challenges, which is particularly an issue for those interested in advancing in academic medicine (ibid). Indeed, “it definitely lacks the glamour of heart transplants or brain surgery or any of the other newsworthy medical events to which doctors flock” (Cole, 1983: 7).

An additional factor related to professional marginalization lies in what Joffe (1995) describes as the atypical history of innovation and dissemination of abortion techniques. A typical route involves a procedure that is developed by an academic who has received research funds, is described at medical meetings and in relevant professional

literature and is taught to colleagues and students. However, because abortion was once illegal, its development largely occurred “underground.”

Lastly, the creation of free-standing abortion clinics has contributed to the marginalization of abortion providers by the medical profession. Clinics have begun to provide a significant percentage of abortions in Canada because there has been a long-term decline in the number of hospitals with the capacity to perform abortions (Studler and Tatalovich, 1996). Moreover, some hospitals use outdated equipment, require physician referral and inappropriately use general anesthesia (Bowes et al., 1998). Clinics seem to be the answer to these issues as well as issues of access, delays, and cruel or thoughtless treatment reminiscent of the treatment of women by Therapeutic Abortion Committees. Health care providers work in these clinics because they care about women and are committed to choice. Clinics require no physician referral, have no minimum age of consent and often provide second trimester services. However, these clinics, while providing excellent medical care, have isolated abortion from medical institutions, thus letting hospitals “off the hook.” While I am certainly not advocating for the further institutionalization of abortion procedures, the reality is that medical education occurs in teaching hospitals.

Clearly, there is evidence to support the marginalization of abortion providers by the medical profession. Some of this marginalization has an historical basis because the procedure was once illegal. And certainly much of this marginalization has to do with the religious and moral arguments against abortion described in the previous section as well with the violence and harassment perpetrated against abortion providers.

Violence and Harassment

A final reason medical schools might dodge the abortion issue is the escalating violence and harassment experienced by abortion providers and their families as well by abortion providing hospitals and clinics.

Although the degree of violence and intimidation against abortion providers is lower in Canada than in the United States (Studlar and Tatalovich: 1996) these tactics, used by a radical minority, appear to be on the rise and certainly pose the possibility of cross-boarder terrorism. According to the Washington-based National Abortion Federation (which also tracks Canadian incidents), violence against abortion providers and their facilities doubled across North American in 1997 as there were more than 220 incidents of arson, assault, vandalism, and attempted murder (*Toronto Star*: November 1, 1998). In the past six years, three Canadian abortion providers and two American abortion providers have been shot. Bomb threats, arson, acid attacks and hate literature are a real and potential occurrence for many providers. In their study, Ferris et al. (1998) found that respondents at 45% of provider hospitals said they experienced harassment such as picketing of hospitals, picketing of homes, hate mail, harassing phone calls and bomb threats during the last two years for providing abortion services. These acts sometimes deter physicians from providing abortion services: Ferris et al. also found that 30% of physicians did not perform abortions because of anti-choice harassment.

It is also reasonable to posit that such violence and harassment act as a deterrent for medical schools providing abortion education and medical students from becoming future abortion providers. In fact, medical students have not been immune from anti-choice harassment. In 1998, Life Dynamics Inc. in Texas mailed a "comic book"

entitled: "Quack the Ripper" to abortion providers and medical students. This piece of hate literature depicts doctors who perform abortions as zealots, amoral buffoons and "drooling psychotics." The violent overtones of this booklet serve to perpetuate a climate of fear for abortion providers, for medical students considering abortion provision as a part of their career and for medical schools.

Further, in 1999, the Genocide Awareness Project of the Centre for Bioethical Reform in the U.S. toured a number of Canadian university campuses. Using large billboards, the Project seeks to illustrate "The Changing Face of Choice". The first billboard depicts Holocaust victims with the heading "Religious Choice", the second illustrates a black man killed by the Ku Klux Klan with the heading "Racial Choice" and the last depicts the limbs of a fetus with the heading "Reproductive Choice." This is a clear attempt to draw links between abortion and the holocaust, slavery and civil rights. The message is as follows: Nazis kill Jews, the KKK kills blacks and women kill babies. These inflammatory images are anti-Semitic, racist and sexist and seek to "shock, horrify and brainwash through a twisted psychological game" (Kaiser, Erin, personal communication, September 17, 1999). Such a display may be a real disincentive for medical schools to broach the issue of abortion with medical students.

Given this violent context, there are some very good reasons to avoid the issue of abortion. Indeed, these tactics enshroud abortion practice in a climate of guilt, intimidation, sensationalism and the grotesque (Petchesky, 1990). The intimidation, harassment and violence perpetrated against abortion providers, combined with the marginalization of abortion providers by the medical profession and the moral and religious arguments made against abortion providers may result in the possible lack of

training medical students receive in abortion issues. The rest of this chapter examines how the slow emergence of women's health issues, in general, into the medical school curriculum may also explain this lack of training.

Teaching Women's Health in Medical School

The slow emergence of women's health issues, in general, into medical school curricula has also contributed to the lack of medical training and education in abortion issues. How can abortion education be integrated into medical school curriculum when women's health issues, as distinct from men's health issues, is barely acknowledged or recognized? It is well documented in the Canadian and American literature that there has been a lack of focus on women's health concerns in the education of medical students. Within a medical model context, the male has been viewed as normative in research, treatment and health care provision and results not only in gender bias in medical education and but also a fragmented approach to teaching women's health issues. Before examining gender bias and fragmentation, it is first necessary to define and examine the medical model.

Medical Model

Orthodox medicine uses the medical model as a framework for describing and classifying illness and disease. With its focus on biological explanations, the medical model has come under scrutiny for being reductionist. Armstrong and Armstrong (1996) outline five assumptions inherent to the medical model that are reflected in both the structure and relations of the Canadian health care system.

The first assumption is that the determinants of illness are primarily biological. Diagnosis of illness involves the discovery of a specific injury, germ or cancerous cell that is detected through medical tests. The treatment of biological abnormalities includes drugs and/or surgery. The second assumes an engineering model of the body. The body is like a machine, made up of a series of parts that can be fixed. The third assumption is that health care is primarily about curing illness or disability. This curative approach often comes at the expense of prevention. The fourth assumption is that medicine is scientific. Science determines cause, effect and cure and all procedures are rigorously examined following strict, value-free procedures. The last assumption is that the doctor is the authority and expert. Only doctors have training in scientific evidence and correct procedures and they determine what patients do and what is done to them.

While Canadians have certainly benefited from this approach in, for example, the successful use of many drug and surgical interventions, it is also problematic. The relationship between the mind and the body is rarely explored and the diagnosis and treatment of individuals are separated from the social and cultural contexts of their lives. In addition, medical discourse also allows physicians to exert control and power over their patients through this narrow definition of health and the treatment of symptoms. As Edginton (1989) describes, this professional power manifests itself through two processes: the macro-process, whereby physicians are supported by institutional structures (government, professional organizations, hospitals and clinics) and the micro-process, where the doctor's power is maintained and expressed in inter-personal interactions and patient control. This authoritarian power and control is largely patriarchal since modern medicine was built and organized around and for men. In fact:

The predominantly male, upper-class, white/anglo background of physicians in Canada determines to a great extent the values and beliefs of the medical profession.... [which] reinforces a particular world view of an elite subculture (Edginton, 1989: 142).

In spite of increasing numbers of women in medical schools, this particular way of seeing health and health care provides a context for medical education. In fact, it is a filter through which medical content and practice is transmitted. Medicine and medical education is clearly built on patriarchal authority, particularly since "...classroom and clinical material are more often than not taught by white men, about white men, and for white men" (Nechas and Foley, 1994: 40). The implications of and challenge to this gender bias will be explored in the following section.

Gender Bias in Medicine

Gender bias in medicine has manifested itself in three ways. First is the issue of women's access to medical education and to leadership positions within academic medicine and national medical organizations. The second focus is on the women's health content in medical curriculum. The third issue involves the quality, atmosphere and climate for women in medicine. While all three factors are equally important and inter-related, I will, for the purposes of this paper, focus on the second issue, curricular content.

In teaching and practicing medicine, the 70 kg., white man was historically presented as the norm with woman defined as "other." Within this context, medicine and health care were modeled after men. Medicine failed to recognize many differences between men and women. As a consequence, medical curricula have not adequately integrated knowledge of sex differences in diseases and conditions that occur in both men and

women. In addition, medical curricula often ignore or give too little attention to diseases and conditions that are unique to women or that are more prevalent or more serious among women. Similarly, inadequate attention may be given to the fact that risk factors for some diseases or conditions may be different for women than for men, or that for certain diseases or conditions the most effective interventions may differ by gender. Additionally, this approach does not address the totality of women's lives, since "if we are to care appropriately for women, we must address what women see as their health priorities" (Cohen, 1998: 791). Clearly, "the very basis of medical knowledge is at issue--whether or not the research and clinical information used to make preventive, diagnostic and treatment decisions about women is adequately comprehensive, and has been derived from studies of women rather than simply generalized from knowledge of men" (Zimmerman, 1996: 5).

As early as the 1960s, the women's health movement raised questions as to whether the medical profession was addressing what women saw as their health priorities. Over the years, it became clear that the medical profession failed to include women as subjects in research studies and paid inadequate attention to gender differences in research. Furthermore, there was a lack of funding of women's health concerns; barriers to health services access; a lack of focus on women's health concerns in public education and in the education of health care professionals; and a dearth of women in senior medical and scientific positions.

Of course, as Levison (1994) points out, we must recognize that physicians are products of this society and that it is not a conspiracy of physicians, researchers and educators to exclude women. However, this lack of focus on women's health issues has

had serious implications for medical training programs. Indeed, “medical school education and physician training programs have over the centuries reflected male attitudes and interests and many of women’s health needs are left unattended or fragmented” (Wallis, 1994: 21).

However, because it is not readily available or analyzed in the literature, it is difficult to measure what medical students are learning and if they are learning it in any kind of meaningful way:

It is [in fact] difficult to know whether or not what is taught in a health professional program addresses women’s health needs and issues. This is because current curricula for health care provider education are not published in the literature. Knowing what is taught, as well, does not necessarily speak to whether or not health professionals are skilled in working with women, for example, in the context of their health needs, sensitivities and issues. Curricular time may not equal knowledge and skill acquisition (McIntyre et al., 1996: 7).

The Society of Obstetricians and Gynecologists of Canada’s discussion paper (1999) and Health Canada’s *Framework for Sexual and Reproductive Health* (1999) call for better training of medical professionals in women’s health issues. And what evidence is available indicates that women’s health education is fragmented leading to deficiencies in physician training (Schur and Nicolette, 1997: 1406). This fragmentation will be described in greater detail below.

Fragmentation

One reason for this fragmentation lies in the fact that obstetrics and gynecology has traditionally been viewed as the women’s health specialty. However, the emphasis of obstetrics and gynecology is limited to reproductive organ health maintenance and disease (although I would argue the exception to this is abortion) thus maintaining an

historically outdated preoccupation with women's reproductive systems (Zimmerman, 1996). As a result, women have often been shuffled between health care specialties. Within this model, not only do women's health needs get lost in the gaps between different specialties, where women are referred back and forth, but "...these priorities do not reflect the reality of women's lives or their medical needs but rather are representative of sexist and out-dated societal values and physicians' social and economic interests" (Gannon et al., 1997: 52).

This fragmentation of women's health issues has lead to incomplete and poorly coordinated care, inconsistent delivery of preventive services and deficiencies in physician training (Schur and Nicolette, 1997) where physicians interested in women's health must pursue it as a sideline (Johnson and Hoffman, 1993). In fact, in a survey of directors of Canadian family medicine residency programs, 90% indicated they felt that current teaching on women's health issues other than in obstetrics and gynecology was inadequate (McCall and Sorbie, 1994).

Clearly, the way in which medical education addresses (or refuses to address) women's health issues is insufficient. However, the way in which women's health issues should be addressed is up for debate. Is a specialty in women's health the answer or should women's health issues be incorporated throughout the curriculum? Proponents of the former approach believe that a specialty would best address unexplored issues in women's health research and education as well as health needs and remedy the bifurcation of women's medical care (Harrison, 1992). On the other hand, women's health needs to be integrated with general medicine because its implications are so critical to any kind of medical care concerning women. Knowledge of women's health is

the responsibility of every health care practitioner and not the responsibility of a few specialists (Levison, 1994). In fact, specialization may further isolate women's issues from mainstream medicine and marginalize its practitioners (Harrison, 1992), a consequence similar to that facing many abortion providers. A third option, however, would be the integration, differentiation and evolution model proposed by Nelson et al. (1997). This model involves incorporating new knowledge into pre-existing courses or departments (integration) or creating a new interdisciplinary course, clinical division or department (differentiation) and then integrating the interdisciplinary knowledge that emerges from this differentiated "home" back into the general curriculum (evolution).

The literature indicates that Canadian medical schools are attempting to integrate, rather than segregate, women's issues into the curriculum. In fact, at the national level, the Gender Issues Committee of the Canadian Medical Association (GIC:CMA) developed four criteria for reviewing Medical Council of Canada licensing examination objectives: a gender issues perspective must be applied when identifying health priorities, the social context must be recognized as an important element of women's health, curricula must address the importance of communication skills and curricula must address the knowledge and attitudes toward sexism and racism in society. Moreover, some medical schools have established gender issues committees, women's health offices, chairs in women's health research, and women's health lectureships. In addition, educational and policy initiatives have occurred at the provincial and national level, particularly in the way of research initiatives (e.g. the Centres of Excellence in Women's Health and the Institute of Gender and Health). While these developments and initiatives are most positive, how these achievements translate into curricular content is largely

unknown or available on an anecdotal basis only.

At a basic level, it appears that medical students are exposed to a determinants of health model, which recognizes how one's social, political, and economic context influences health and well-being. This meets the second criteria of the GIC: CMA, that social context must be recognized as an important element of women's health. The Women's Health Inter-School Curriculum Committee (WHISCC), now defunct, published the following definition of women's health:

Women's health involves women's emotional, social, cultural, spiritual and physical well-being, and it is determined by the social, political and economic context of women's lives as well as by biology. This broad definition recognizes the validity of women's life experiences and women's own beliefs about and experiences of health. Every woman should be provided with the opportunity to achieve, sustain and maintain health, as defined by that woman herself, to her full potential (Phillips, 1995: 507-508).

While this progressive definition does indeed expose students to a contextual model of understanding women's health and lives, it also poses a certain danger. Such a broad focus on "well-being" opens up the possibility of medicalizing all aspects of life and narrowing our approach to social problems (Walters et al., 1995). Ways of defining and understanding women's health and women's health issues need to be developed that recognize women's realities without medicalizing them.

On a more specific level, an annual "Gender Issues in Health Care" session is conducted for first year medical students at an Ontario medical school. This session was one of the only sites of exposure students had to women's issues. However, this past year, due to a backlash of comments in evaluative feedback suggesting discrimination by the presenters towards men, this session was replaced with one that was devoid of a gender-based analysis. The lecture, entitled "Professional Identity: Retaining One's Own

Humanity,” discussed the importance of eating, sleeping, exercise, physical health, mental health and relationships for medical students. While I am not trying to undermine the importance of such a presentation, it is discouraging that it occurs at the expense of a session on women’s health issues and does not draw out gender-specific patterns. And it is very discouraging that a session on women’s health did not take place as a result of backlash.

While these examples cannot be generalized to measure the status of women’s health education in medical school curricula, when combined with the academic literature, certain conclusions can be drawn from them. Although several progressive initiatives have taken place in the form of committees, policies (e.g. sexual harassment policies) and research, the emergence of women’s health issues into medical school curriculum has been fragmented, ad hoc and slow. The research indicates that one of the difficulties in attempting to alter medical education is that much clinical teaching is done on an apprenticeship or tutorial basis, where students often learn by emulating their teachers (Phillips, 1995). Thus, teacher awareness and sensitivity to gender bias is crucial, as teachers must change before their students can. This includes challenging, rather than backing down from, backlash from students, administration and faculty. Indeed, challenging such “chilly climates” needs to be a priority before any meaningful curricular change can occur. In fact, “even when curricular changes are made, it is difficult to imagine how women’s health can be effective if medical school climate contradicts the very cultural and gender competencies being taught” (Zimmerman, 1996: 12).

This issue also demonstrates how the concerns of the women’s movement (or, more specifically, the women’s health movement) have been absorbed and institutionalized. In

calling for improved health care for women, the door was open to state remedy. Taken out of its political context, these issues are simply health care and medical issues like any other and an analysis that addresses power relations and structural oppression is largely absent. Indeed, "...both science and medicine have ignored women because within the broader social culture, women's lives have never been sufficiently important or valued" (Levison, 1994: 391). It appears that the medical profession has recognized the importance of including women's health concerns on the agenda. However, their narrow approach to doing so (e.g. add a lecture and stir) does not adequately address the content of knowledge nor the way knowledge is organized and transmitted. The structural inequities and gender bias inherent in medical education itself have not been sufficiently addressed.

In so far as abortion education is concerned, it must be advocated for in the context of better women's health education in medical curricula. This is to ensure that abortion, like other women's health issues, is not marginalized and taught in addition to the rest of medicine and to thus properly address the totality of women's lives. Abortion education, however, poses its own set of issues. When we are trying to divorce women's health from a strictly reproductive perspective, it is difficult to advocate for abortion education when we are trying to emphasize that women's health is more than obstetrics and gynecology and women are more than just uteruses. And abortion education is unique to the rest of women's health education given its controversial nature and even stigma. Nonetheless, both abortion education and women's health education need to be better integrated into medical curricula in order to meet the health needs of Canadian women. The issue of abortion is particularly critical as we are experiencing a shrinking

pool of abortion providers thus placing further restrictions on women's access to the medical procedure. The question as to whether or not medical schools are giving students the education and training necessary to provide this service will begin to be explored in the next chapter as I describe the methodology for my study.

METHODOLOGY

In order to explore the status of abortion education in Ontario medical schools, I developed a survey. A survey seemed to be the easiest way to enter the field since the medical profession tends to respond well to quantitative data as it is deemed rigorous and valid and fits with a scientific focus. A survey also has the potential to reach a wider audience thus providing a more complete picture with results that can often be generalized to the wider population. Further, a survey better ensures anonymity and confidentiality, both of which are necessary when dealing with a controversial issue and in discussing and/or critiquing one's educational institution. Given all of these factors, a survey seemed to be the best way to measure the status of abortion education in Ontario medical schools.

Creation of the Survey Tool

From January to April 1999, I completed a practicum with the Canadian Abortion Rights Action League (CARAL). The goal of my work there was to explore the status of abortion education in Ontario's medical schools. I designed a survey tool in consultation with *A Medical Student's Guide to Improving Medical School Curricula* (1997). This guide is a joint project of the American Medical Women's Association (AMWA) and Medical Students for Choice (MSFC) and aims to "provide tips for evaluating medical school curricula and to assist in the design and implementation of strategies to improve reproductive health curricula." (AMWA and MSFC, 1997: 1)

The first half of my survey includes questions regarding abortion procedures, the physician-patient relationship as it relates to abortion and ethical issues that require the respondent to provide a rating to indicate the quantity of education, the teaching forum and the integration of the material into the curriculum. This series of questions aim to support my first hypothesis that students receive little education and training in abortion issues. In the second half of the survey, a Likert rating scale is used for a number of opinion questions regarding abortion education in undergraduate medical training. These questions aim to explore the possible reasons for a lack of training in abortion issues (e.g. abortion education is elective rather than required, students do not believe abortion education is necessary, that abortion education is not appropriate for undergraduate medical education, a lack of learning opportunities). These questions also aim to support my second hypothesis that few medical students are planning to offer abortion services as part of their future medical practice.

The survey was given to both Dr. Pat Armstrong (my practicum supervisor) and Dr. Konia Trouton (Reproductive Health Division, Health Canada) for input and suggestions. Once revised, I submitted the survey to the Ethics Committee, School of Canadian Studies, Carleton University (please see appendix one for a copy of the survey tool). Ethics approval was granted January 1999 (please see appendix two for a copy of ethics approval).

The Pilot Project

Originally, I intended to survey the Ontario medical schools, via faculty, residents and undergraduate students, for my practicum placement and then all Canadian medical

schools for my thesis project. However, as will become apparent, this was not possible and my practicum work served as a pilot test for the current study.

The survey was sent to faculty members via e-mail February 1999. Specifically, it was sent to the program directors of obstetrics and gynecology as well as family medicine at each of Ontario's five medical schools (University of Ottawa, Queen's University, University of Toronto, McMaster University and the University of Western Ontario). The survey was also e-mailed to members of the Gender Issues Committee of Ontario Faculties of Medicine (GIC:COFM), a committee of which I was once a member. GIC:COFM was a logical group to forward my survey to since its members represent all five Ontario medical schools and are committed to and work towards better integration of women's health issues into medical school curricula as well as promoting a healthy climate for women students, faculty and administration. E-mail was used in the hope that it would be more convenient, accessible and easier for faculty to respond to. It would also be easier for faculty members to forward the survey to other faculty as well as to undergraduate students and residents. Such a snowball sample was used to try to ensure a greater response rate, given the controversial nature of the topic.

I also attended the annual Ontario Medical Students Weekend (OMSW) February 1999 at McMaster University, an annual conference for medical students to discuss current issues in health care and medicine and network with other students and faculty. There, I was able to randomly disseminate the questionnaire to medical students.

A total of 52 surveys were analyzed for this project. I did not receive any responses from either faculty or from residents. I received ten responses from undergraduate students as a result of a medical student distributing the survey to his

tutorial group. Of the 50 surveys disseminated at the OMSW, 42 were returned for a response rate of 84%. The high response rate can be attributed to a variety of factors: it was administered in-person and under non-stressful conditions, it was optional and it was confidential.

There were several obstacles that contributed to such a low response rate, thus making the study more conducive to a pilot test. Clearly, one of the more obvious obstacles was the lack of response from faculty and residents. This could be attributed to many factors, such as time constraints on the part of faculty and residents, the sensitive and controversial nature of the topic and the somewhat hostile response I received from an Assistant Dean at one of the medical schools that was copied to faculty at the four other medical schools. It reads as follows:

I have consulted with several of my colleagues both here and at other medical schools and regret to tell you that I will not circulate the survey to students and faculty. This is an extremely important issue with a high profile in the community and because of that great care must be exercised to conduct this study properly. We believe there are problems with respect to the nature of sampling (it must be systematic and rigorous) and although this study was reviewed at your Ethics Review board, it would need to be reviewed at each school. In addition, before participating, each school would need to see the results of a pilot that validated the survey tool itself. As presented to me in your correspondence, the validity of results would be questionable. There is no doubt that the results however would be of great interest to the press. Although faculty and students can request a summary of the results, there would be no control over the dissemination of the report.

Although I wrote a letter to respond to these concerns, I did not receive any completed questionnaires, or any further correspondence from the Assistant Dean. This, in itself, illustrates not only the controversial nature of the subject matter, but also a need, on behalf of the medical profession, to control health care research.

An additional obstacle was the fact that the majority of my 52 respondents (84%) were in their first or second year of undergraduate training and I received no responses from fourth year students. As a result, the first half of the survey that determines what students had learned was largely invalid. They were unable to adequately reflect on the overall quality of undergraduate medical education because they were at the beginning of their academic careers. In the words of one student:

When you ask undergraduate medical students about their education in abortion provision, choices, and the issues surrounding it, their responses will depend on which year of the program they are in. Most of the medical students at OMSW are in first and second year, because the third and fourth year students are too busy with clinical rotations in the hospital. You would get a better picture of abortion provision at my school if you could get this questionnaire to third and fourth year students, after they've studied obstetrics and perhaps had a clinical rotation in that area.

Although I was unable to utilize the first half of the survey, I did examine the data collected from the second half of the survey. This included a series of opinion questions using a Likert Scale, such as the need for and integration of abortion training in undergraduate medical education as well as disincentives to pursue abortion training.

The preliminary results I obtained did offer some valuable insight regarding what students want to learn, how and when they want to learn it as well as what barriers prevent them from learning about abortion issues.

In response to the question how necessary abortion training is in undergraduate medical education, almost all of the respondents (94%) agreed that abortion education for physicians in training is either "very necessary" (69%) or "somewhat necessary" (25%). When asked whether there needs to be more or less abortion education in undergraduate training, over half of the respondents (60%) believed that "a lot more" or "more" abortion education is needed. No one indicated that there needs to be "less" or "a lot less."

When asked how abortion education should be implemented into curricula, the majority of students surveyed believed that abortion education should be required in course work (67%), tutorial sessions (68%) and seminar presentations (57%). Fifty percent believed that clinical placement should be elective. In response to being asked when the best time is to incorporate abortion education into medical training, respondents indicated that it is “very appropriate” to incorporate abortion education in the undergraduate level (65%), during an obstetrics/gynecology residency (85%) and during a family medicine residency (74%). No one indicated that it is “inappropriate” to incorporate abortion education at any of these three levels. When asked if there are pressures for students not to undertake abortion education, fifty-nine percent responded that there are no pressures for students not to undertake abortion education. For those who responded “yes”, moral/religious beliefs and violence/harassment were cited most frequently as a “strong influence.” When describing the opportunities to learn about abortion from faculty, ancillary staff, residents and the community surrounding the institution, the majority, 37%, 59%, 57% and 48% respectively, responded: “don’t know.” These preliminary results offered some valuable insight: medical students want to learn about abortion but the curricula and learning opportunities are inadequate in meeting this expectation.

Further, the pilot test provided me with valuable insight for how to proceed with my thesis research. First, I needed to revise my survey tool. Some respondents felt that parts of the survey were “vague” or “confusing.” As a result, some terms and questions needed to be defined more clearly. I also wanted to revise my population sample. Since I was unable to elicit any responses from either residents or faculty members, it may be easier and more realistic to survey only undergraduate students. Given this focus on

undergraduate medical education, I concluded that the survey should be disseminated to students in their final year of the undergraduate program as they can best reflect upon and evaluate the entire undergraduate curriculum. Gaining administrative support to complete this project was crucial. I needed to get the support from all five medical schools to access students in order to conduct this study. This could be achieved by sending a package to each Dean, Associate Dean and/or Academic Coordinator with any of the following: a letter of intent; a copy of the pilot project report; letter(s) of support from medical faculty, medical students as well as government agencies and/or organizations. Lastly, in order to produce legitimate data, I needed a higher response rate. This could be achieved by not only accomplishing the above, but also through visiting each of the five medical schools to disseminate the survey. After a brief presentation, respondents could personally hand-in their completed surveys.

Gaining Entry

During summer 1999, I e-mailed a few people I knew from my work at McMaster University as Coordinator, Women's Health Office, Faculty of Health Sciences, to see if anyone might be willing to write a letter of support for my project. After reviewing my letter of intent, survey tool and pilot testing results, two people agreed. The first was Dr. Barbara Lent, University of Western Ontario and Chair, Gender Issues Committee, Council of Ontario Faculties of Medicine. The second was Dr. Pat Smith, McMaster University and Director, Women's Health Program, Hamilton Health Sciences Corporation. By August 1999, I mailed to each medical school dean a package which included: a cover letter, a copy of the survey, an executive summary of the pilot test

results as well as the two letters of support (see appendix three). By February 2000, I had received permission from each of the five schools to disseminate the questionnaire to medical students in their final year of the undergraduate program. This process, however, varied from school to school.

School A⁴

The Dean of this medical school indicated to me in writing that he had “no problems with my survey or approach” and “no reservations.” However, he forwarded my proposal to three senior faculty members (one of which was the same assistant dean who wrote to me during the pilot testing phase) and suggested I meet with them to work out the logistics of my request.

In September 1999, I met with the three faculty members to discuss my project. Their major concerns focussed on how rigorous my research would be and how I would proceed in obtaining the permission of the four other medical schools. By the end of the meeting, I had agreed to not identify the schools in my report, to make some minor adjustments to my survey tool and to ensure each school receives a copy of the results with an aggregate score.

In February 2000, I attended an examination session where most of the graduating class was present. Prior to commencing the exam, I was given twenty minutes to distribute and collect my surveys. Ironically, the school that had caused me the most anxiety provided me with the best response rate: a total of 70 surveys were turned in to me for an 82.4% response rate.

School B

In September 1999, I received written permission from the Dean to disseminate my survey with a request to forward a copy of my ethics review approval for his files. I was also referred to the President of the Aesculapian Society in order to work out the logistics of the survey dissemination who then referred me to the Class President. He recommended that I not visit the university since the students are rarely together for a class as they are on placement. He asked that I mail to him a sufficient number of copies that would be put in student mailboxes, collected and forwarded back to me.

I mailed the surveys in January 2000. In March 2000, I received twelve completed surveys for a response rate of 15.6%. Concerned, I wrote to the dean to ask if I could visit the medical school to elicit a few more responses, particularly in light of the excellent response rate at School A. He notified me that, since our last correspondence, he had stepped down as dean and that he would forward my request to his successor and an associate dean. Although I followed-up with these two individuals, neither acknowledged my correspondence.

School C

In September 1999, the dean indicated that he was "highly supportive of pursuing this project." The matter was then referred to the Chair of the Undergraduate M.D. Programme who informed me that the medical school would conduct their own ethics review. I forwarded a second package for ethics committee review.⁵ By December 1999,

⁴ One of the conditions I agreed to in order to obtain permission to conduct my study was to not identify the medical schools in my report. Henceforth, the institutions will be referred to as School A, B, C, D and E.

⁵ It is uncommon to seek approval from additional institutions. According to the Tri-Council Policy Statement, *Ethical Conduct for Research Involving Humans*: "[r]esearchers should apply to the designated REB and not seek review by another REB, whether inside or outside the institution." (p. 1.4)

I received notification that the committee had some concerns that needed to be addressed prior to approval. The major concerns focussed on clarity of instructions and consent. I addressed all concerns in writing and in January 2000, was informed that my survey was approved. I was instructed to forward a sufficient number of surveys to the school, where they would be put in students mailboxes, collected and forwarded back to me. In March 2000, I received fourteen completed surveys for a response rate of 14%. I wrote to the Chair to ask if I could visit the medical school to elicit a few more responses, particularly in light of the excellent response rate at School A. In response, he wrote:

I have checked in to your survey. We have sent out reminders to students. One of the problems for our students is that they feel they are surveyed to death, from both within and outside research studies... I can ask for a further reminder to go out but we cannot cajole our students to participate.

School D

In August 1999, I received correspondence from the Dean indicating that he would forward my request to an Associate Dean. This Associate Dean then forwarded it to a different Associate Dean who informed me that an ethics review at his institution would be necessary.⁶ By February 2000, I received ethics approval and the Associate Dean then referred me to the Class President to work out the logistics of dissemination. I was presented with two options: a sufficient number of surveys could be sent to the school, put in student mailboxes and returned to me or I could send a sufficient number of surveys to the Class President for him to disseminate at a popularly attended lecture. Since my attending the school was not an option, I opted for the latter given the poor response rate at School B and School C. Surveys were distributed during the last two

⁶ see note 5.

lectures of the academic year in April 2000 where approximately half of the graduating class would be in attendance. A total of fourteen surveys were sent back to me for a response rate of 7.9%. In written correspondence to me, the Class President indicated that “a lot of people mentioned to me that the survey is a bit long and they don’t have time to fill it out.” I was unable to obtain any more responses as the academic year had come to an end.

School E

In September 2000, the Dean’s office informed me that my request was forwarded to an Associate Dean. The Associate Dean promptly informed me that he saw “no reason why it [the survey] could not be taken to the graduating class” and that the students would be accessible in March and April. He asked that I contact him in February to arrange a date and time for me to visit the school to disseminate the survey. In February 2000, I contacted the Associate Dean who referred me to the Class President to set up a date and time. In April 2000, I visited the school and attended a lecture where over half of the graduating class was present. I described my project to the class at the beginning of the lecture and students filled in the surveys during the break. I received a total of 42 completed surveys for a response rate of 42%.

Obstacles to Research

Although survey research elicits a low response rate at the best of times, my overall response rate was lower than anticipated. An enormous amount of time and effort was spent in obtaining approval from the five medical schools to conduct this research (e.g.

pilot testing, obtaining letters of support, ethics review by more than one institution, continuous correspondence). Because of this approval, I anticipated a higher level of support from the medical schools and thus a higher overall response rate. However, given the varying response rates from school to school (as low as 7.9% and as high as 82.4%), I encountered several obstacles when conducting this research that will be explored below.

In Chapter Two, I described how abortion is a controversial and sensitive subject. This in itself can explain some of the resistance I experienced as a researcher as well as a lower overall response rate than I anticipated. Medical students will obviously represent the society from which they come: some will be pro-choice, some will be anti-choice and others will be in-between. One respondent wrote: “my bet is that there’s more pro-abortion medical students than anti-abortion.” While this may be true, one student noted that: “I have religious beliefs that do not see abortion as an appropriate method of treatment for unwanted pregnancy.” Another student recognized that: “too often it seems this topic is avoided in medical education because it is controversial and loaded with religious and moral issues.” While this may inspire some students, who are committed to and passionate about abortion issues, to fill out the survey it may also be a deterrent to others who are against abortion.

Additionally, I have already in this chapter alluded to a few barriers and restrictions I experienced in conducting this research that I will examine in a more in-depth manner now. Obtaining ethics approval in more than one institution, accordingly making modifications to my survey tool and agreeing to certain stipulations (e.g. not identifying the schools in my report) not only delayed the research process but also meant a lack of control over my research. This suggests physicians are trained to control the

situation and this spills over into control over health care research even when done with tools outside their area of expertise.

Further to this control over my survey tool, I also experienced a lack of control as to when, where and how dissemination of the survey would occur. I explicitly requested a visit to each school to disseminate and collect my surveys. This request was granted at only two out of five schools. At one of the two schools where this was possible, it was disseminated prior to an exam when, although the majority of the graduating class was present, it was deemed by one respondent as: “too long and administered under conditions of stress.” Similarly, another respondent felt that: “this questionnaire is difficult to fill out/think about prior to an OSCE exam.” At two other schools, surveys were put into student mailboxes where students were left to their own initiative to complete and hand-in. At the fifth school, the class president disseminated and collected surveys at a lecture. Using three different methods of dissemination may contribute to inconsistent survey results. However, I was unable to successfully negotiate consistent survey dissemination and collection.

In negotiating survey dissemination and collection, one dean noted that medical students are “surveyed to death.” This may also partially explain a varied and overall low response rate. In the words of one respondent: “Declined to participate. Why should I. We as a group are surveyed to death. Thanks for ‘inviting my participation.’ Get lost.” Clearly, being the recipient of continuous survey research would be annoying to anyone. However, it is the medical profession that has intentionally situated itself as the gatekeeper to health care and health care research. In fact, in most instances, the medical profession is “culturally presumed and legally mandated to be the ‘expert’ body best

equipped to define and respond to health care needs” (Kellough, 1996: 136). Specifically, physicians are gatekeepers to abortion as it was the Canadian Medical Association that successfully lobbied for abortion to be a private decision to be made by a woman in consultation with her doctor. Indeed, in the absence of any law, it is the medical profession who plays a substantial role in abortion policy in Canada.

The final set of barriers to obtaining a better response rate lie in the survey tool itself. Some respondents were very positive about the research topic (e.g. “thank you for exploring this sensitive area of medicine,” “thanks for looking into this important topic!”). Some students were also very supportive of the survey tool itself. In the words of one respondent: “A good choice of study. I like how you include current education assessment and personal willingness.” However, there were some students who felt that the survey was “too long and cumbersome,” “confusing” and “not the easiest format.” One respondent indicated: “Tedious questionnaire. Obviously poor understanding of how medical curriculum is delivered (maybe need to do more background work before putting questionnaire together).” However, this type of hostile response may have just as much to do with the subject of study and when the survey was delivered as well as frustration regarding the survey tool.

Some respondents also felt that the survey reflected researcher bias. In the words of one student: “This questionnaire seems designed to come to certain conclusions, i.e., that more abortion education is needed in undergraduate medical programs.” Another student noted that: “Sounds biased towards showing abortion not being highlighted enough in medical education.” Anti-choice students, in particular, may have chosen not to participate in the study if they felt the study was designed to reach certain conclusions.

Lastly, a few respondents noted problems with recall, that “it is hard to recall what was done in which context.” In the words of another student: “You require information that’s very specific but difficult to recall given that we studied OB/GYN on average more than one year ago. This will bias your results and may not be very reflective of what’s actually going on in our schools.” Recall would have been an issue for the first three sections of the survey that explore abortion procedures, the physician-patient relationship and ethical issues and require the respondent to indicate the depth of education, what forum the issue was taught in and whether it was required or elective.

The problems I experienced in terms of exploring a controversial issue, having little control over my research and experiencing negative feedback on the survey tool itself are all inter-related and all contribute to a varied and lower than expected response rate. In light of these obstacles, however, some very clear and consistent patterns emerged from the data that will be explored in the following chapter.

SURVEY RESULTS

This chapter will present and discuss the survey results in order to assess my hypotheses that undergraduate medical students are receiving little training in abortion issues and as a result, few students will plan or will be able to provide abortion services as a part of their future medical practices. Survey responses were analyzed using SPSS statistics software to compute frequencies, analysis of variance (ANOVA), t-tests and chi square analyses. Survey results will be divided into three sections: demographic information, abortion education and opinion on abortion education to explore how much education medical students perceive receiving in abortion issues as well as their opinions on abortion education. Following this presentation of results will be a brief discussion on the limitations to the data. The last section of this chapter will include a discussion of the results and how they relate to the theoretical framework discussed in chapter two.

Demographic Information

As discussed in the previous chapter, there was variation in the response rate from the five medical schools. Table 1 presents the response rates by school as well as an overall response rate. The response rates from Schools A and E are representative while data from Schools B, C, and D tends to be underrepresented. Overall, a total of 152 surveys were collected for a response rate of 28.2%.

Table 1. Number in Survey Universe and Response Rates.

School	Survey Universe	Response Rates	
		N	%
A	85	70	82.4%
B	77	12	15.6%
C	100	14	14%
D	177	14	7.9%
E	100	42	42%
TOTAL	539	152	28.2%

As can be seen in Illustration 1, the respondents were fairly evenly distributed by sex at Schools A and E. There was greater variability amongst the other three schools. Of the 152 surveys collected, 69 (45.4%) of respondents were male while 83 (54.6%) of respondents were female. There was a slight over-representation of female responses since 52% of Canadian medical school students are female (ACMC, 1996).

Illustration 1. Percentage of Male and Female Respondents. (N=152)

The average age of respondents from all five schools was 26.33 years. There was little variability in age across the five schools (Table 2).

Table 2. Average Age of Respondents.

School	Average Age	Std. Deviation	N
A	26.17	1.9997	70
B	26.91	2.0714	12
C	27.21	3.4234	14
D	26.77	2.9482	14
E	26.02	1.6452	42
TOTAL	26.33	2.1818	152

The majority of respondents in all five schools had completed rotations or units in obstetrics and gynecology as well as family medicine (Illustration 2). Since this is where the bulk of abortion education would occur, it is expected that respondents will provide a measurable representation on the status of abortion education at their respective institutions.

Respondents were not asked to identify their ethnicity, race or religious affiliation. In retrospect, however, collection of this data would have been interesting and may have been useful when examining, for example, student opinions on abortion education.

Abortion Education

In order to ascertain the quantity of abortion education medical students are receiving and to prove or disprove my hypothesis that medical students are receiving little education in abortion issues, respondents were asked to provide a rating between one and five on a range of procedures related to abortion provision. This five-point scale is as follows: 1 (*none*), 2 (*scant education*), 3 (*some education; not in-depth*), 4 (*in-depth coverage*), and 5 (*extensive coverage*). The first set of questions relate to the medical procedure, the second relate to the physician-patient relationship and the third relate to ethical issues.

Abortion: The Medical Procedure

The first set of questions relate to abortion, the medical procedure. Rather than examine all eighteen questions independently, the data were divided into two groups. The first group of five questions relate to diagnosing pregnancy and the second group of thirteen questions relate to the actual abortion procedure (see Table 3). This grouping of questions was statistically valid as all were significantly correlated at the 0.01 level. The grouping of questions was further supported by factor analysis.

Table 3. Diagnosing Pregnancy Questions; Abortion Procedure Questions.

Diagnosing pregnancy	Abortion procedures
Pregnancy tests	abortion procedure options
Gestational age assessment	pain-control options
Rho(D) testing	cervical block
Interpreting hcG tests	use of cervical dilators
	use of vacuum aspiration
	use of D & C
	use of methotrexate and misoprostol
	1 st trimester abortion
	2 nd trimester abortion
	complications (immediate, delayed, late)
	pre- and post-abortion counselling
	post-op. care
	follow-up care

In terms of diagnosing pregnancy, a mean of 3.2,⁷ representing *some education; not in-depth*, was reached for all five schools. Schools A and C had the lowest mean at 3.0 while School E had the highest mean of 3.4 (Table 4). However, the only statistically

Table 4. Diagnosing Pregnancy: Quantity of Education.

School	Mean	Std. Deviation	N
A	3.0	.7174	69
B	3.4	.50780	12
C	3.0	.6632	14
D	3.3	.7505	13
E	3.4	.5571	41
TOTAL	3.2	.6803	149

significant difference was between School A and School E where $F(4,144) = .013$, $p < .05$ which means, from the students' perspective, that School A provides significantly less training and education in diagnosing pregnancy when compared to School E. There were no significant differences between male and female responses; in fact, both males and females scored a mean of 3.2. As for teaching forum, as seen in Illustration 3, the

⁷ All numbers have been rounded to one decimal place.

majority (73.3%) reported diagnosing pregnancy was taught in clinical placement, followed by lecture (48.6%) and tutorial (33.2%). With regard to integration of the material into the curriculum, 79.2% of respondents indicated that the course material was required while 14.3% indicated that it was elective (see Illustration 4).

As for abortion procedures, a mean of 2.6 was reached for all five schools, which falls between *scant education* and *some education; not in-depth*. School E had the lowest mean at 2.4 while School D had the highest mean at 3.1 (Table 5). However, the only

Table 5. Abortion Procedures: Quantity of Education

School	Mean	Std. Deviation	N
A	2.6	.7091	67
B	3.0	.6564	12
C	2.5	.5794	14
D	3.1	.7457	12
E	2.4	.6971	39
TOTAL	2.6	.7196	144

statistically significant difference was between School D and School E where $F(4, 139) = 3.730$, $p < .05$ which means that, from the students' perspective, School E provides significantly less education and training in abortion when compared to School D. There were no significant differences between male and female responses; in fact, both males and females scored a mean of 2.6. As demonstrated in Illustration 5, the majority (59%) indicated that abortion procedures are taught in clinical placement, followed by lecture (37.5%) and tutorial (33.2%). As for integration of the material into the curriculum, 59.9% indicated that abortion procedures was required while 24.9% indicated it was elective (see Illustration 6).

Illustration 5. Abortion Procedures: Forum. (N=144)

* Percentage exceeds 100% where respondents selected more than one answer.

** Respondents who replied "none" to questions on quantity of education.

Illustration 6. Abortion Procedures: Integration. (N=144)

* Percentage exceeds 100% where respondents selected more than one answer.

** Respondents who replied "none" to questions on quantity of education.

At first glance, it appears that medical students receive more education on diagnosing pregnancy than on abortion procedures (see Illustration 7). In fact, when comparing the education students receive on diagnosing pregnancy with the education they receive on abortion education (type of education), some statistically significant differences can be noted. There were statistically significant differences in the type of education where $F(1, 132) = 44.7, p < .05$, which means that students perceive receiving more education and training in diagnosing pregnancy when compared to education and training on abortion issues. There were also statistically significant differences in the type of education by school where $F(4, 132) = 7.254, p < .05$, which means that the type of education is significantly different across schools. There were no statistically significant differences in type of education by sex or type of education by school and sex combined.

The Physician-Patient Relationship

The second set of questions relate to the physician-patient relationship as it pertains to abortion (see Table 6). Again, instead of examining all nine questions independently, the data was compiled into one group. This grouping of questions was statistically valid as all were significantly correlated at the 0.01 level. The grouping of questions was further supported by factor analysis.

Table 6. Physician-Patient Relationship Questions.

Physician-Patient Relationship
effective communication techniques
barriers to effective communication
patient-centred interviews
sexual history-taking skills
principles of effective patient education
informed consent
pregnancy counselling & decision-making
managing emotions
contraception counselling

For the physician-patient relationship, an overall mean of 3.0, representing *some education; not in-depth* was reached for all five medical schools. School C had the lowest mean at 2.7 while School D had the highest mean at 3.5 (see Table 7). However, there

Table 7. Physician-Patient Relationship: Quantity of Education.

School	Mean	Std. Deviation	N
A	2.9	.9476	68
B	3.0	1.2255	11
C	2.7	1.0417	12
D	3.5	1.0438	13
E	3.0	1.1121	40
TOTAL	3.0	1.0384	144

were no statistically significant differences between schools or significant differences based on sex. As demonstrated in Illustration 8, the majority (58.8%) indicated that the physician-patient relationship is taught in a clinical placement (58.8%) followed by tutorial (44.7%) and lecture (37.5%). As for integration of the material into the curriculum, 69.3% of respondents indicated that this training is required and 24.9% indicated that it is elective (see Illustration 9).

Illustration 8. Physician-Patient Relationship: Forum. (N=144)

* Percentage exceeds 100% where respondents selected more than one answer.

** Respondents who replied "none" to questions on quantity of education.

Illustration 9. Physician-Patient Relationship: Integration.
(N=144)

* Percentage exceeds 100% where respondents selected more than one answer.

** Respondents who replied "none" to questions on quantity of education.

Ethical Issues

The last set of questions includes ethical issues as they relate to abortion. There were only two questions, both of which will be examined separately.

The first question involves giving a rating on ethical issues surrounding reproductive choice. An overall mean of 2.7, which falls between *scant education* and *some education; not in-depth* was reached for all five medical schools. School E had the lowest rating at 2.4 and School B had the highest rating at 3.5 (see Table 8). However,

Table 8. Ethical Issues Surrounding Reproductive Choice: Quantity of Education.

School	Mean	Std. Deviation	N
A	2.6	.90	69
B	3.5	1.09	12
C	3.1	1.33	14
D	3.1	1.14	14
E	2.4	1.00	41
TOTAL	2.7	1.05	150

while there were no statistically significant differences based on sex, there were statistically significant differences between Schools A and B as well as between Schools B and E where $F(4, 145) = 3.610, p < .05$. This means that students at both Schools A and E perceive receiving significantly less education on ethical issues when compared to School B.

The second question involved providing a rating for the discussion of strategies for reconciling one's personal beliefs with the medical, legal, and ethical obligations as a physician. An overall mean of 2.1, which represents *scant education*, was reached for all five medical schools. School E had the lowest rating at 1.9 while School B had the highest rating at 2.8 (see Table 9). Again, there were no statistically significant

Table 9. Discussion of Strategies for Reconciling One's Personal Beliefs with the Medical, Legal and Ethical Obligations as a Physician: Quantity of Education

School	Mean	Std. Deviation	N
A	2.0	.94	69
B	2.8	1.29	12
C	2.5	1.45	14
D	2.6	1.28	14
E	1.9	1.03	40
TOTAL	2.1	1.11	149

differences based on sex, but there were statistically significant differences between schools where $F(4, 144) = 2.589, p < .05$. However, no clear difference between schools was detected in post hoc testing.

As for teaching forum, as can be seen in Illustration 10, the majority (45.6%) indicated that ethical issues are taught in tutorial, followed by lecture (40.4%) and clinical (31.6%). In terms of integration of the material into the curriculum, 56.6%

indicated that ethical issues are required while 25% indicate they are elective (see Illustration 11).

Illustration 10. Ethical Issues: Forum. (N=150)

* Percentage exceeds 100% where respondents selected more than one answer.

** Respondents who replied "none" to questions on quantity of education.

Illustration 11. Ethical Issues: Integration. (N=150)

* Percentage exceeds 100% where respondents selected more than one answer.

** Respondents who replied "none" to questions on quantity of education.

Opinion on Abortion Education

This series of questions, which uses a Likert rating scale, asks a number of opinion questions on abortion education to ascertain possible reasons for a lack of training in abortion issues. This exploratory data will examine, for example, whether

medical students think abortion education is unnecessary or adequate as is, and whether there is a perceived shortage of learning opportunities.

As can be seen in Illustration 12, 67 respondents (45%) believed abortion education for physicians in training is “very necessary” and 75 (50%) indicated it is “necessary”. Only 5 (3%) of respondents deemed it “unnecessary” and 4 (2%) “very unnecessary.” No one indicated “don’t know.”

When asked if there needs to be more or less abortion education, 76 respondents (50%) indicated “more” and 36 (24%) “a lot more”. As can be seen in Illustration 13, an additional 36 (24%) indicated “adequate as is.” Only 1 respondent believed there needs to be “less” (1%) and no one indicated “a lot less.” Only 1 respondent (1%) indicated “don’t know.”

Illustration 13. Does there need to be more or less abortion education at your institution? (N=150)

As demonstrated in Illustration 14, 93 respondents (70%) indicated that abortion should be “required” in course work, 115 respondents (82%) believed it should be required in tutorials (82%), and 92 (69%) indicated that it should be required in seminars. While 50 respondents (34%) believed it should be “required” in clinical placement, 79 students (54%) believed it should be “elective” in clinical placement. Less than 10% of respondents indicated that abortion education is “not appropriate” in any forum.

Illustration 14. How should abortion education be implemented in the curricula?

Upon being asked when the best time is to incorporate abortion education, 131 students (90%) deemed the OB/GYN residency and 109 students (75%) indicated family medicine residency levels as “very appropriate”. As can be seen in Illustration 15, 70 respondents

(48%) believed undergraduate education to be “appropriate” while 68 (46%) declared it “very appropriate.” Very few respondents indicated “inappropriate”, “very inappropriate” or “don’t know.”

The next question asked respondents to indicate if there are pressures for students not to undertake abortion education. As demonstrated in Illustration 16, 106 students (71%) indicated “no.” Of the 42 (29%) who responded “yes,” they were then asked to indicate which influences contributed to these pressures. As can be seen in Illustration 17, 16 respondents (40%) indicated that moral/religious beliefs constituted a “strong influence” followed by 11 respondents (30%) who also indicated that educational opportunities constituted a “strong influence”. In addition, 11 respondents (28%) described violence/harassment as a “moderate influence”. Future financial remuneration

was seen as “no influence” by 24 respondents (65%) and 16 respondents (43%) indicated that support from peers was a “minimal influence”.

Illustration 16. Are there pressures for students NOT to undertake abortion education? (N=149)

Illustration 17. Pressures.

- Violence/harassment (N=39)
- Future financial remuneration (N=37)
- Educational opportunities (N=37)
- Support from peers (N=37)
- Moral/religious beliefs (N=40)

As demonstrated in Illustration 18, the majority of students believed that “some learning opportunities are available” from faculty (80 students or 56%), ancillary staff (51 students or 23%), residents (59 students or 21%) and the community surrounding the institution (48 students or 34%). However, some students indicated that it is “hard to access learning opportunities” from faculty (26 students or 18%), ancillary staff (32 students or 23%), residents (29 students or 21%) and the community surrounding the

institution (30 students or 22%). Fewer respondents indicated that “learning opportunities are readily available” (26 respondents or 18%, 14 respondents or 10%, 24 respondents or 17% and 18 respondents or 13% respectively). Even fewer indicated that “no opportunities are available” (4 respondents or 3%, 11 respondents or 8%, 14 respondents or 10% and 13 respondents or 10% respectively). Some respondents indicated “don’t know” (8 respondents or 6%, 32 respondents or 22%, 17 respondents or 11% and 31 respondents or 22% respectively).

The next question asks respondents to indicate their willingness to discuss the issue of abortion with women patients facing an unintended pregnancy. As demonstrated in Illustration 19, 67 respondents (45%) were “very willing” and 45 respondents (31%) “willing”. In addition, 31 respondents (21%) indicated they were “very unwilling” and the remaining 5 respondents (3%) comprise the categories of “unwilling” and “don’t know.” Further statistical analysis found no significant relationship between the amount of education respondents receive in diagnosing pregnancy, abortion procedures, the

physician-patient relationship and ethical issues and their likelihood to discuss the issue of abortion with women patients facing an unintended pregnancy.

The following question asks respondents to indicate whether they would be willing to refer women patients to physicians who provide abortion services. As can be seen in Illustration 20, 83 students (56%) indicated “very willing” and 49 students (34%) “willing”. Only two students (1%) were “unwilling” and six students (4%) “very unwilling.” Seven students (5%) indicated “don’t know.” Further statistical analysis found no significant relationship between the amount of education respondents receive in diagnosing pregnancy, abortion procedures, the physician-patient relationship and ethical issues and their likelihood to refer women patients to physicians who provide abortion services.

Illustration 20. As a future physician, would you be willing to refer patients to physicians who provide abortion services? (N=146)

Of the 152 surveys collected, 62 respondents indicated that they were planning to enter a family medicine residency. As can be seen in Illustration 21, 18 students (29%) indicated “don’t know” when asked to rate their willingness to perform abortions as part of their future medical practice followed closely by 17 students (27%) who indicated “very unwilling.” Twelve students (19%) indicated they were “unwilling.” On the other hand, 11 students (18%) indicated they were “willing” and five students (8%) indicated they were “very willing.” There were no statistically significant differences based on sex.

Illustration 21. If entering family medicine, how would you rate your own willingness to perform abortions? (N=62)

Of the 152 surveys collected, only nine respondents indicated that they were planning on entering an obstetrics/gynecology residency. As demonstrated in Illustration 22, three respondents (33%) indicated they were “very willing” to provide abortion

services as a part of their future medical practice and an additional three respondents (33%) indicated that they were “willing.” The remaining three respondents indicated “unwilling,” “very unwilling” and “don’t know” respectively. There were no statistically significant differences based on sex.

Limitations to the Data

While the data present some interesting trends that will be discussed in the following section, there are some limitations to the data. The first limitation is the result of a varying and sometimes low response rate. Although this issue was examined in greater detail in the former chapter, I will summarize here. While Schools A and E had a representative sample, Schools B, C, and D all had underrepresented samples. While it can be hypothesized that those who returned surveys were likely to have strong opinions about the topic, it is not clear whether this biased the sample. All schools combined, however, had a fairly representative sample particularly since the responses were surprisingly consistent across schools and not many statistically significant differences were detected. A second limitation has to do with language. The first potential

block?” Another possible discrepancy is related to the term “abortion.” While I specifically meant (and I think the survey reflected) therapeutic/elective abortion, there is a chance that respondents may have interpreted “abortion” to include spontaneous abortion/miscarriage. As one respondent stated: “...we learn about abortions in the context of therapeutic as well as elective.” If there was confusion, the data may be overestimating. A third limitation has to do with recall bias. The first half of the survey requires respondents to reflect upon their medical education by providing a rating, a teaching forum and level of integration on a range of medical, communication and ethical issues. As one respondent indicated:

You require information that's very specific but difficult to recall given that we studied OB/GYN on average more than one year ago. This will bias your results and may not be very reflective of what's actually going on in our schools.

The last limitation involves the possibility that respondents did not want their school to reflect badly in comparison to other schools. While there were few statistically significant differences between schools, it is not clear whether or how this may have biased the results.

Discussion

Overall, the data supports the hypothesis that undergraduate medical students in Ontario are receiving little abortion education. Upon examining the results from the first half of the survey (diagnosing pregnancy, abortion procedures, the physician-patient relationship and ethical issues), the data indicate that medical students receive *scant to some education; not in-depth*. This conclusion is strengthened by the fact that all questions were correlated, there were very few statistically significant differences across

schools and no statistically significant differences based on sex. This indicates that the data are consistent and that certain conclusions can be drawn from them.

An overall rating of 2.6, which falls between *scant to some education; not in-depth* was reached for training on abortion procedures in all five medical schools. On the other hand, an overall rating of 3.2, representing *some education; not in-depth*, was achieved for diagnosing pregnancy. In comparing the two, it was noted that medical students receive statistically significant less education in abortion procedures as opposed to diagnosing pregnancy. While data were not collected on other, non-abortion issues, this does suggest that medical students receive less training and education in abortion issues when compared with other topics. And perhaps it is more than coincidence that medical students receive more extensive education on diagnosing pregnancy as compared to abortion. It is indeed interesting that medical students are trained to diagnose pregnancy but are not prepared to assist women faced with unintended pregnancies. This does not address the totality of women's lives and, moreover, may indicate, on some level, that the medical establishment does not see abortion as a morally acceptable choice for women. In a sense, then, the medical profession acts as a moral gatekeeper since "physicians are more than willing agents of the scheme that prevents women from practising 'indiscriminant' sexuality... by making it impossible for us to deal with unwanted pregnancies" (Cole, 1983: 7).

An overall rating of 3.0, representing *some education; not in-depth*, was achieved for training on the physician-patient relationship as it pertains to abortion issues at all five medical schools. Compared to abortion procedures, this score was slightly higher. One possible reason for this is that these communication skills are not specific to abortion. As

one student said: "...issues regarding communication, counselling, [and] history taking are universal and taught in many forums." On the other hand, students were asked to provide a rating as these techniques pertained to abortion. In this case, one student noted "we are trained in all those areas, just not as they specifically relate to abortion."

However these questions were interpreted (communication techniques in general or as they relate to abortion only) a rating of *some education; not in-depth* is dangerously low and has implications beyond abortion education. Perhaps this is the result of the shift towards a "health care team" approach where, although the physician acts as the catalyst, much of this kind of work is left to nurses and social workers. If this is indeed the case, this perpetuates the role of the physician as one performing a single medical procedure and thus limits medical education to a medical model approach. It further creates problems in solo practice or physician-based practices where nurses and social workers may not be employed.

An overall rating of 2.7 was reached for the first question on ethical issues at all five medical schools. This indicates that medical students perceive that they have received *scant to some education; not in-depth* on ethical issues surrounding reproductive choice. In addition, a rating of 2.1 was reached for the second question on ethical issues. This indicates that medical students perceive they have received *scant education* on discussing strategies for reconciling personal beliefs with the medical, legal and ethical obligations as a physician. This illustrates how abortion has been extracted from its political context and reduced to a medical procedure where students are more likely to be taught the mechanics of the procedure at the exclusion of any discussion on the socio-political issues involved.

In sum, undergraduate medical students in Ontario are receiving little education on abortion issues. To expand on this finding, a number of questions were included in the survey to ascertain why there is little medical training in abortion issues. While some data provide explanations for this, a number of students indicated overwhelming support for abortion education.

In fact, 95% of respondents indicated that abortion education for physicians in training is either “very necessary” or “necessary.” Moreover, while 24% of respondents indicated that abortion education at their institution is “adequate as is,” 74% believe there needs to be “more” or “a lot more.” In the words of one student: “... we need more abortion-related teaching in our curriculum. We had one lecture during our Ob/Gyn course work and spent one morning with the hospital ethicist discussing the topic. During our Ob/Gyn clinical rotation, the subject was not taught in our tutorial sessions...” In addition, 94% of respondents indicated that abortion education is either “very appropriate” or “appropriate” for undergraduate medical education. Further, the majority of respondents indicated that abortion education should be “required” in course work (70%), tutorials (82%), and seminars (69%). While 34% believed it should be “required” in clinical placement, the majority (54%) believed it should be “elective” in clinical placement. On the whole, respondents believe abortion education is necessary, that there needs to be more of it, it is appropriate for the undergraduate level and should be required. Clearly, the majority of students were supportive of abortion training. This seems to indicate that any disincentives are external.

When asked if there are pressures for students not to undertake abortion education 71% replied “no.” Although in the minority, 29% indicated that there were pressures and

this provides one possible explanation for a lack of training and education in abortion issues. Moral/religious beliefs were cited as a “strong influence” (40%) as were educational opportunities (30%). Violence/harassment was cited as a “moderate influence” (28%) and peer support as a “minimal influence” (43%). Future financial remuneration was seen as “no influence” (65%). While it is encouraging that the majority of respondents feel there are no pressures, this does support the theory that abortion has been extracted from its political context and through the process of medicalization has become a medical procedure like all others. The medical nature of the procedure dominates at the exclusion of the socio-political context. Of those respondents who did identify pressures, many of these pressures were a direct result of the controversial nature of abortion (particularly moral/religious beliefs, violence/harassment, peer support/marginalization). Several students noted tension in the classroom as a result of this controversy. In the words of one student: “Although I am very pro-choice, I have found that some of the pro-lifers in the class are quite vocal and condescending. As a result, I choose to keep my convictions to myself.” On the other hand, another student noted that: “[Our] education consists of a presentation by an extreme pro-choice advocate, followed by rigged “discussion groups” where presenters out-number medical students and any dissent is quickly stifled.” Perhaps the technique of presenting one or both sides of the abortion debate is not helpful in the context of medical education. Or, if such a debate were to occur, it needs to occur in a climate where students can freely and safely discuss the issues. As one student pointed out: “One attempted session in CSD (community skills development) was dominated by religious beliefs against [abortion]

(pro-life) and pro-choice factions and unfortunately not open to an open discussion.”

Such a climate is not conducive to learning or discussing ethical issues.

As formerly mentioned, 30% of respondents felt educational opportunities were a “strong influence” in deterring abortion education. To further expand upon the availability of learning opportunities, a series of four questions were asked. The majority of respondents indicated that learning opportunities were either “readily available” or “some learning opportunities are available” from faculty (51.4%), ancillary staff (33.6%), residents (40.8%) and the community surrounding the institution (33.6%). However, there was a significant number of respondents who indicated that these opportunities were either hard to access or not available (14.6%, 22.1%, 21.8%, 22.8% respectively). It is also telling that some respondents indicated “don’t know” (4.1%, 15.7%, 7.7%, 15.7% respectively). It is indeed encouraging that students feel that learning opportunities are available. However, it is unclear how widely available, and known, these opportunities are. In the words of one student: “I feel that much of my exposure to teaching on abortion issues has occurred because I have asked questions and sought out faculty to discuss the issue. Not a lot has been included in our core curriculum.” This speaks to the phenomenon of professional marginalization where the historically underground development of abortion providers persists in modern day educational institutions where abortion is taught “on the side” according to student interest. While much medical education occurs through mentoring and apprenticeship, abortion is unique given its controversial nature and stigma and the fact that, perhaps, learning opportunities are not widely advertised.

Another possible explanation for a lack of training in abortion issues lies in the forum the material is taught in and method of integration into the curriculum. The majority of respondents indicated that abortion education (specifically, diagnosing pregnancy, abortion procedures and the physician-patient relationship as it pertains to abortion) at their schools is largely required and most often occurs in a clinical setting. Although this is encouraging at first glance, it is not only questionable given the above discussion, but also somewhat problematic. First, several respondents (representing all five medical schools) noted that a significant amount of abortion education is optional and only available for students to seek out on their own. As one student noted: “[It is] very important to recognize that there is little/no formal training on this subject. Anything I know, I’ve learned by specifically searching for clinical experience in this.” Another student indicated elective learning opportunities are available, but not widely advertised: “...we were offered the option of spending time in the abortion clinic but this was neither required or promoted.” In addition, a respondent described students who organized their own learning opportunities: “I did an OB/GYN rotation at a Catholic hospital... The only abortion education we had was a half-day that we (the students) organized with a community provider. There was no provision for TA [therapeutic abortion] education in our curriculum.”

This illustrates an additional point and that is the availability of clinical experience. Are all students in teaching facilities with abortion services? As in the previous described scenario, not necessarily, since religious affiliated hospitals do not provide training in abortion procedures. And as a result of health services restructuring, abortion services are becoming less available in hospitals. In the words of one student,

“...because there are fewer clinics, the opportunities are likewise sparse.” This in itself threatens student access to education and it is not possible to ascertain from the data collected whether medical students are able to access training in free-standing abortion clinics. Clearly, the way abortion education is transmitted depends on site-to-site variability and, as one student noted, “...clinical experience is dependent on the preceptor one is assigned to.” If students are not getting exposure to abortion issues in the clinical setting, according to respondents there is less chance of exposure in a tutorial or lecture setting. This heavy reliance on clinical experience, while valuable, perpetuates the medicalization and marginalization of abortion. In this context, it is simply a surgical procedure that takes place in a specialized clinic. Moreover, this approach demonstrates a fragmented approach to teaching women’s health. From an education standpoint, it is largely based on the luck of the draw as to whether students have access to preceptors and clinical experience and women’s issues are taught outside of and in addition to the rest of medicine.

Clearly, there is evidence to suggest that students are receiving inadequate education in abortion issues and that the reasons for this are largely external to student willingness. In addition to this, the data also indicates that few medical students are planning to provide abortion services as part of their future medical practices, although no statistical significance was achieved in terms of predicting the likelihood of providing abortion services based on the quantity of abortion education received.

The majority of respondents indicated that they are “very willing” or “willing” to discuss the issue of abortion with women patients facing an unintended pregnancy (52%)⁸ and either “very willing” or “willing” to refer patients to physicians who provide abortion services (90%). However, the majority of respondents are unwilling to offer abortion services themselves. Of the 63 students surveyed who are planning on entering a family medicine residency, only 26% are “very willing” or “willing” to provide abortion services while 46% are either “very unwilling” or “unwilling.” Moreover, 29% responded “don’t know.” Of the nine students surveyed who are planning on entering obstetrics and gynecology, six (66%) indicated that they are “very willing” or “willing” to provide abortion services. The remaining three (33%) were evenly distributed amongst the remaining categories (“very unwilling,” “unwilling” and “don’t know”). It is encouraging to see that the majority of respondents are willing to discuss abortion with patients and refer women to abortion providers. As one student indicated:

“Too often this topic is avoided in medical education because it is controversial and loaded with religious and moral issues. Despite this, I think it is essential that all graduating physicians should be comfortable knowing abortion options and counselling women about them irrespective of their personal beliefs.”

However, there is a clear dichotomy between being willing to discuss abortion or refer women to abortion providers as opposed to offering abortion services. As a result of their research on training family medicine residents in abortion procedures, Steinauer et al. (1997) found that agreement with training does not guarantee abortion provision. There is a clear discrepancy between beliefs and action. Sometimes this discrepancy boils down to

⁸ I suspect, however, that this number should be higher and more in-line with the responses collected for willingness to refer. Because the answers for each question alternated between positive to negative wording and negative to positive wording, this may have caused confusion for respondents.

personal convictions. According to one student: “I have religious beliefs that do not see abortion as an appropriate method of treatment for unwanted pregnancy. Therefore, I would discuss, counsel and refer patients for abortion – but would not do it myself.”

Some students may not see abortion provision as a possibility, since one student indicated that: “Most of us aren’t entering OB/GYN thus by circumstance won’t be doing abortions.” This may partially account for the number of soon-to-be family medicine residents who replied “don’t know” when asked about their willingness to provide abortions. Additionally, the violence and harassment perpetrated against abortion providers and abortion providing facilities may also act as a deterrent. One student stated: “I am willing to and am passionate about providing complete care for women including TA’s [therapeutic abortions]. But the violence and threats surrounding this field will definitely impact on my future decisions.”

The fact that the majority of medical students asked are unwilling to provide abortion services illustrates how the medical profession controls women’s access to the procedure. Indeed, “...a woman’s right to choose the [abortion] procedure is always circumscribed by the physician’s right not to perform it” (Imber in Joffe, 1995: 48). In fact, as Petchesky (1990) points out, it is the conjunction of medical, corporation (e.g. pharmaceutical companies) and state interests in the management of reproduction that has defined the choices of all women (though they differ depending on women’s class and race). When the development and implementation of abortion policy was delegated from the courts to the medical profession, the process of absorption perpetuated the maintenance of the status quo where women are still struggling to access abortion services. No medical or other state institution has addressed the political context

surrounding the issue of abortion (e.g. the rights of women). Similarly, in discussing wife battering, Walker notes that this "failure to address the role of patriarchy and the structural features of oppression leaves the justice system free to manage violence in ways which bolster and reassert the status quo" (Walker, 1990: 84).

This is not to say, of course, that individual physicians ignore this context. In the words of one survey respondent:

Anti-choice individuals need to realize that making abortion illegal will not stop women from undergoing the procedure, it will only make it an unsafe procedure with dangerous complications. It is our duty as physicians to promote and facilitate autonomous health care decisions by our patients. This means respecting the reproductive freedom of our female patients (and male patients). Denying our patients counselling, information and access to the service is ethically wrong and in my opinion should be considered medical malpractice.

In addition, another respondent indicated:

The issue of abortion was not addressed in our curriculum... I think this is a travesty, as we are being paid to treat our entire community and we should be trained to do so. This violates women's rights.

However, the medical profession on the whole does not recognize or address this context. As this study indicates, abortion education, much like the rest of women's health education, is fragmented and students interested in the issues are encouraged to seek out training in addition to the "regular" curricula. Moreover, a medical model approach, which reduces abortion to a surgical procedure, is perpetuated at the expense of discussing the political context and ethical issues involved. The process of absorption has reduced abortion to a private, medical problem rather than a matter of sexual and reproductive freedom and rights which "eliminates the possibility of a more radical critique" (Walker, 1990: 86). And abortion education is further marginalized when

compared to other women's health issues (e.g. diagnosing pregnancy) as a result of its controversial nature and stigma.

As discussed in chapter two, abortion education needs to be advocated for in the context of better integration of women's health issues into the curricula. The reform of medical education is indeed necessary, since there is a tendency to focus on the science ("hard science") at the exclusion of the social science ("soft science") of medicine therefore excluding discussion of women's "difference" within the context of women's lives. Indeed, this failure to address the role of patriarchal and structural feature of oppression not only results in an inadequate public (or medical) response, but bolsters and reasserts the status quo or, more specifically, the continuance of sexism and patriarchal power.

CONCLUSION

The goal of this study was to explore the status of abortion education in Ontario medical schools as a way of understanding whether women's access to abortion is eroding. The data collected support my hypothesis that undergraduate medical students are receiving little training in abortion issues, although I was unable to support my second hypothesis that because of this lack of training, medical students are not planning to provide abortion services as part of their future medical practices. However, the fact that undergraduate medical students are receiving inadequate training in abortion issues supports the argument of the Canadian Abortion Rights Action League (CARAL) that we are experiencing a shrinking pool of abortion providers, a shrinkage which is partially explained by this lack of abortion training in medical schools.

Several difficulties arose from conducting this research which illustrate the sensitive nature of the topic. Nevertheless, these issues merit further research at the undergraduate, residency and post-graduate levels. It would be valuable to repeat the study in both Ontario and the other medical schools in Canada to obtain more extensive information about the availability of abortion education. In order to successfully do this, it would be important to obtain administrative support in order to access students and/or faculty members. It would also be helpful to simplify the survey tool itself since many respondents indicated that it was complicated and cumbersome and some of the information requested too difficult to recall. For example, rather than asking respondents to provide a rating, teaching forum and level of integration on several, very specific abortion-related procedures, the information requested could be elicited through a few

multiple choice questions that examine abortion education more broadly. Further, given the results of this study, it would also be interesting to examine why physicians with favourable attitudes toward abortion training do not themselves provide abortion services. In addition, it would be valuable to survey program directors as well as students since training availability is associated with more favourable attitudes about abortion training (Lerner and Taylor, 1994; Steinauer et al., 1997). In addressing the totality of women's lives, it would be additionally interesting to evaluate the integration of abortion in medical school curricula alongside other women's health issues.

It would also be interesting to examine abortion education and physician willingness to provide abortion services in light of a changing political and medical climate of choice. Abortion was a major issue in this past federal election, especially for the Canadian Alliance party. With the Canadian Alliance as the official opposition, there are important questions that need to be investigated about how this will affect the views and beliefs of the Canadian public or, more specifically, the views and beliefs of the medical profession. Will public opinion and abortion policy in Canada change as a result? Will medical schools continue to dodge this controversial and often divisive issue?

Furthermore, in April 1998, the Harris government and the Ontario Medical Association (OMA) agreed to changes to the OHIP fee schedule that place a cap on the number of abortions for which a physician may bill OHIP. Given the shrinking pool of abortion providers we are currently experiencing, will women be able to access abortion services once an abortion provider has reached this cap? Will this be an additional disincentive for physicians interested in providing abortion services? This not only

contravenes the principle of accessibility of the *Canada Health Act*, but also further marginalizes abortion providers and perpetuates abortion as a physician's issue, in the context of funding, rather than as a right of women to health care.

How will new abortifacients, including RU-486, influence medical education, physicians' attitudes toward abortion and their willingness to provide abortion services? RU-486 was very recently approved for use in the United States. Proponents of this new technology hail it as more private and discreet in comparison to surgical abortion as medical abortion can be completed in the office of any physician (Foubister, 2000). Moreover, it doesn't require special equipment or state-regulated facilities, and training for medical abortion is simpler than training for surgical abortion (ibid). However, this does not resolve the moral dilemma of abortion and this option is still dependent on a physician's willingness to prescribe it. In fact, a physician who prescribes RU-486 must be willing to provide surgical intervention for failed medical abortion or be willing to refer such patients to other abortion providers who are prepared and willing to provide surgical abortions.

If we were to allow mid-level practitioners to provide abortion services in Canada, as is starting to happen in the United States, how might this influence medical education? Abortion is indeed a very simple medical procedure. In fact, prior to the 20th century, contraception, abortion and childbirth were largely the responsibility of local lay practitioners. And when abortion was illegal in the United States, members of Jane, part of the Chicago Women's Liberation Union, not only referred women for safe and illegal abortions but actually taught themselves how perform abortions, providing 11,000 abortions in a span of four years. In 1996, the National Abortion Federation in the United

States held a symposium establishing that physician assistants, nurse practitioners, and nurse-midwives could be trained to provide first-trimester abortions and medical abortions for very early pregnancies. The role of nurses and nurse practitioners is expanding in Canada. Along with this is an increasing recognition that registered nurses with advanced knowledge and decision making skills in assessment, diagnosis and health care management can do 90% of what a primary care physician does (Morgan and Cohen, 1992; Van Der Horst, 1992; Mitchell et al., 1993). If nurse practitioners were to provide abortion services, would this increase women's access to abortion? Just as the midwifery movement aims to de-medicalize childbirth, would these same proponents improve women's access to abortion outside of a medical model? How might this influence or change the accountability and control of the medical profession? Or would it let physicians "off the hook"? Would issues prevail around training health care providers? Would it further marginalize abortion providers?

In addition to these questions and issues arising from medical education and women's access to health care are also equally important implications for the women's movement in Canada. The abortion debate is in itself an example of a victory transformed. Although legal prohibitions have been eliminated, physicians remain as gatekeepers and the problem of getting physicians to provide abortion services, thus ensuring women's access to health care, prevails. This theme of continual struggle results in a need to defend and struggle for women's rights. This is much like other victories of the women's movement. Take for example the issue of violence against women. Although we have had a Royal Commission, a Canadian Panel and myriad other initiatives to address the problem, we are currently experiencing slashed funding to front-

line services like shelters, second stage housing, and sexual assault/rape crisis centres. This, like the abortion debate, provides the women's movement with an opportunity to reflect on our strategies in order to avoid continually defending past gains. As Walker argues, we "need to understand [the process of absorption] if we are to develop strategies to avoid fragmentation and absorption in the future" (Walker, 1990: 66). We must discover ways of ensuring meaningful social change through state institutions by ensuring recognition of the political context of women's issues so as not to perpetuate the status quo. Indeed, this is a call to feminists to continue to struggle for rights and against bureaucratic attempts to depoliticize it (ibid).

We need to develop new strategies to ensure that this political context is addressed, since the 1988 Supreme Court decision did not address whether women had reproductive rights nor make any attempt to reconcile women's rights with those of the fetus (Brodie et al., 1992). We must make this discourse of women's rights and reproductive rights central to the abortion debate since full sexual and reproductive freedom is an essential condition to women's full and equal participation in society. This might mean, perhaps, that we need to revisit the abandoned resolution put forth by the 1981 Ad Hoc Conference on the *Charter of Rights and Freedoms* that the *Charter* be amended to include the right to reproductive freedom. In addition, perhaps we should "be moving towards a national strategy to integrate the full range of sexual and reproductive health information and services which would ensure accessibility and affordability for all women" (McDonald, 1996: 21). The opportunity is ripe for the women's movement to reevaluate their strategies so as to instigate meaningful and lasting social change.

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Appendix One

[Date]

Dear Medical Student:

I am a graduate student in the School of Canadian Studies at Carleton University. I am conducting a study to examine the status of abortion education in the five Ontario medical schools for my M.A. thesis. I am disseminating a short questionnaire to undergraduate (to receive M.D.) students in their final year of study. This is a very important research project since there is currently no available data on this particular topic.

Please take a few minutes to fill out the attached questionnaire. You may fill out as much or as little of the questionnaire as you feel comfortable with. Confidentiality is ensured since the data I am collecting does not include any identifying information. In fact, the identification of the schools themselves will remain confidential. If I quote any part of the questionnaire (i.e. from the "comments" section) in my report, the source will simply be cited as "a student." All responses I receive (including the consent to participate) will be destroyed in a timely manner once the data is collected.

If you have any questions about this questionnaire or the study itself, please do not hesitate to contact me.

Thanking you in advance,

Erin Connell
School of Canadian Studies
Carleton University
E-Mail: erin_connell@hotmail.com
TEL: (613) 727-3384

CONSENT TO PARTICIPATE

I have read the information letter describing the purposes and the tasks involved in participation in a study on abortion education which is being conducted by Erin Connell of the School of Canadian Studies at Carleton University. I further understand that should the information I provide be used in publications or for teaching purposes, my identity will be protected. I acknowledge that I may withdraw my consent to participate at any time.

This study has been reviewed by, and has received ethics clearance, through the School of Canadian Studies. This Office will receive any complaints or concerns with regard to your involvement in this study.

Participant's Name:

Date:

Academic Supervisor: Pat Armstrong, PhD

TEL: (416) 736-2100 ext. 22550

Graduate Supervisor: Julian Smith, PhD

TEL: (613) 520-2366

QUESTIONNAIRE

1. Demographics

- a) Sex: ☐ male ☐ female
- b) Age:
- c) Have you completed a rotation or unit in obstetrics and gynecology: ☐ yes ☐ no
- d) Have you completed a rotation or unit in family medicine: ☐ yes ☐ no

2. Abortion Procedures

- ▶ In column one, please use a numerical rating to indicate the quantity of education. Leave blank if you have not had instruction in the skill specified.
1- none 2- scant education 3- some education; not in-depth
4- in-depth coverage 5- extensive coverage
- ▶ In column two, please use T, L or C to indicate what forum the intervention is taught in (do not fill in if rating = 1).
- ▶ In column three, please use R or E to indicate the integration of material in the curriculum (do not fill in if rating = 1).

	Quantity of Education 1 2 3 4 5	Tutorial/Lecture/ Clinical Placement (T, L, C)	Required/Elective (R, E)
Pregnancy tests			
Gestational age assessment (by bimanual)			
Rho(D) testing			
Interpreting hCG tests			
Reading diagnostic ultrasound			
Abortion procedure options			
Pain-control options			
Cervical block			
Use of cervical dilators			
Use of vacuum aspiration			
Use of D & C			
Use of methotrexate & misoprostol			
1st trimester abortion			
2 nd trimester abortion			
Complications (immediate, delayed, late)			
Pre- & post-abortion counselling			
Post-op. care			
Follow-up care			

3. Physician-Patient Relationship

Please evaluate these communication skills as they relate to abortion issues only.

- ▶ In column one, please use a numerical rating to indicate the quantity of education. Leave blank if you have not had instruction in the skill specified.

**1- none 2- scant education 3- some education; not in-depth
4- in-depth converge 5- extensive coverage**

- ▶ In column two, please use T, L or C to indicate what forum the intervention is taught in (do not fill in if rating = 1).
- ▶ In column three, please use R or E to indicate the integration of material in the curriculum (do not fill in if rating = 1).

	Quantity of Education 1 2 3 4 5	Tutorial/Lecture/ Clinical Placement (T, L, C)	Required/Elective (R, E)
effective communication techniques			
barriers to effective communication			
patient-centred interviews			
sexual history-taking skills			
principles of effective patient education			
informed consent			
pregnancy counselling and decision-making			
managing emotions			
contraception counselling			

4. Ethical Issues

Please evaluate these ethical issues as they relate to abortion issues only.

- ▶ In column one, please use a numerical rating to indicate the quantity of education. Leave blank if you have not had instruction in the skill specified.

**1- none 2- scant education 3- some education; not in-depth
4- in-depth converge 5- extensive coverage**

- ▶ In column two, please use T, L or C to indicate what forum the intervention is taught in (do not fill in if rating = 1).
- ▶ In column three, please use R or E to indicate the integration of material in the curriculum (do not fill in if rating = 1).

	Quantity of Education 1 2 3 4 5	Tutorial/Lecture/ Clinical Placement (T, L, C)	Required/Elective (R, E)
ethical issues surrounding reproductive choice			

	Quantity of Education 1 2 3 4 5	Tutorial/Lecture/ Clinical Placement (T, L, C)	Required/Elective (R, E)
discussion of strategies for reconciling personal beliefs with medical, legal, ethical obligations as a physician			

5. General Questions

a) In your opinion, is abortion education for physicians in training...

- 1) very necessary
- 2) necessary
- 3) unnecessary
- 4) very unnecessary
- 5) don't know

b) In your opinion, does there need to be more or less abortion education at your institution:

- 1) a lot less
- 2) less
- 3) adequate as is
- 4) more
- 5) a lot more
- 6) don't know

c) In your opinion, how should abortion education be implemented in the curricula (check appropriate box):

	required	elective	not appropriate	don't know
course work				
tutorial				
seminar				
clinical placement				

d) In your opinion, when is the best time to incorporate abortion education (check appropriate box):

	very appropriate	appropriate	inappropriate	very inappropriate	don't know
undergraduate					
residency: OB/GYN					
residency: family med.					

e) In your opinion, are there pressures for students NOT to undertake abortion education?

No ____

Yes ____

If “yes” (check appropriate box):

	strong influence	moderate influence	minimal influence	no influence	don't know
violence/harassment					
future financial remuneration					
educational opportunities					
support from peers					
moral/religious beliefs					

other: _____

f) Regarding abortion education, how would you describe the opportunities to learn from the... (check appropriate box):

	learning opportunities readily available	some learning opportunities available	hard to access learning opportunities	no opportunities available	don't know
faculty					
ancillary staff					
residents					
community surrounding institution					

g) As a future physician, would you be willing to discuss the issue of abortion with women patients facing an unwanted pregnancy?

1) Very unwilling

2) Unwilling

3) Willing

4) Very willing

5) Don't know

h) As a future physician, would you be willing to refer women patients to physicians who provide abortion services?

- 1) Very willing
- 2) Willing
- 3) Unwilling
- 4) Very unwilling
- 5) Don't know

i) Are you planning on entering family medicine? ____ yes ____ no

If yes, how would you rate your own willingness to perform abortions as a part of your medical practice?

- 1) Very unwilling
- 2) Unwilling
- 3) Willing
- 4) Very willing
- 5) Don't know

j) Are you planning on entering obstetrics and gynecology? ____ yes ____ no

If yes, how would you rate your own willingness to perform abortions as a part of your medical practice?

- 1) Very willing
- 2) Willing
- 3) Unwilling
- 4) Very unwilling
- 5) Don't know

k) Any comments on any part of this questionnaire:

Appendix Two

ETHICS COMMITTEE APPROVAL FORM

STUDENT: Eren Connell

DATE OF SUBMISSION TO ETHICS COMMITTEE: Feb 3/99

PROPOSED TITLE _____

ABORTION EDUCATION IN ONTARIO

MEDICAL SCHOOLS

THESIS ☒ ~~Abstract~~ RESEARCH ESSAY _____ SUPERVISOR: Pat Armstrong

ETHICS COMMITTEE SIGNATURES:

1. Pat Armstrong

2. Julian Smith

3. _____

DATE OF ETHICS COMMITTEE APPROVAL: FEB 15/99

IF REVISIONS ARE REQUIRED BEFORE APPROVAL CAN BE GIVEN, PLEASE
DETAIL BELOW:

I wondered why you need to know
the year of training. It may be on identification

Appendix Three

970 Green Valley Crescent
Ottawa, ON. K2C 3K7

Dean
Faculty of Medicine

September 1999

Dear:

I am a graduate student in the School of Canadian Studies at Carleton University. I would like to conduct a study to examine the status of abortion education in the five Ontario medical schools for my M.A. thesis project, to be completed during the 1999/2000 academic year. This is an important project since, although some data are available in the U.S., none are available in the Canadian context. The importance and validity of this project is reiterated in a letter of support from Dr. Pat Smith, McMaster University and from Dr. Barbara Lent, University of Western Ontario.

Upon receiving approval from the Ethics Committee, School of Canadian Studies, Carleton University, I conducted a pilot project between January and April 1999 in order to test my survey tool and to gather preliminary results. An Executive Summary is attached for your information.

If able to obtain your permission and support, I would like to visit each medical school in order to disseminate my survey to a convenience selection of students in their final year of the undergraduate medical program. Confidentiality would, of course, be ensured, particularly since the survey contains no identifying features and consent forms would be destroyed in a timely manner. I have also included a copy of my survey for your consideration.

If you have any questions, concerns, or comments, please do not hesitate to contact me. I can be reached via e-mail at erin_connell@hotmail.com or you can call me at (613) 727-3384. Thank you for your time in this matter and I look forward to hearing from you.

Sincerely,

Erin Connell
School of Canadian Studies
Carleton University

[Date]

Dear Medical Student:

I am a graduate student in the School of Canadian Studies at Carleton University. I am conducting a study to examine the status of abortion education in the five Ontario medical schools for my M.A. thesis. I am disseminating a short questionnaire to undergraduate (to receive M.D.) students in their final year of study. This is a very important research project since there is currently no available data on this particular topic.

Please take a few minutes to fill out the attached questionnaire. You may fill out as much or as little of the questionnaire as you feel comfortable with. Confidentiality is ensured since the data I am collecting does not include any identifying information. In fact, the identification of the schools themselves will remain confidential. If I quote any part of the questionnaire (i.e. from the "comments" section) in my report, the source will simply be cited as "a student." All responses I receive (including the consent to participate) will be destroyed in a timely manner once the data is collected.

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Thanking you in advance,

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- d) Have you completed a rotation or unit in family medicine: ____ yes ____ no

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1st trimester abortion			
2 nd trimester abortion			
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Post-op. care			
Follow-up care			

3. Physician-Patient Relationship

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	Quantity of Education 1 2 3 4 5	Tutorial/Lecture/ Clinical Placement (T, L, C)	Required/Elective (R, E)
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Barriers to effective communication			
Patient-centred interviews			
Sexual history-taking skills			
Principles of effective patient education			
Informed consent			
Pregnancy counselling and decision-making			
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Contraception counselling			

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- 2) less
- 3) adequate as is
- 4) more
- 5) a lot more
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c) In your opinion, how should abortion education be implemented in the curricula (check appropriate box):

	required	elective	not appropriate	don't know
Course work				
Tutorial				
Seminar				
Clinical placement				

d) In your opinion, when is the best time to incorporate abortion education (check appropriate box):

	very appropriate	appropriate	inappropriate	very inappropriate	don't know
Undergraduate					
Residency: OB/GYN					
Residency: family med.					

e) In your opinion, are there pressures for students NOT to undertake abortion education?

No ____

Yes ____

If “yes” (check appropriate box):

	strong influence	moderate influence	minimal influence	no influence	don't know
Violence/harassment					
Future financial remuneration					
Educational opportunities					
Support from peers					
Moral/religious beliefs					

f) Regarding abortion education, how would you describe the opportunities to learn from the... (check appropriate box):

	learning opportunities readily available	some learning opportunities available	hard to access learning opportunities	no opportunities available	don't know
faculty					
ancillary staff					
residents					
community surrounding institution					

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- 1) Very willing
- 2) Willing
- 3) Unwilling
- 4) Very unwilling
- 5) Don't know

k) Any comments on any part of this questionnaire:

**The Status of Abortion Education in Ontario's Medical Schools:
A Pilot Survey
Executive Summary**

Introduction: Although abortion is the most common surgical procedure Canadian women undergo, there has been a decline in the number of abortion providers in recent years. This decline is attributable to three main causes: the aging of abortion providers, violence against abortion providers and a lack of medical education and training in abortion procedures currently available to physicians in training. As such, this study aims to examine the status of abortion education in Ontario's medical schools.

Design: Survey.

Setting: Ontario.

Dissemination: This survey was sent via e-mail to encourage a snowball sample. The survey was also disseminated at the annual Ontario Medical Students Weekend (OMSW) 1999.

Response Rate: Ten responses were received as a result of e-mail dissemination. Of the 50 surveys disseminated at the OMSW, 42 were returned for a response rate of 84%. A total of 52 surveys were used in this pilot project. All respondents were undergraduate students (to receive M.D.).

Analysis: The results gathered from the first half of the survey (measuring what students have learned) were deemed invalid due to the high proportion of first year students who completed the survey (44%). The second half of the survey was utilized since it measured opinion and perception regarding abortion education.

Results: Almost all of the respondents (94%) agreed that abortion education for physicians in training is either "very necessary" (69%) or "somewhat necessary" (25%). Over half of respondents (60%) believed that "a lot more" (25%) or "more" (35%) education is needed and no one believed there needs to be "less" or "a lot less." The majority of students believed that abortion education should be required in course work (67%), tutorial sessions (68%) and seminar presentations (57%). According to respondents, it is "very appropriate" to incorporate abortion education at the undergraduate level (65%), during an OB/GYN residency (85%) and during a Family Medicine residency (74%). No one indicated that it is "inappropriate" to incorporate abortion education in any of these venues. When asked whether there are pressures for students not to undertake abortion education, the majority of students (59%) replied no. Pressures that were identified by the remaining 41% included moral/religious beliefs and violence/harassment. When describing opportunities to learn abortion from faculty, ancillary staff, residents and the community surrounding the institution, the majority, 37%, 59%, 57% and 48% respectively, responded "don't know."

Conclusion: Students believe that abortion is a necessary part of their medical training and that there needs to be more learning opportunities on a largely required basis. The lack of educational opportunities from faculty, ancillary staff, residents and the community presented as the greatest barrier for students obtaining abortion training.

THE VICTORIA FAMILY MEDICAL CENTRE

60 Chesley Avenue, London, Ontario N5Z 2C1
Telephone : Clinical - (519) 433-8424 Fax: (519) 433-5796
Administration - (519) 433-8428 Fax: (519) 433-2244

James McSherry
M.B., Ch.B., F.C.F.P., F.R.C.G.P., F.A.A.F.P., F.A.B.M.P.
Medical Director, VFMC
Chief of Family Medicine, LHSC

Barbara Lent
M.A., M.D., C.C.F.P.
Assistant Medical Director

Stephen Wetmon
B.Sc., M.Sc., M.D., C.C.F.P.

Sharon Graham
M.D., C.C.F.P.

Gail Janus
Registered Nurse
Co-ordinator Family Medicine

August 9, 1999

Dear Colleague,

I am writing in support of Ms. Erin Connell's research project looking at the quantity and quality of education on therapeutic abortion, that is offered to students at Ontario medical schools. Specifically, the study aims to provide information on what is currently taught to medical students about the technical aspects of the procedure and about related ethical and doctor-patient relationship issues. A pilot study of 52 undergraduate medical students showed that 60% felt that more education on abortion was needed.

It is important for medical educators to know what is currently taught to medical students about abortion, in order to ensure that future physicians are able to respond to the physical and emotional needs of women faced with unwanted pregnancies. Despite the large numbers of Canadian women who undergo therapeutic abortions each year (106,658 in 1995), the number of providers is decreasing, due in large part to the ongoing social and political controversies surrounding this medical procedure.

I hope that you are able to assist Ms. Connell in her efforts to explore this issue with Ontario medical students.

Sincerely,

Barbara Lent
Chair, Gender Issues Committee, Council of Ontario Faculties of Medicine

HAMILTON HEALTH SCIENCES
CORPORATION
McMaster Campus, Room 4V33
1200 Main Street West
P.O. Box 2000
Hamilton, ON L8N 3Z5
905-521-2100 ext. 73253#
Fax: 905-529-8632

Memo

To: Deans of Ontario Medical Schools
From: Pat Smith, M.D.
Director, Women's Health Program
Hamilton Health Sciences Corporation
Date July 19, 1999
Re: **Proposed Abortion Education Survey by Ms Erin Connell**

I am pleased to provide a letter of support for the project Ms Connell is proposing. Access to abortion services in North America has been severely negatively affected by a decreasing number of abortion providers. This issue has become so critical that the National Abortion Federation has committed substantial resources to the training and recruitment of new providers.

As Ms Connell has suggested, the shortage of abortion providers is affected by a complex set of issues. This project will address one of these - the education of future users and providers of reproductive health services to women. Most future physicians whether they become providers of abortion services or not will certainly come in contact with patients who experience unplanned and unwanted pregnancies. These physicians require an opportunity to acquire the knowledge, skills and attitudes that will appropriately inform their care of these patients.

Ms Connell's survey will begin to document the status of abortion education in Ontario. This information will provide a good starting place for curriculum planning at the undergraduate level.

I hope you will support and assist her in this very important and useful piece of research.