

I read with interest the guest editorial on access to abortion.<sup>1</sup> As a rural physician for 10 years, I have seen that getting access to abortion is particularly difficult in rural areas. Teens, single women and nonwhite women already face difficulties with access, and those who live in a rural setting face additional barriers such as isolation, cultural differences, lack of transportation and low socioeconomic status.

Rural women often require 3 visits to a referral centre for termination of a pregnancy: one visit for dating ultrasonography, a second visit for specialist consultation and a third for the surgical procedure itself. Issues related to transportation, financial burden and accompanying support people are compounded with each additional visit. Many of these women lose continuity of care and never follow up with the person who completed the termination or with any other physician for that matter.

Rural GPs with the appropriate skill set could provide appropriate counselling and continuity of care for patients facing decisions related to an unintended pregnancy. In addition, many rural GPs already have access to operating room time and have (or could readily develop) the skills needed to perform pregnancy terminations, if supported by health authorities and hospital staff. This could facilitate or improve access to care for rural patients, thus narrowing the gap in access to pregnancy termination services. Interested physicians should consider adding this service to their local scope of practice, and health authorities should do their utmost to encourage and support local hospitals and physicians in this area.

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#### REFERENCE

1. Rodgers S, Downie J. Abortion: ensuring access [editorial]. *CMAJ* 2006;175(1):9.

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I am deeply disturbed by the negative responses (posted as e-letters) to the

guest editorial by Sanda Rogers and Jocelyn Downie.<sup>1</sup> Most of the authors articulate an uncompromising ideological position in favour of the right to life of a fetus, while ignoring the basic human rights of women who, presumably, are their patients. Most of these writers show a complete disregard for the consequences of the criminalization of abortion for women's physical and mental health and, indeed, their very right to life.<sup>2,3</sup> The lack of histori-

cal context evidenced by the writers is also striking. In particular, they ignore the importance of sexual and reproductive autonomy for women. Denying abortion services to a woman who does not want to carry a pregnancy to term is to make her the instrument of someone else's will.

Why should we allow a doctor's personal, ideological or religious bias against abortion to negatively affect his or her female patients? Why, in a rural

region or a small town, should we allow these views to control the access to health care of a whole community? Why should an individual doctor's personal beliefs trump the legal definition of "person" and of "human being," violate the constitutionally entrenched rights of women to sexual and reproductive autonomy, and violate international human rights?

In the face of the demonstrated resistance of individual doctors to offering adequate abortion services in most institutions and regions across Canada, the medical profession has a collective responsibility to ensure access to this procedure.

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#### REFERENCES

1. Rodgers S, Downie J. Abortion: ensuring access [editorial]. *CMAJ* 2006;175(1):9.
2. Walsh J, Mollman M. International human rights law and abortion in Latin America. City: Human Rights Watch; 2005. Available: <http://hrw.org/backgrounder/wrd/wrd0106/> (accessed 2007 Jan 19).
3. Badgley R, chair. *Report of the Committee on the Operation of the Abortion Law*. Ottawa: Ministry of Supply and Services Canada; 1977.

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#### [The authors respond:]

Jaro Kotalik and Janet Epp Buckingham are mistaken in claiming errors and misrepresentations in our descriptions<sup>1</sup> of *Morgentaler*,<sup>2</sup> the CMA Code of Ethics<sup>3</sup> and the CMA Policy on Induced Abortion.<sup>4</sup>

They allege that, because the Court recognized a state interest in the fetus, we were wrong to say that the Court recognized a right to continue or terminate a pregnancy. As is clear from the quotation from the *Morgentaler* decision (see Kotalik's letter), this interest is taken into account in the section 1 analysis, but only after legislation has

been found to violate Charter rights. Our claim regarding women's rights is in fact reinforced by the quotation.

Epp Buckingham is correct that abortion legislation was introduced after the *Morgentaler* decision, but that legislation failed to pass. Should the government eventually pass new legislation, it will be measured against women's section 2, 7 and 15 rights. If such legislation violates any of those rights, the government would bear the burden of defending that violation. It is impossible to speculate whether such a defence would succeed. What is clear is that the legislation would have to be measured first against women's Charter rights.

Paragraph 12 of the CMA Code of Ethics<sup>3</sup> does require that a physician "inform your patient when your personal values would influence the recommendation or practice of any medical procedure..." The prohibition of "discrimination on the basis of sex, marital status and medical condition" is found in paragraph 17. Each of the Code's obligations informs the others and is informed by CMA policies, including the Policy on Induced Abortion.<sup>4</sup> That policy states, "A physician whose moral or religious beliefs prevent him or her from recommending or performing an abortion should inform the patient of this so that she may consult another physician." No physician is under an obligation to recommend or to perform an abortion, but all physicians are under an obligation to refer. The Policy on Induced Abortion

is clear: "The patient should be provided with the option of full and immediate counselling services in the event of unwanted pregnancy;" "early diagnosis of pregnancy and determination of appropriate management should be encouraged;" and "[t]here should be no delay in the provision of abortion services." These statements recognize the need for timely referral. A physician who does not participate in abortion does not violate CMA policy. A physician who sets up barriers to prevent women from accessing abortion elsewhere does violate CMA policy. The Policy on Induced Abortion allows conscientious objection by a physician who need not "recommend" or "perform" or "assist at" an abortion. It does not allow a right of conscientious objection in relation to referrals.

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#### REFERENCES

1. Rodgers S, Downie J. Abortion: ensuring access [editorial]. *CMAJ* 2006;175(1):9.
2. *R. v. Morgentaler* (1988), 1 S.C.R.
3. *Code of ethics*. Ottawa (ON): Canadian Medical Association; 2004. Available: [http://www.cma.ca/index.cfm/ci\\_id/2419/la\\_id/1.htm](http://www.cma.ca/index.cfm/ci_id/2419/la_id/1.htm) (accessed 2006 Jan 5).
4. Induced abortion [CMA policy]. Ottawa (ON): Canadian Medical Association; 1988.

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