19556

SUPREME COURT OF CANADA

(On Appeal from the Court of Appeal for Ontario)

B E T W E E N :

DR. HENRY MORGENTALER
DR. LESLIE FRANK SMOLING
DR. ROBERT SCOTT

Appellants

- and -

HER MAJESTY THE QUEEN

Respondent

ADDITIONAL FACTS RELIED ON BY THE APPELLANTS

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ADDITIONAL FACTS RELIED ON BY THE APPELLANTS

INTRODUCTION

1. At the hearing of the appeal, the Court granted leave to the parties to submit additional statements of the facts which the parties felt would be of assistance to the Court in determining the issues before it. Each party was given leave to file additional material and not, as the Attorney General for Ontario suggests in paragraph 1 of its Additional Facts, just the Respondent. The following statement of facts, therefore, is an expansion upon, and clarification of, the statement of facts in Part I of the Appellants' Factum and the document entitled "Evidence to be Referred to in Oral Argument", and is intended to assist the Court in assessing the evidence before it. As stated in the Appellants' Factum, the Appellants rely on all the evidence adduced, both at the motion to quash brought at the outset of the trial (herein referred to as the "pre-trial motion") and at trial, for purposes of the constitutional issues.

(A) EVIDENCE RELATING TO THE CONSTITUTIONAL VALIDITY OF SECTION 251 OF THE CRIMINAL CODE

(I) THE PLACE OF THE ABORTION DECISION IN CONTEMPORARY CANADIAN SOCIETY

2. Following the 1969 amendments to what is now section 251 of the Criminal Code (S.C. 1968-69, c. 38, s. 18), the number of abortions performed in Canada increased dramatically. According to Statistics Canada, well over half a million abortions have been performed in Canada since 1969. In 1982 alone, Statistics Canada reported that 66,319 were performed.

Assuming levels remained constant in 1983, 1984 and 1985, the number is closer to one million. (P.T. Ex. 64; T. Ex. 59; P.T. Ex. 75, p. 14; T. Ex. 51, p. 14)*

3. In addition, many Canadian women have abortions in the United States and in clinics - public and private - in Quebec, which are not reported by Statistics Canada. Studies by Dr. Christopher Tietze, an epidemiologist and expert in abortion statistics, reported that 3,970 abortions were performed on Canadian women in the United States in 1981. Other studies found that Statistics Canada figures of Canadians having abortions in the United States are consistently lower than the actual numbers, sometimes by as much as one-half. (Orton, Vol. 9, p. 1994 l. 25 to p. 2007 l. 30, and Vol. 16, p. 3517 l. 29 to p. 3524 l. 14; P.T. Ex. 76 and 77; compare to P.T. Ex. 33, p. 119)

4. Statistics Canada reported that in the Province of Quebec 9,042 abortions were performed in 1981. However, Dr. Augustin Roy, Registrar and President of the Corporation Professionelle de Medecins du Quebec (the governing body of physicians in the Province of Quebec), testified that this figure does not, for that year, include some 8,500 additional abortions performed in doctors' offices and private clinics, and over 100 procedures performed weekly in community health clinics and women's health centres by government-salaried physicians. (Roy, Vol. 3, p. 573 l. 7 to p. 590 l. 20; p. 673 l. 26 to p. 676 l. 14)

5. The empirical evidence demonstrated that abortion is a common and accepted procedure in today's society. It was also shown that the decision to have an abortion is regarded by women as a personal, private decision to be made in consultation with her physician. Women desiring abortions were described as desperate, frightened and threatened. Many witnesses emphasized the importance of allowing women to make their own decision

*"P.T. Ex." refers to Exhibit numbers of the pre-trial motion, and "T. Ex." refers to exhibits at the trial.

whether to terminate their pregnancy, and that it is regarded as an urgent and very personal decision by all women confronted with an unplanned and unwanted pregnancy. The importance of counselling was also emphasized. The Canadian Association of Social Workers stated that abortion should be a decision made by a woman and her doctor as "self-determination" is a fundamental social work principle. (Christianson, Vol. 15 p. 3347 l. 1 to p. 3363 l. 6; Tripp, Vol. 15 p. 3311 l. 8 to l. 30; Roy, Vol. 16, pp. 3452 l. 31 to p. 3462 l. 31; Buckham, Vol. 15, p. 3197 l. 3 to p. 3198 l. 5; Sacks, Vol. 10, p. 2252 l. 7 to p. 2267 l. 22; T. Ex. 20; Watters, Vol. 16, p. 3547 l. 1 to p. 3549 l. 30; Orton, Vol. 16, p. 3513 l. 20 to p. 3517 l. 25; P.T. Ex. 78; T. Ex. 56)

6. The abortion decision was also described as a fundamental moral and religious issue which, according to several major religions, is to be made by the individual woman following counselling. (Hutchinson, Vol. 11, p. 2474 to p. 2593; P.T. Ex. 96) The fundamental personal importance of the abortion decision to women is most pointedly demonstrated by the psychological effects women suffer when delayed in having the abortion or are uncertain whether they will have it, and the lifetime effects on women who are forced to bear unwanted children and the effects on the children themselves. (See below at paras. 17-21, 31-35, 68-70) See also personal accounts of women in the Badgley Report at pp. 177-200 (P.T. Ex. 64; T. Ex. 59).

(II) THE ABORTION PROCEDURE

(a) Types of Procedures and Safety

7. Dr. Philip Stubblefield, an Associate Professor of Obstetrics and Gynaecology at Harvard Medical School, and expert in abortion safety and procedures who has published over 40 articles on the subject, gave evidence of the various methods of performing abortions. (Stubblefield, Vol. 2, p. 301, l. 24 to p. 319, l. 4; p. 367 l. 10 to l. 14; P.T. Ex. 11, 13) Dr.

David Grimes, a physician at the Atlanta Centres for Disease Control (an agency of the United States Government) and author of numerous papers on abortion safety, gave similar evidence at the trial of the methods of performing abortions. Dr. Grimes's findings were adopted by the United States Supreme Court in City of Akron v. Akron Centre for Reproductive Health Inc. et al. (1983), 103 S.Ct. 2481. (Grimes, Vol. 15, p. 3222 l. 10 to p. 3263 l. 7; T. Ex. 52)

8. The method of performing abortions depends on the "trimester" of pregnancy. During the first trimester (the first 12 weeks after the last menstrual period) a procedure, known as "D & C" (for dilatation and curretage), is used. It is a form of minor surgery which takes approximately 5 minutes and is usually done under local anaesthetic. It is regularly performed in doctors' offices and free-standing clinics in the United States and many physicians use some form of the procedure up to 16 weeks. (Stubblefield, Vol. 2, p. 321 l. 7 to p. 327, l. 30)

9. In the first four weeks of the second trimester (13 to 16 weeks), a variation of the curretage procedure known as "D & E", for dilatation and evacuation, can be used. This procedure was developed in the 1970's and began to be used widely in the United States after 1977. Prior to this time it was felt that there was no suitable method for performing abortions during the 13th to 16th weeks and patients at this stage of pregnancy were forced to wait until the seventeenth week when a more complicated, painful and dangerous instillation procedure could be used. D & E procedures are regularly performed in physicians' offices and clinics under local anaesthetic in the United States and at Dr. Morgentaler's clinic in Montreal. The procedure takes between 5 and 15 minutes. (Stubblefield, Vol. 2, p. 329 l. 22 to p. 341 l. 27; Grimes, Vol. 15, p. 3229 l. 25 to p. 3234 l. 17; P.T. Ex. 28, 30 and 44, p. 401; Hodgson, Vol. 17, p. 3624 l. 7 to p. 3626, l. 5; Morgentaler, Vol. 17, p. 3672 l. 7 to l. 32)

10. Following the sixteenth week of gestation, termination of pregnancy may be performed through induced labour caused by the instillation or injection of a saline or prostaglandin solution into the uterus. This procedure is more complicated, dangerous and painful than D & C and D & E. The woman undergoes labour for an average of 35 hours, following which a stillborn fetus is expelled. After delivery of the fetus a D & C or D & E may also be necessary. The possibility of hemorrhaging is substantially increased and the woman must remain in hospital for a number of days. This procedure is done under local anaesthetic in hospitals. (Stubblefield, Vol. 2, p. 339 l. 20 to p. 350 l. 21; Grimes, Vol. 15, p. 3243 l. 12 to p. 3244 l. 30; Christianson, Vol. 15, p. 3353, l. 15 to p. 3354, l. 10; Lamont, Vol. 4, p. 774, l. 9 to page 777, l. 22 and p. 808, l. 5 to p. 809, l. 20)

11. In Pre-trial Exhibit 31, an article published in 1981, Drs. Cates and Grimes stated:

> Legally induced abortion has become one of the most frequently performed - and one of the safest - operations in the United States. Fewer than one woman per 100 suffers a major complication from abortion, and, in the last two years, fewer than two per 100,000 women die from the procedure. The risk of death from abortion is lower than that of other surgical procedures or than continuing the unwanted pregnancy to term. [emphasis added]

Dr. Grimes testified that the risk of mortality for a legal abortion performed by a qualified physican is equivalent to the risk from receiving one shot of penicillin, while the risk of mortality in childbirth is seven times as high (13 to 15 deaths per 100,000). Additionally, abortion has a number of gynaecological health benefits, and women who have received them are better contraceptors afterwards. (Grimes, Vol. 15, p. 3245 l. 6 to p. 3246 l. 30; Tietze, Vol. 2, p. 468 l. 4 to p. 477 l. 30; Sacks, Vol. 10, p. 2265 l. 5 to l. 15; P.T. Ex. 18) There have been no deaths from abortions reported in Canada since 1975. (T. Ex. 51)

(b) Consequences of Delay and Denial

12. Each week of delay in obtaining an abortion causes an increase of 20% to 25% in the complication rate. The increase in the mortality rate is even greater: 30% per week of gestation. D & C is safer than D & E, and D & E is safer than instillation methods. Abortions performed under local anaesthetic are safer than those done under general anaesthetic. If the patient is asleep she cannot alert the physician to incidence of pain and thus complications. (Tietze, Vol. 2, p. 468 l. 4 to p. 477 l. 30; P.T. Ex. 18 (7)(8)(11)) The D & E method used between 13 and 16 weeks is nearly 3 times safer than when used after 16 weeks. There is a substantial increase in risk to a woman's life if abortion is delayed even one or two weeks in the 15th to 20th weeks of gestation. (Stubblefield, Vol. 2, p. 324 l. 11 to p. 348 l. 20; P.T. Ex. 11, 33 and 34) Women who undergo instillation procedures may experience complications such as hemorrhaging and infection.

13. Statistics Canada figures also indicate that delay increases risk. Complication rates increase dramatically with the use of the instillation procedure. (P.T. Ex. 33, p. 105) Canadian statistics on complications show a higher rate than American figures presented by Dr. Tietze. (P.T. Ex. 33,p. 136) Overall, the Canadian complication rate according to Statistics Canada for 1981 was 2.3% and 2.4% in 1982. (P.T. Ex. 33, p. 130; P.T. Ex. 75, p. 17) While Dr. Grimes agreed at trial that the complication rate appears low, he noted that the Canadian definition is very restrictive and doesn't include criteria used in other jurisdictions. Accordingly, one could expect a higher rate in Canada if the criteria were expanded. (Grimes, Vol. 15, p. 3267 l. 25 to p. 3284 l. 20; Sacks, Vol. 16, p. 3420 l. 30 to p. 3424 l. 20; T. Ex. 51 pp. 28-30)

14. Women suffer psychologically as a result of delay. A woman who has made the personal decision to terminate her pregnancy experiences great stress. Women desiring abortions tend to be nervous, frightened and feel threatened. Any delay in obtaining their abortion prolongs and increases the strain. (Christianson, Vol. 15, p. 3347 l. 15 to p. 3349 l. 18; Egan,

Vol. 1, p. 147 l. 11 to p. 153 l. 7; Cohen, Vol. 8, p. 1730 l. 6 to l. 22; Sacks, Vol. 10, p. 2169 l. 10 to p. 2172 l. 25 and p. 2251 l. 10 to p. 2265 l. 15; David, Vol. 5, p. 1065 l. 15 to p. 1069 l. 17; see also paras. 31-35, 68-70 below.) If a woman is delayed until the 16th week and must undergo an instillation procedure the strain is increased. She runs a higher risk of complication and must experience a much more painful and prolonged procedure. Dr. Jane Hodgson, an obstetrician and gynaecologist in practice since 1944 who is the Medical Director of the Women's Health Centre in Duluth, Minnesota, teaches at the University of Minnesota Medical School and has also received numerous prestigious awards and has written widely on the subject of abortion (P.T. Ex. 91), described the saline abortion procedure as an obsolete and cruel method of abortion. She stated regarding Canadian women who travel to her Duluth clinic at Vol. 10, p. 2354:

> May I add one other thing that I think is very vital, and that is that many of these women come down because they know they will be delayed in getting, first, permission, then delayed in getting a hospital bed, or getting into the hospital, and so they know they will have to have saline procedures. And some of them have been through this, and others know what it's about, and they will do almost anything to avoid having a saline procedure.
>
> And of course, that is - I consider that a very cruel type of medical care and will do anything to help them to avoid this type of treatment.
>
> . . .
>
> The cost, the time consumed, the medical risks, the mental anguish - all of this is cruelty, in this day and age, because it's an obsolete procedure that is essentially disappearing in the United States.

15. Dr. Henry David, who has over 200 publications to his credit and has been a consultant to many governments on fertility control, was qualified as an expert in the area of the psychological impact of refused abortion and delay in obtaining an abortion. He has found in his studies that there is increased psychological stress on women desiring abortions but who are forced to wait which is compounded by the uncertainty over whether an abortion will be obtained where committee approval is necessary.

16. In his study of women who desired abortions in Hawaii, Dr. David found that for a significant number of women pregnancy was accidental. Women with stable relationships who wished to marry did so. Others decided to terminate their pregnancy and postpone childbearing to a time when they were older, economically better off and involved in a stable relationship. In a follow-up study he found that the young women who chose abortion were better contraceptors and were successful in avoiding future unwanted pregnancies. Children subsequently born were enhanced by the improved economic, social and educational level of the parents. Any feelings of regret which might have existed were felt to be justified when compared to the severe consequences of forced marriage and compulsory parenthood. (David, Vol. 5, p. 1059 l. 30 to p. 1069 l. 17; p. 1119 l. 7 to p. 1145 l. 24; P.T. Ex. 53-56, 59)

17. Dr. David's Czechoslovakian study of women twice denied abortion matched 'unwanted' children to children of women who did not request abortions and who had similar parental socio-economic status, attended the same schools, had the same number of siblings and were in the same birth order. It revealed that children of mothers denied abortion had poorer school records, and a greater proportion did not finish high school and were more socially maladapted than the children of mothers who did not want abortions. The mothers denied abortions had experienced more difficult relationships and the overall finding was that their children had less satisfactory lives than the others despite identical medical histories and similar scores on intelligence tests. The Czechoslovakian law has since been amended to permit women to terminate pregnancies on request. (David, Vol. 5, p. 1156 l. 24 to p. 1160 l. 16; P.T. Ex. 57 and 58)

18. Dr. Wendell Watters, a Hamilton psychiatrist and author of Compulsory Parenthood: The Truth About Abortion, testified that women denied abortions suffer very negative emotional reactions to their pregnancy and the parenthood which is thrust upon them, while women freely choosing and obtaining abortions suffer no detrimental effects. (Watters, Vol. 6, p. 1259 l. 32 to p. 1264 l. 30 and Vol. 16 p. 3547 l. 1 to p. 3549 l. 10)

(c) Free-Standing Clinics: Safety and Other Advantages

19. Statistical evidence indicated that abortions performed in free-standing clinics are as safe, if not safer, than those performed in hospitals. Dr. Tietze, an expert in demography and epidemiology whose findings (110 articles relating to abortion alone) have been accepted by the U.S. Supreme Court (e.g. Roe v. Wade), testified that the majority of approximately 1.5 million abortions performed annually in the United States are done in free-standing clinics and doctors' offices rather than in hospitals. As of 1981, 90% of the clinics performed abortions up to 12 weeks gestation (all did up to 10 weeks), while approximately 50% of clinics performed abortions up to 14 weeks and 20% accepted patients up to 16 weeks. About 10% of the clinics did procedures up to 20 weeks and a very small number to 24 weeks. (Tietze, Vol. 2, p. 450 l. 16 to p. 467 l. 8; P.T. Ex. 14, 18(3), (4))

20. Both before and after 12 weeks, abortions are more safely performed in clinics than in hospitals. The D & E procedure can be safely done in clinics. (Tietze, Vol. 2, p. 483 l. 15 to p. 485, l. 24; P.T. Ex. 17, 18(13), 28, 31, 44) Dr. Grimes noted that abortions at clinics are performed by physicians with expertise while at hospitals they are performed by less experienced physicians or by residents in training. Other advantages of clinics such as convenience, reduced costs, no delay, and sympathetic surroundings and counselling were noted. Dr. Grimes testified that one cannot argue a substantial case for restricting abortion to hospitals and that the United States Supreme Court agreed with this in the City of Akron decision. (Grimes, Vol. 15, p. 3233 l. 23 to p. 3250 l. 12; see also P.T. Ex. 60, 61) Dr. Stubblefield noted that the treatment of complications resulting from second trimester abortion is much easier today in the United States. Conventional complications, which arise with at least equal frequency in hospitals, can be treated at clinics. (Stubblefield, Vol. 2, p. 359 l. 25 to p. 369 l. 9)

(III) IMPACT AND APPLICATION OF SECTION 251 OF THE CRIMINAL CODE: THE HOSPITAL AND COMMITTEE RESTRICTIONS

(a) The Hospital Requirement: Lack of Facilities, Unequal Availability and Delay

21. The Badgley Report, a federal government report to the Attorney General of Canada in 1977 (P.T. Ex. 64, T. Ex. 59), found that fewer and fewer hospitals were performing most abortions. In 1974, 12.5% of hospitals did over 400 abortions each, accounting for 70% of all legal abortions in Canada. Of 599 eligible hospitals in Canada in 1974, only 48.5% had therapeutic abortion committees and of those with committees 17.4% performed no abortions. Reasons hospitals gave for not setting up therapeutic abortion committees included the refusal of doctors and medical staff to perform the procedure, the hospital's religious affiliation, and a desire to avoid public controversy associated with abortion. (P.T. Ex. 64; T. Ex. 59, pp. 101-127; Egan, Vol. 1 p. 135, l. 25 to p. 158 l. 19)

22. The Report found that 40% of the population was not served by a hospital with a therapeutic abortion committee (see p. 109 of Report). Indeed 58.5% of Canadian hospitals were ineligible to even have therapeutic abortion committees (p. 105). The Report also found at p. 106 that there was "no uniformity across the nation of the standards of medical care relating to the quality of services or the requisite facilities required to undertake the abortion procedure in a general hospital." Indeed, in its opening paragraph at p. 17, the Report stated:

> The procedures set out for the operation of the Abortion law are not working equitably across Canada. In almost every aspect dealing with abortion which was reviewed by the Committee, there was considerable confusion, unclear standards or social inequity involved with the procedure. In addition to the terms of the law a variety of provincial regulations govern the establishment of hospital therapeutic abortion committees and there is a diverse interpretation of the indications for this procedure by hospital boards and the medical profession. These factors have led to: sharp disparities in the distribution and accessibility of therapeutic abortion services; a continuous exodus of Canadian women to the United States to obtain this operation; and delays in women obtaining induced abortions in Canada.

At p. 141 the Committee concluded that "the procedure provided in the Criminal Code for obtaining abortion is in practice illusory for many Canadian women." It also noted at p. 174 that "a substantially higher proportion of single women who had had children were poor." Similarly, "fewer poor women who were single or married had had abortions."

23. Statistics Canada figures confirm that the Badgley Report is still valid today and that the situation requiring women to have abortions in hospitals has deteriorated. In 1981 only 267 of 861 hospitals in Canada had therapeutic abortion committees. More than 20% of those with committees performed no abortions and 15% performed over 400 abortions accounting for 73% of the total of 65,127 abortions. In 1982 the number of hospitals with committees had decreased to 261. (P.T. Ex. 33, p. 21; P.T. Ex. 75, p. 16)

24. Dr. James Murray, Executive Director of the Candian Council on Hospital Accreditation (C.C.H.A.) which, although a voluntary organization, accredits hospitals thereby permitting them to set up therapeutic abortion committees under the Criminal Code, and a Crown witness at trial, testified that the situation described in the Badgley Report continues today. Indeed, he was aware of vast differences in the application of the abortion law across Canada and noted that hospitals often do not buy the most advanced equipment for abortions as they are a low priority for hospitals. Dr. Murray testified that delay in obtaining abortions in hospitals is inevitable because of limited operating room availability. (Murray, Vol. 12, p. 2719 l. 10 to p. 2785 l. 22, esp. pp. 2763-2785)

25. Despite its role under s. 251 of the Criminal Code, the C.C.H.A. does not monitor abortion services in Canada and feels no responsibility to ensure that abortion needs are being met, nor does the C.C.H.A. wish to have this role as a "gatekeeper" of abortion services. (Murray, Vol. 12, p. 2768 l. 26 to p. 2777 l. 25) Similarly, Mr. Malcolm Walker, who testified on behalf of the Ministry and the Minister of Health for Ontario as a Crown witness, demonstrated indifference on the part of the Ministry regarding abortion services. Hospitals are considered to be autononomous institutions

and the Ministry has no policy on abortion or involvement in ensuring that hospitals provide abortions. (Walker, Vol. 13, p. 2847 l. 5 to p. 2869 l. 20)

26. Hospitals are unsuitable facilities for the abortion procedure. Even if the committee requirement were removed, problems of inaccessibility and delay would continue because of the internal politics of hospital administration, bureaucratic delays, economic and social constraints, great demands on hospitals in other areas of health care and the divided opinion of hospital staff on the abortion issue. Hospitals are inflexible institutions that do not adapt well to the sensitive and specialized abortion procedure, nor did they respond effectively to the liberalization of abortion laws in the United States, where clinics were necessary to meet the demand and provide the necessary service. The Badgley Report found an 8 week delay between the first visit of a woman to her doctor and the performance of the abortion (pp. 31 and 146). Dr. Roy noted that delay and denial necessarily results from the hospital restriction because of the limited number of abortions hospitals can perform. (Roy, Vol. 16, p. 3439 l. 15 to p. 3441 l. 11 and p. 3464 l. 28 to p. 3472 l. 20; Sacks, Vol. 10, p. 2282 l. 10 to p. 2291 l. 23; Lamont, Vol. 4, p. 776 l. 20 to p. 777 l. 9; Paquin, Vol. 9, p. 1981 l. 14 to p. 1984 l. 30; Hodgson, Vol. 17, p. 3612 l. 30 to p. 3614 l. 10; Grimes, Vol. 15, p. 3249 l. 25 to p. 3250 l. 11)

27. In contrast, waiting time at clinics is minimal. At private clinics same day treatment is common, and at community clinics the maximum delay is four days. Dr. Roy's studies have found that delays in hospitals vary from one to six weeks, and there is uncertainty about whether the procedure will be performed at all. At clinics women are assured the procedure will be performed and therefore avoid the psychological strain of uncertainty. (Roy, Vol. 3 p. 577 l. 11 to p. 590 l. 8; Venne, Vol. 7, p. 1563 l. 3 to l. 23) Additionally, Dr. Watters emphasized the need for counselling because of the "tremendous" strain women undergo, and noted that it "is very difficult for social workers and other health care professionals to do decent abortion counselling" in the hospital setting. (Watters, Vol.

16, p. 3549 l. 11 to p. 3561 l. 15; P.T. Ex. 47) Janis Tripp testified that women who had abortions in clinics were positive about the way they were treated, while those who went to hospitals provided negative reports regarding the unfriendly and unsympathetic treatment they had received. (Tripp. Vol. 15, p. 3301 l. 24 to p. 3302 l. 12)

(b) The Committee Requirement: "Medically Contra-Indicated"

28. Dr. Wendell Watters gave evidence at the pre-trial that was not subject to cross-examination that there is no reason to justify the existence of the committees required by the Criminal Code. The committee is expected to act as a judge in interpreting a legal rather than a medical requirement. There is no medical diagnosis to be made by the time an application reaches the committee, and the approval requirement only serves to interfere with the doctor-patient relationship. It places the physician in an adversarial position with the committee and prevents the physician from dispensing medical advice is an open and unobstructed manner. In Dr. Watters' opinion the committee requirement is "medically contra-indicated" and results in inferior medical treatment. (Watters, Vol. 6, p. 1257 l. 12 to p. 1277 l. 14)

29. At trial, Dr. Watters emphasized the detrimental effects of committees. "I think it is bad, bad medicine" he stated, and it puts great stress on women. "It is like a lottery. She goes and doesn't know whether she is going to make it or not." Although Dr. Watters described the system at Chedoke-McMaster as a "rubber stamp procedure", he stated that it is "a colossal misuse of physicians' time." Dr. Watters further stated that "I don't think physicians, as I said before, should be the ones to impose their notions of whether a woman should have it or not, because they don't believe in abortion. I think that is immoral." (Watters, Vol. 16, p. 3559 l. 1 to p. 3562 l. 25) See also evidence of Dr. Stubblefield, (Vol. 2, p. 351 l. 4 to l. 12), Dr. Lamont (Vol. 4, p. 797 l. 25 to p. 802 l. 12), Dr. Roy (Vol.

3, p. 604 l. 28 to p. 609 l. 25), Dr. Carr (Vol. 6, p. 1295 l. 17 to p. 1296 l. 7), Dr. Sacks (Vol. 16, p. 3402 l. 5 to l. 25), and Dr. Hodgson (Vol. 17, p. 3612 l. 30 to p. 3614 l. 10).

30. Women experience stress because of uncertainty and delay associated with the committee requirement. (David, Vol. 5, p. 1065 l. 13 to p. 1069 l. 17) Counsellors who assist women in obtaining abortions complained of the detrimental effects of the committee requirement. (Egan, Vol. 1, p. 147 l. 22 to p. 153 l. 7; Christianson, Vol. 15, p. 3347 l. 15 to p. 3351, l. 8) Women are concerned about the increased dangers associated with delay, and they fear they may be compelled to leave the province or the country to get an abortion. Psychological stress is increased for women who are approved by the committee but must then wait until the 16th week to undergo a saline abortion. (Lamont, Vol. 4, p. 767 l. 15 to p. 809, l. 20; Egan, Vol. 1, p. 147 l. 22 to p. 153, l. 7; Tripp, Vol. 15, p. 3318 l. 25 to p. 3319 l. 4; Sacks, Vol. 10, p. 2169 l. 10 to l. 25 and p. 2251, l. 10 to p. 2265 l. 15; Sacks, Vol. 17, p. 3394 l. 11 to p. 3399 l. 25)

31. At trial, Dr. Roy drew a parallel between the therapeutic abortion committee and sterilization committees which existed in hospitals many years ago to approve tubal ligations, and noted that many physicians prescribed contraceptives contrary to the Criminal Code prior to the 1968-69 amendments. He noted that no other medical procedure requires committee approval. (Vol. 16, p. 3468 l. 24 to p. 3474 l. 5) Dr. Hodgson testified that the presence of a committee interferes with the physician-patient relationship. She described the committee's role as "bizarre", and noted that "in other medical situations, the physician determines whether or not the woman is a candidate for hospitalization, whether it is advisable or not. I don't know why this procedure should be any different." (Hodgson, Vol. 17, p. 3612 l. 30 to p. 3614 l. 10. See also: Sacks, Vol. 10, p. 2251 l. 10 to p. 2265 l. 15; Vol. 16, p. 3397 l. 25 to p. 3424 l. 20; Hutchinson, Vol. 11, p. 2516 l. 22 to p. 2517 l. 32 and p. 2557 l. 7 to p. 2558 l. 27.)

32. Rosemary Christianson, a social worker at Chedoke-McMaster Hospital who counsels women desiring abortions, stated that women are upset because they don't know who is on the committee, what the committee's criteria are and because the decision is not theirs' to make. Women forced to go through the committee system feel humiliated, frightened and anxious. The committee system facilitates humiliation, denies equal access and punishes women by forcing them to have abortions in painful ways or by forcing them to bear unwanted children. (Christianson, Vol. 15 p. 3347, l. 15 to p. 3363 l. 6) Maureen Orton, who teaches social work at McMaster University, testified that the committee system, in depriving women of the decision to terminate their pregnancy, interferes with the "principle of self-determination" which is essential to effective counselling and a basic social work principle, and is contrary to the Canadian Association of Social Workers' position that the abortion decision should be made by a woman and her doctor, and should not be subject to committee approval. (Orton, Vol. 16, p. 3508 l. 30 to p. 3517 l. 27; T.Ex. 56; P.T. Ex. 78)

33. The uncontradicted evidence from the Badgley Report and viva voce testimony was that the hospital and committee requirements cause considerable delay. The Badgley Report found an average delay of eight weeks between the time a woman consults her physician and the time she obtains an abortion. (P.T. Ex. 64, T. Ex. 59 at p. 31, 41, and 146 et seq.) A delay of one to six weeks exists in hospitals in Quebec (but not in clinics) and there is uncertainty whether the procedure will be performed at all. (Roy, Vol. 3, p. 603 l. 5 to p. 609 l. 24; Venne, Vol. 7, p. 1563 l. 20 to l. 22; Christianson, Vol. 6, p. 1358 l. 32 to p. 1373, l. 9) Drs. Cohen and Sacks stated that delays of one to three weeks were normal for their teenage patients in Toronto. (See below, paras. 56-59) Janis Tripp testified that the delay in Toronto is 2 to 3 weeks, assuming one can get a hospital to take the patient. (Vol. 15, p. 3300 l. 5 to p. 3301 l. 25) (See below, para. 46) There was agreement that delay, and sometimes denial, was a

direct result of the hospital and committee requirements and was not attributable to delay in contacting a physician. (Sacks, Vol. 11, p. 2282 l. 10 to p. 2291 l. 23; Lamont, Vol. 4, p. 776 l. 10 to p. 777 l. 9; Vol. 3, p. 577 l. 11 to p. 590 l. 8; Murray, Vol. 12, p. 2779 l. 1 to 2784 l. 16)

34. The Badgley Report found that because of the vagueness of the term "health" in section 251(4)(c) of the Criminal Code each physician, each hospital and even different committees in the same hospital reach different decisions on whether continuation of a pregnancy would or would be likely to endanger the life or health of the woman. Two out of five hospitals would only consider applications from residents within their service catchment areas, and many hospitals had quotas on the number of procedures they would permit and limits on the number of gestational weeks during which the procedures would be performed. Some hospitals apply the World Health Organization definition of "health", which is "a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity." Others require proof of danger to life while still other hospitals apply definitions between the two extremes. Some hospitals require psychiatric assessments and compulsory counselling while others will not grant approval to married women. The Badgley Report concluded that the manner in which the concept of health is interpreted, and the criteria used by committees across Canada were so variable as to be inequitable in their application, and caused considerable inequality in the distribution and accessibility of abortion in Canada. (P.T. Ex. 64, T. Ex. 59, at pp. 20, 21, 29-30, 251-56, 267-279)

35. Dr. Watters and Dr. Roy confirmed that "health" in s. 251(4)(c) of the Criminal Code is so vague and broad that committees are free to apply their own criteria in considering applications. Committees do not publish their criteria and often acceptance or rejection can depend on who is sitting on the committee on a given day. Dr. Roy testified that the committees are all different and each hospital has different rules. Standards applied by committees are capricious and not based on medical grounds. The test in section 251 of the Criminal Code is foreign to the

practice of medicine, and violates the doctor-patient relationship, as it is impossible to determine with any certainty in the majority of circumstances whether continuation of pregnancy would or would be likely to endanger health. (Watters, Vol. 6, p. 1269 l. 19 to p. 1277 l. 13; Roy, Vol. 3, p. 603 l. 5 to p. 609 l. 24; p. 663, l. 25 to p. 664 l. 13; and Vol. 16, p. 3467 l. 25 to p. 3468 l. 18; Lamont, Vol. 4, p. 799 l. 14 to p. 807 l. 23; Carr, Vol. 6, p. 1295 l. 10 to p. 1301 l. 21 and p. 1341 l. 20 to p. 1351 l. 21; Stubblefield, Vol. 2, p. 352 l. 23 to p. 359 l. 5; Hodgson, Vol. 10, p. 2371 l. 23 to p. 2372 l. 20)

36. Dr. Watters stated at trial that committees' decisions are usually based on a doctor's letter and that as a "medical committee" it "violates all the principles of medicine... if it is a judicial committee, I don't think the public realizes doctors are not lawyers, they don't know beans about law, if it is a legal committee the woman would have legal rights to redress the situation. It is a committee in a social no-man's land as far as I'm concerned and I think people can play all kinds of games with it and do." Dr. Watters further described the system as a "lottery." Some committees give "rubber stamp" approval, others do not. Some accept the World Health Organization ("W.H.O.") definition of health and others do not. A woman may or may not meet the criteria of a hospital in her community. (Watters, Vol. 16, p. 3565 l. 11 to p. 3568, l. 26)

37. Members of therapeutic abortion committees need have no experience with abortion procedures. A committee can have any number of members (not less than three) and a majority of members sitting at any time can approve an abortion. There are no requirements as to how often or seldom a committee must meet. Documents may be sent to each member or decisions made over the telephone. (Carr, Vol. 6, p. 1295 l. 10 to p. 1301 l. 21) Some committees limit the number of applications and approve all while, as the Badgley Report found, some committees approve no abortions. The C.C.H.A. does not set standards for therapeutic abortion committees to follow even though it is aware that committee standards vary widely across Canada. It

requires that committees have the prior recommendation of 2 or 3 doctors before approving an abortion (this additional requirement is not contained in the Criminal Code). (Murray, Vol. 12, p. 2737 l. 8 to p. 2768 l. 25)

(c) High Incidence of Second Trimester Instillation Abortions

38. There is evidence that because of the delay caused by the hospital and committee requirements, as well as other problems associated with hospitals (e.g., Lamont, Vol. 4, p. 810 l. 5 to l. 25), many women are required to undergo the more traumatic and dangerous saline instillation procedure. (Roy, Vol. 3, p. 581 l. 7 to p. 592 l. 4; Egan, Vol. 1, p. 161 l. 26 to p. 187 l. 6; Lamont, Vol. 4, p. 767 l. 15 to p. 916 l. 28, Carr, Vol. 6, p. 1297 l. 15 to l. 27; Christianson, Vol. 6, p. 1359 l. 20 to p. 1387 l. 29)

39. Witnesses agreed that the saline procedure is cruel and contrary to principles of good medical practice when a substantially safer and less painful procedure is available at an earlier gestational age (which procedure is not carried out due to delays and other obstacles inherent in the hospital and committee requirements). (Sacks, Vol. 10, p. 2251 l. 25 to p. 2253 l. 9; Pacquin, Vol. 9, p. 1968 l. 21 to p. 1970 l. 14; Stubblefield, Vol. 2, p. 338 l. 20 to p. 350 l. 21; Hodgson, Vol. 10 p. 2354) When second trimester patients are told that they will have to wait until the 16th week to have a saline procedure, they are horrified and shocked to learn that they must deliver a stillborn fetus in their hospital room rather than an operating room. (Christianson, Vol. 6, p. 1387 l. 12 to l. 17)

40. In Hamilton in 1982 the Chedoke-McMaster Hospital performed 47.8% of all second trimester abortions by saline instillation, while at Hamilton Civic Hospital 63% of second trimester procedures were done by urea instillation. At London Victoria Hospital 72.3% of all second trimester procedures were by urea instillation. In Metropolitan Toronto in 1982, 87.5% of second trimester abortions were by saline instillation at Toronto

General and at Toronto Northwestern the number was 48.3%. Overall, statistics for Ontario in 1982 record that 57.8% of all second trimester abortions are done by some form of dilatation and suction while at least 33.4% are done by instillation. (P.T. Ex. 122)

41. When compared to the United States, Canada has an unduly high number of second trimester and instillation abortions. Dr. Tietze's studies for the Population Council revealed that in 1980 15% of abortions in Canada were second trimester while the proportion was 10% in the United States. The percentage of procedures performed after 16 weeks was 3.6% in Canada and only 2.7% in the United States. (Tietze, Vol. 2, p. 500 l. 16 to p. 501 l. 20; P.T. Ex. 16, pp. 68-9; P.T. Ex. 75, p. 17)

(d) Availability of Abortion: Some Specific Examples

42. Mrs. Carolyn Egan, administrative co-ordinator of the Birth Control and Veneral Disease Centre since 1978 and a former President of the Board of Directors of the Y.W.C.A. of Metropolitan Toronto, described the difficulties she has encountered assisting women in obtaining abortions in Toronto. The Centre receives patients directly and by referral from physicians who have been unsuccessful in referring patients to a hospital for an abortion. Many women have attempted themselves without success to obtain a therapeutic abortion. Many of the hospitals have unwritten rules regarding abortion. Toronto General will only book 6 abortions per day. On Monday the hospital accepts patients from outside Toronto, while Tuesday to Friday are reserved for women from Toronto. Mrs. Egan has often spent one-half hour constantly dialing the Hospital and, when finally getting through, found the daily quota filled. Toronto Western Hospital has a quota of 20 per week, which is booked on Monday afternoon each week. Mount Sinai has a weekly quota of 12, and Women's College Hospital does only 3 and will only accept appointments from W.C.H. physicians. Many Toronto hospitals only accept appointments from women in the geographical area they serve. However, many women Mrs. Egan helps are from Northern Ontario where abortion is unavailable. (Egan, Vol. 1, p. 130 l. 25 to p. 162 l. 6)

43. The delay associated with getting into the system (i.e. obtaining an appointment for an abortion) and the subsequent delay caused by committee approval, increases risks to women. Many patients who come to the Centre in their tenth week of pregnancy, when it is still possible to perform a D & C procedure, must wait until the 16th week to undergo a saline abortion because they are unable to get approval before the 13th week (if they in fact get into the system to get approval) and some hospitals will not perform the D & E procedure. Many women choose to leave the province to get an abortion rather than wait or hope for the more dangerous and traumatic saline procedure. In addition, many Toronto hospitals no longer perform second trimester abortions and women denied access must go to Buffalo, New York or Quebec for the procedure. Mrs. Egan said that many women who come to the Centre at 9 weeks gestation are forced to leave the province to obtain the procedure. (Egan, Vol. 1, p. 161 l. 26 to p. 187 l. 6; see also Tripp's evidence at trial)

44. Abortion procedures at Chedoke-McMaster Hospital in Hamilton are classified as elective surgery and physicians must schedule abortions in the operating room time allocated to them. For a period of 4 to 5 weeks each summer no abortions are done except in an emergency. Ms. Rosemary Christianson, a social worker who co-ordinates appointments and counsels women with unwanted pregnancies at Chedoke-McMaster, has had to turn patients away many times because no operating room space was available. Women who come to Chedoke-McMaster must go through counselling and assessment before the procedure is approved. An initial assessment occurs within a day or two and the patient is then required to return two or three weeks later to see a physician after which the appointment for the abortion is made. (Christianson, Vol. 6, p. 1357 l. 10 to p. 1378 l. 17; Lamont, Vol. 4, p. 770 l. 14 to p. 772 l. 5)

45. Chedoke-McMaster receive calls from women throughout Ontario, many of whom have been rejected because their hospital does not perform second trimester abortions, the patient is married, or the arbitrary quota is

filled. A number of women come from Sudbury where access to abortion is restricted. At one point 80% of abortion patients at Chedoke-McMaster were from outside Hamilton; however the hospital no longer accepts first trimester patients from outside the region and only one of two doctors performing second trimester abortions will see patients from outside Hamilton. (Christianson, Vol. 6, p. 1373 l. 15 to Vol. 7, p. 1399 l. 15; Lamont, Vol. 4, p. 826 l. 7 to l. 32)

46. Abortions at Chedoke-McMaster, which is one of the most advanced hospitals in Canada, are performed under general anaesthetic, leading to a greater number of complications than if local anaesthetic were used. The hospital requires general anaesthetic which can only be used in the operating room. The suction equipment used at the hospital is inferior to that used in free-standing clinics in the United States and Quebec. D & E procedures are not performed between 13 and 16 weeks and patients who have not received committee approval prior to the 13th week must wait until the 17th week to undergo a much more dangerous instillation procedure. In 1982, 17% of all pregnancy terminations at Chedoke-McMaster were by saline instillation, and 58% of these were on patients from outside the greater Hamilton area. When patients learn of the saline procedure they are horrified, but are sufficiently desperate for an abortion that they agree to the procedure. (Lamont, Vol. 4, p. 767 l. 15 to p. 916 l. 28; Carr, Vol. 6, p. 1297 l. 15 to l. 27; Christianson, Vol. 6, p. 1359 l. 20 to p. 1387 l. 29).

47. Dr. Hughes Chasse, a physician practicing at the Hull community health clinic, testified that the demand for abortion procedures in Hull exceeds availability. He performs eight to ten abortions per week under local anaesthetic up to 12 weeks gestation at the Women's Health Centre in Hull. The Centre is the only facility in Hull that performs abortions. Only one other doctor does the procedures at the Centre, who is a physician at Ottawa General Hospital. Access to abortions in Ottawa is limited. Monfort Hospital, the Children's Hospital and Ottawa General do not perform abortions. Queensway Cariton Hospital has two physicians who do abortions

up to 10 weeks, and Ottawa Civic has three, one of whom does procedures over 12 weeks and is the only doctor in Ottawa to do so. Ottawa's Riverside Hospital has 2 doctors who do abortions up to 12 weeks. Accordingly, Dr. Chasse performs abortions on women from Hull, Ottawa and the surrounding area. If women are more than seven weeks pregnant the delay associated with therapeutic abortion committee approval puts them over the 10 week limit at Queensway Carlton Hospital, the only Ottawa facility that accepts Quebec patients - although Riverside will do abortions on women from Quebec but the $600 fee effectively prevents this. Women who cannot be accommodated at the Hull clinic are referred to clinics in Montreal. (Chasse, Vol. 9, p. 1952 l. 9 to p. 1966 l. 19).

(e) Women Forced to Leave Their Community of Residence for the Abortion Procedure

48. The uncontradicted evidence was that many women are forced to leave their community of residence and travel long distances to obtain an abortion as a direct result of unavailability and undue delay due to the hospital and committee requirements. Women come to Toronto for the abortion procedure from areas of the province where access is restricted or non-existent. So many patients come to Chedoke-McMaster from outside Hamilton that it has became necessary to restrict first trimester abortions to Hamilton residents. Patients are forced to go to the United States or Quebec because of unavailability and delays associated with the hospital and committee requirements. The situation is deteriorating in Toronto as fewer hospitals do second trimester abortions, and those that do impose an arbitrary quota system. (Egan, Vol. 1. p. 135 l. 25 to p. 158 l. 19 and p. 184 l. 25 to p. 197 l. 6; Sacks, Vol. 10, p. 2251 l. 10 to p. 2266 l. 15; Christianson, Vol. 15, p. 3345 l. 7 to p. 3356 l. 22; Chasse, Vol. 9, p. 1958 l. 25 to p. 1959 l. 26).

49. Statistics Canada reported 1,644 abortions on Canadian residents occurred in the U.S. in 1980, and 2,651 in 1981. (P.T. Ex. 33, p. 119) Dr. Tietze's 1980 figure was much higher, at 3,970. (P.T. Ex. 16, p. 26) For

1982, Statistics Canada reported 3,156 abortions on Canadian women in the United States. (T. Ex. 51, p. 54) Mrs. Maureen Orton's investigations into Canadian adolescents travelling to the United States for abortions revealed that a number of states, including large ones such as Michigan, do not report to Statistics Canada. She found that Statistics Canada figures of Canadian women having abortions in the United States were lower than her projections, sometimes by as much as one-half. Mrs. Orton also found a substantial increase in the number of abortions obtained by Ontario women at the Morgentaler Clinic in Montreal between 1981 and 1983. In 1981, 192 Ontario women attended the Clinic, but in the first 6 months of 1983 alone, 388 women from Ontario attended for an abortion. (Orton, Vol. 9, p. 1990 l. 17 to p. 2014 l. 14; P.T. Ex. 76 and 77).

50. The Badgley Report found a correlation between the number of women who travelled to another province or to the United States for an abortion and the availability of abortion facilities in the province. It noted that Ontario had the best access to abortion, but 34.8% of the population was still not served by a hospital with a therapeutic abortion committee. (P.T. Ex. 6c; T. Ex. 59, pp. 75-80 and p. 109) Pre-Trial Exhibit 15, "Abortion Services in the United States, 1979-1980" noted at p. 19 that higher numbers of abortions were noted in the border states, "partly because of restrictive abortion policies in Canada."

51. Marilynn Buckham, an administrator and counsellor at abortion facilities in Buffalo for 11 years, testified that at the Erie Medical Centre, a large out-patient abortion clinic, 8 - 10% of the 4,500 abortions performed there each year are on Canadian women. At the Buffalo G.Y.N. Clinic approximately 30% of the 30 abortions per week are on Canadian women. Women come to Buffalo from all over Ontario, including North Bay and Sudbury (at trial she added that patients come from Timmins and Newfoundland), where abortion is not available or access is restricted by a quota system. Dr. Jane Hodgson's Women's Health Centre in Duluth, Minnesota has seen an increasing number of Canadian women from towns in northern Ontario and Manitoba since its founding in 1981. Women come from such places as

Winnipeg, Thunder Bay, Wawa, Atikokan, Kenora, Chapleau and Fort Frances (by the time of trial she stated that women had come from as far away as Alberta). Many were referred to the Clinic by physicians; others travelled there on their own initiative. Women go to Buffalo and Duluth because of uncertainty and delay associated with the hospital and committee requirements and the concern that they would be required to wait and undergo a saline procedure. Others travel to the United States because of the arbitrary requirement that women seeking an abortion must undergo psychiatric counselling. (Buckham, Vol. 1, p. 218 l. 32 to p. 230 l. 27 and Vol. 2, p. 412 l. 13 to p. 421 l. 18; Hodgson, Vol. 10, p. 2338 l. 26 to p. 2354 l. 28; P.T. Ex. 85 and 91).

52. At the trial, Janis Tripp, Rosemary Christianson, Marilynn Buckham, Maureen Orton and Doctors Chasse, Sacks, Hodgson and Morgentaler all gave evidence of women being forced to leave their communities as a result of the restrictive abortion law, and this evidence is relied upon by the Appellants.

(f) Abortion and Teenagers

53. An inordinately high number of teenagers are susceptible to riskier second trimester abortion procedures. Statistics Canada figures for 1981 indicated that 19% of legal abortions on teenagers were done after 12 weeks. In contrast, for women aged 25 to 29 the figure was 9.9%. The World Population Council figures for 1980 also suggest that Canadian teenagers subject to the hospital and committee requirements have later abortions than their American counterparts. (P.T. Ex. 33, p. 133; P.T. Ex. 16, pp. 68-69; P.T. Ex. 29, 88)

54. Doctors Sheila Cohen and Diane Sacks have both worked at the Adolescent Medical Clinic (the "Teen Clinic") at the Hospital for Sick Children in Toronto, which provides counselling to pregnant teenagers and assists young women in obtaining an abortion if they choose to have one.

The Clinic sees children from all socio-economic levels and from areas throughout Ontario. Drs. Sacks and Cohen noted that teenagers are notoriously late in taking steps to obtain an abortion. Irregular periods, ignorance of the symptoms of pregnancy, embarrassment, ambivalence and psychological denial point to a high incidence of second trimester procedures in this age group. Delay in obtaining a procedure is increased by the hospital and committee restrictions. Teenagers are afraid of big institutions such as hospitals. (Cohen, Vol. 8, p. 1713 l. 11 to p. 1737 l. 25; Sacks, Vol. 10, p. 2161 l. 8 to p. 2174 l. 6; Tietze, Vol. 2, p. 500 l. 16 to p. 501 l. 20; P.T. Ex. 29, 88)

55. The Hospital for Sick Children does not have a therapeutic abortion committee, so the 2 physicians at the Clinic who perform abortions must do them at Toronto General and Toronto Western Hospitals where they have admitting privileges. Hospital policies and physical restrictions have led to an arbitrary quota of 4 abortions per week for each of the two physicians. As a result many patients must wait more than the minimum of 2 weeks and are delayed into the second trimester. Only Toronto General does second trimester procedures and these are saline procedures done after 16 weeks and the teenagers must compete with all other women in Toronto to obtain one in the quota system. Teenagers faced with a second trimester procedure are advised to leave the province or the country to obtain an abortion more quickly, and therefore more safely, because it is extremely difficult to find alternative facilities in Toronto. (Sacks, Vol. 10, p. 2165 l. 4 to p. 2174 l. 6 and p. 2280 to p. 2282; Cohen, Vol. 8, p. 1716 l. 25 to p. 1722 l. 9; Egan, Vol. 1, p. 161 l. 26 to p. 187 l. 6)

56. When teenagers decide to terminate their pregnancy they feel an acute need to have the procedure performed immediately. However, when told of the delay and uncertainty involved, Dr. Sacks has seen patients become angry, hostile, anxious, depressed, and even suicidal. Patients are advised to leave Ontario to have the procedure done quickly to avoid the detrimental psychological and physical consequences of delay. Parents of teenagers also become hostile, confused and sometimes desperate when told of the delay

because of the committee requirement. They cannot understand why their adolescent daughters, who normally receive medical treatment as quickly as possible, must wait and be subjected to committee approval for this procedure. (Sacks, Vol. 10, p. 2251 l. 10 to p. 2265 l. 15; Cohen, Vol. 8, p. 1730, l. 6 to l. 22; see also Sacks' evidence at trial)

10

(g) Availability of Abortion in Quebec: Non-Application of the Criminal Code

57. After Dr. Henry Morgentaler was acquitted for the third time on charges of violating s. 251 of the Criminal Code in 1976, the Quebec government ceased prosecuting doctors who performed abortions. The Quebec Minister of Justice suggested to his federal counterpart that the Criminal Code be amended so that only abortions by persons who are not physicians be prosecuted. Since 1976 abortions in Quebec have been performed in doctors' offices, private clinics, government-funded community health clinics (C.L.S.C.'s) and women's health centres. The procedures are covered by Quebec Health Insurance, or performed by government-salaried physicians. These facilities are neither accredited nor approved hospitals within the meaning of s. 251 and do not have therapeutic abortion committees. They meet a demand for abortion services not met by hospitals and provide more suitable surroundings than hospitals in which to perform abortions. The clinics are safer than hospitals, have fewer complications, and their procedures have caused hospitals to improve their techniques. Delays in obtaining abortions, and the number of second trimester abortions performed, have decreased dramatically. (Roy, Vol. 3, p. 570, l. 30 to p. 717 l. 10; P.T. Ex. 34, 35, 73 and 97)

58. Dr. Jeanne St.-Amour, a physician at the Community Health Centre in Laval, testified that her C.L.S.C. performs an average of 8 abortions per week under local anaesthetic up to 12 weeks gestation. The clinic has done over 325 abortions without any major complications. Each patient meets with a counsellor who ensures that the decision is final and free of coercion, and is given routine blood and pap tests the day before the abortion. If

anything unusual is discovered the patient is referred to a hospital. The community clinics have established emergency procedures and comply with the requirements of the American National Abortion Federation. (P.T. Ex. 5) The clinics are regularly inspected, and it is the intention of the Quebec government to increase the number of clinics. (St-Amour, Vol. 8, p. 1853 l. 23 to Vol. 9 p. 1908 l. 11; Paquin, Vol. 9, p. 1966 l. 29 to p. 1979; Venne, Vol. 7, p. 1500 l. 11 to p. 1541 l. 10)

(IV) THE ABORTION DECISION AND FREEDOM OF CONSCIENCE AND RELIGION

59. Dr. Roger Hutchinson was qualified as an expert in the theological basis of abortion. He obtained a Doctorate in Christian Ethics from the University of Toronto in 1975 and teaches at Victoria College in the same University. One of his courses is called Contemporary Problems in Religious Ethics, which considers the positions of major religious denominations in Canada on abortion and the abortion law. (Vol. 11, p. 2474 l. 8 to p. 2479 l. 140 P.T. Ex. 96)

60. Dr. Hutchinson testified that the concept of religion does not necessarily involve a deity but involves a dimension of a person's life that relates to ultimate beliefs and their practice. Similarly, the notion of conscience involves making decisions through discourse with others free of coercion. Dr. Hutchinson noted that all the major religions in Canada - which he described as Presbyterian, Lutheran, United, Roman Catholic, Anglican and Jewish - regard abortion as a deeply religious and moral issue and there is no unanimity on the issue within the religions themselves. Abortion as a religious issue centres on the moral issues of whether one emphasizes the importance of the pregnant woman or of foetal life. Section 251 of the Criminal Code, unlike other provisions such as those dealing with murder, is permissive and treats abortion as an issue over which persons may disagree. (Hutchinson, Vol. 11, p. 2477 l. 11 to p. 2557 l. 19)

61. The Roman Catholic religion takes a foetus-centred position that life begins at conception, and restricts abortion to the most extreme circumstances. The Presbyterian Church permits pregnancy termination if the physical or mental health of the women is threatened, after committee approval. The Christian Reform Church stresses both the rights of the foetus and the role of individual conscience. Because the Bible is not clear on abortion, the termination of pregnancy in good conscience should not be condemned. (Vol. 11 p. 2524 l. 14 to p. 2593 l. 22)

62. Reform Judaism takes the view that human life begins at birth. This is a women-centred religion. The woman has an obligation to consider the impact of the birth of a child on her responsibilities to existing children and to her husband. The right to be born is relative to the absolute right to life of existing persons. There is an obligation to seek advice and the decision to terminate the pregnancy must be based on the religiously-informed conscience of the woman. The Anglican Church's position is that the abortion decision is a matter of informed conscience for the woman to make in consultation with her religious advisor and physician. The placing of the decision-making power in the hands of a committee, therefore, violates her freedom of religion because she cannot exercise her religious conscience. The decision is no longer hers, and her right to act as a moral agent is lost. (Vol. 11, p. 2483 l. 23 to p. 2558 l. 27)

63. The United Church places even greater emphasis on the role of the pregnant woman as a responsible moral agent exercising an informed conscience in consultation with her religious advisor and physician. It emphasizes the role of counselling and the notion that an essential aspect of being a responsible, human moral agent is to act in accordance with one's informed conscience. Accordingly, criminal prohibitions on abortion up to 20 weeks gestation should be removed, although legislation should require that abortions be performed in approved facilities by qualified physicians. (Vol. 11 p. 2496 l. 8 to p. 2588 l. 24)

64. Dr. Hutchinson also testified that section 251 of the Criminal Code violates women's rights to exercise their conscience. Regardless of the decision by the committee, the fact that the decision is taken away from the woman prevents her from exercising her informed conscience as a free moral agent. A counselling requirement would not violate the exercise of conscience so long as the ultimate decision is left to the woman. (Vol. 11 p. 2516 l. 22 to p. 2517 l. 32 and p. 2557 l. 7 to p. 2558 l. 27)

(V) EVIDENCE RELATING TO THE DEFENCE OF NECESSITY

(a) Evidence of an Emergency

65. Uncontradicted evidence was presented at the trial that women faced with unwanted pregnancies are in a state of crisis. Women with unwanted pregnancies were described as desparate, anxious and frightened by their situation: "She needs to feel she can be in control, she has to try and make decisions that will allow her to assume control." (Christianson, Vol. 15, p. 3348 l. 7 to p. 3357 l. 28; Tripp, Vol. 15, p. 3296 l. 27 to p. 3298 l. 1; T.Ex. 54) Marilynn Buckham, of the Buffalo GYN clinic which treats many Canadians, described women with unwanted pregnancies as angry and in danger as a result of delays encountered in Canada, especially after they have made the difficult personal decision to have an abortion. She stated that all of the 60 - 70,000 women she has seen in her job regard abortion as a very personal decision. (Vol. 15, p. 3189 l. 5 to l. 25; p. 3197 l. 3 to l. 13)

66. Dr. Diane Sacks, who treats teenagers with unwanted pregnancies at Toronto's Hospital for Sick Children, testified that girls are desperate to have abortions and sometimes become suicidal. The young women and their parents may become hysterical about the situation and angry about the delays they encounter in trying to obtain the abortion procedure. She stated that her patients, when encountering delay, face the risk of emotional complications beyond merely stress: "This is real, anxiety about

termination, amount of waiting, suicide attempts. This is much more than stress, I am not talking about taking a sleeping pill, you know, to go to sleep." (Vol. 16, p. 3397 l. 25 to l. 28; p. 3402 l. 5 to p. 3404 l. 5; p. 3418 l. 20 to l. 30; p. 3424 l. 1 to l. 20)

67. Dr. Wendell Watters, a psychiatrist at Chedoke-McMaster Hospital, described women desiring abortions as frightened and experiencing stress. He noted that a woman desiring an abortion suffered no negative consequences if she obtained one - indeed her mental state may improve - while women who are denied abortions suffer a quite negative impact on their lives. (Vol. 16, p. 3547 l. 1 to p. 3549 l. 11; p. 3566 l. 25 to p. 3567 l. 8; T. Ex. 58) Dr. Jane Hodgson, Medical Director of the Women's Health Centre in Duluth, Minnesota, described Canadian women who come to her clinic for abortions because of delay or denial experienced in Canada as "humiliated and extremely disturbed, distraught." (Vol. 17, p. 3608, l. 8 to l. 25; T. Ex. 60) Dr. Augustin Roy, Registrar and President of the Corporation Professionelle de Medecins du Quebec, stated that the decision to have an abortion is a very difficult decision for a woman to make. (Vol. 16, p. 3431 l. 12 to l. 27; p. 3452 l. 31 to p. 3454 l. 5) Dr. Morgentaler also testified that he regularly sees desperate women at his clinic in Montreal. (Vol. 17, p. 3640 l. 25 to p. 3641 l. 10) Evidence of the emergency situation of women confronted with unwanted pregnancies may also be found in T. Ex. 33, 34 and 35, and in the Badgley Report (T. Ex. 59) at pp. 178-200.

68. Uncontradicted medical evidence was presented that <u>any</u> delay in obtaining an abortion increases risk to life and health. The earlier an abortion is done, the safer is the procedure and the lower the risk of complications. Dr. David Grimes, an obstetrician and gynaecologist at the Atlanta Centres for Disease Control, testified that the requirement of committee approval causes delay, with the health consequences of "increased risk to the women of complications and increased expense and increased emotional turmoil." Dr. Grimes testified that there are no longer committees approving abortions in the United States as they serve no medical purpose, and that from a public health point of view there is no need to

restrict abortions to hospitals. He described therapeutic abortion as one of the safest medical procedures (seven times safer than childbirth), and also one of the most common operations, performed in the United States. (Vol. 15, p. 3229 l. 1 to p. 3245 l. 30; T. Ex. 52) Dr. Grimes described the various abortion procedures, including the development of D & E in the United States to avoid causing women to wait until the 16th week of pregnancy to undergo a saline induction method. He noted that women do not use abortion as a form of contraception. On the contrary, studies have found that "women who have had an abortion tend to be better users of contraception than women who have not had an abortion." (Vol. 15, p. 3230 l. 5 to p. 3246 l. 30) See also references to evidence of Drs. Grimes, Hodgson and Morgentaler given at trial at paras. 10, 12-14, above, relating to the abortion procedure.

69. The earlier an abortion is performed the safer is the procedure. Dr. Morgentaler stated that each week of delay increases risk of complications by 20% and risk of death by 30%. As a result, many women are forced to travel to obtain an abortion within a reasonable time, or undergo much more dangerous saline abortions. (Vol. 17, p. 3644 l. 25 to p. 3646 l. 24; T. Ex. 50; Roy, Vol. 16, p. 3457 l. 26 to p. 3460 l. 29; p. 3464 l. 28 to p. 3474 l. 28; see also: T. Ex. 59 at pp. 43-80, 299-321; T. Ex. 61) Dr. Hodgson testified that "accessibility of abortion services is necessary for women's health", and described the effects of the Canadian committee system as causing delay, humiliating women, denying the procedure to some, forcing many to undergo the "obsolete" saline procedure, and causing many to travel to Duluth to have a safer procedure. (Vol. 17 p. 3599 l. 10 to l. 13; p. 3603 l. 1 to p. 3609 l. 23) Dr. Sacks described the emotional complications which result from delay and denial (above, para. 69). Dr. James Murray, Associate Executive Director of the Canadian Council on Hospital Accreditation (C.C.H.A.), agreed that delay is not a good medical outcome and that the inequitable effects of the abortion law described in the Badgley Report still exist. (Vol. 12, p. 2779 l. 1 to p. 2784 l. 16; see also Watters, Vol. 16, p. 3550 l. 1 to p. 3558 l. 9; T. Ex. 59)

70. Uncontradicted evidence was presented by defence and Crown witnesses that many women were unable to get abortions within a reasonable time in Ontario and Canada, thereby causing danger to their life and health. The evidence established that women with unwanted pregnancies were delayed in obtaining abortions, or unable to obtain them at all, and this caused many women to leave their province or the country to obtain the procedure in Quebec or the United States. Witnesses testified that access to abortion in Toronto was deteriorating and an increasing number of women were travelling to Montreal to terminate unwanted pregnancies.

71. Ms. Tripp described the telephone 'lottery' system in Toronto, which is the way to get into the quota system. Toronto General Hospital only does 6 CHIP abortions per day (3 first trimester and 3 saline abortions after 16 weeks) and these are booked by phoning the hospital at 10:30 a.m. and dialing continuously until getting through. Usually by the time she gets through to the hospital all the places have been taken that day and Ms. Tripp must try again the following day. Mondays are set aside for women from out of town, so that if you are not from Toronto and don't get an appointment one week, then you must wait a week before even trying again. Similarly, if a women does not get an appointment in time for a first trimester abortion she must wait until the 16th week and try to get an appointment for a saline induced abortion. (Vol. 16, p. 3290 l. 25 to p. 3298 l. 1)

72. Toronto Western Hospital has a quota of about twenty first trimester abortions (up to 14 weeks gestation) per week - although this fluctuates between 15 and 25 - and appointments are made on the same basis as T.G.H. Mount Sinai Hospital does 12 abortions per week and the Wellesley Hospital does 20. Both of these hospitals book appointments in the same way as T.G.H. and Toronto Western. Women's College Hospital does only 3-5 per week and only for women referred by the hospital's doctors, effectively cutting it off from women who seek help from Ms. Tripp at the Birth Control and V.D. Centre. Toronto General is now the only hospital she can send people to for second trimester abortions, if she can get into the

system. Ms. Tripp is therefore forced to refer many women to Buffalo or Dr. Morgentaler's clinic in Montreal where they can obtain first trimester or second trimester D & E procedures within a few days. (Vol. 15, p. 3293 l. 1 to p. 3332 l. 1)

73. Dr. Sacks testified that many of her patients have tried to obtain appointments through the phone 'lottery' system for 2 or 3 weeks without success. Gynaecologists at the Teen Clinic at the Hospital for Sick Children can book 8 abortions per week (4 at T.G.H. and 4 at Toronto Western, as there is no committee at the Hospital for Sick Children), but there is a three week delay in obtaining these. Therefore, she advises patients who are 10 weeks or over to call a private gynaecologist if they can afford it, or to go to the United States or Quebec. Dr. Sacks stated that some girls beg for the money to obtain the procedure, and that the delays in the system cause young women to undergo painful saline abortions late in their second trimester in the United States. The situation has deteriorated and, while most will get the procedure, they'll get it 5 or 6 weeks later than they should. Dr. Sacks testified in cross-examination that "the people with money, the people who know the system can get an abortion and people who have to go to a clinic cannot get an abortion or have difficulty getting an abortion." (Vol. 16, p. 3386 l. 10 to p. 3410 l. 30; p. 3420 l. 25 to l. 30)

74. Constable Robert Kelman introduced Exhibit 9 at the trial, containing materials seized during the police raid on the Toronto clinic. Exhibit 9 contains materials which describe the quota system in Toronto Hospitals and delays in the system. Other material seized from the clinic included appointment books and receipts which indicated a need for the Clinic. (T. Ex. 6, 9, 11, 12, 14 and 18) Other evidence of delays and need in Toronto can be found T. Ex. 50 and 51.

75. Dr. Murray testified that the C.C.H.A. requires 2 or 3 doctors to refer a patient to a therapeutic abortion committee. He admitted that hospitals are limited by operating room space and that committees use a

variety of standards in deciding whether to approve abortions. Despite being one of two gatekeepers to abortion access, the C.C.H.A. does not regulate abortion access and doesn't know how many women get rejected by committees, nor is there any mechanism to determine this. However, Dr. Murray agreed that the Badgley Report is still accurate when it states that many women must leave the country to get an abortion or carry their pregnancies to term, and that this is an "unfortunate outcome of the regulations as we live with them." (Vol. 12, p. 2732 l. 23 to p. 2739 l. 21; p. 2761 l. 5 to p. 2784 l. 16) Dr. Watters also testified that the facts described in the Badgley Report still exist today. (Vol. 16, p. 3550 l. 1 to p. 3558 l. 9; T. Ex. 59)

76. Rosemary Christianson described access to abortion at Chedoke-McMaster Hospital. The hospital only takes referrals from its catchment area in the Hamilton-Niagara region because it was becoming overloaded by women from other areas of the province. Abortion patients are seen at the clinic two-and-a-half days a week. The patient must come to the hospital for three separate appointments prior to the procedure being performed. The women come to the same clinic as women with children and the rooms have literature and posters about pre-natal care. Women who have the abortion under general anaesthetic wake up in recovery rooms with men. Ms. Christianson described women as "very humiliated" by the process and described the difficulty of counselling women in this environment. She testified that women are automatically referred to Buffalo for abortions. (Vol. 15, p. 3346 l. 10 to p. 3360 l. 15)

77. 2-3,000 Canadian women travel to Buffalo for abortions each year, from as far away as northern Ontario. These women come because it is difficult to obtain the procedure in a reasonable time in Toronto and elsewhere or because it is difficult to obtain the procedure at all. Statistics Canada figures on the number of women who have abortions in the United States were incomplete. Maureen Orton described the entire

committee and hospital process as "systematic barriers" to abortion. (Buckham, Vol. 15, p. 3188 l. 13 to p. 3217 l. 15; Orton, Vol. 16, p. 3517 l. 30 to p. 3536 l. 15; T. Ex. 55)

78. Dr. Hughes Chasse, who performs abortions at the Women's Health Centre in Hull, Quebec, testified that 20% of the patients he sees come from Ottawa. This had increased from 1983 when only 10% came from Ottawa. Dr. Chasse described the limited access to abortion in Ottawa, noting that only 3 hospitals do abortions in that city. He stated that his clinic could not meet the demand and many women are sent to Montreal for the procedure. (Vol. 17, p. 3587 l. 30 to p. 3595 l. 10). Dr. Hodgson described the situation at her clinic in Duluth, Minnesota, which is seeing an increasing number of Canadian women who are travelling great distances to her clinic to obtain abortions because they cannot obtain the procedure, or cannot obtain it within reasonable time and will be forced to have a saline abortion in Canada. (Vol. 17, p. 3606 l. 25 to p. 3609 l. 10) Dr. Morgentaler confirmed that many women travel to his Montreal clinic from great distances. 60% of his patients come from outside Montreal because they cannot get an abortion within a reasonable time or have been rejected. He stated that women come from all over the country to see him and that the situation is deteriorating. At the date of trial, the number of women who came from Ontario had increased from 6 to 9 per week. (Vol. 17, p. 3640 l. 25 to p. 3641 l. 7; p. 3645 l. 5 to p. 3660 l. 5; Roy, Vol. 16, p. 3457 l. 26 to p. 3474 l. 28)

(b) Evidence of Involuntariness

79. In a tape of a speech given by Dr. Morgentaler in November, 1982, which contained more than sufficient evidence of the defence of necessity to justify leaving it with the jury, Dr. Morgentaler described women bearing unwanted children, and of women forced to travel great distances for an abortion because of a lack of access to facilities in their community. He

stated that governments don't care and will not change the law. Many Ontario women were coming to his clinic in Montreal, and to his knowledge many more were going to the United States for abortions. Dr. Morgentaler stated that he was opening a clinic in Toronto so that women would not have to travel or suffer undue delay or danger, and therefore that he was coming to protect women's health. He also stated he felt obligated to come to Toronto after Dr. Smoling was unable to set up a clinic in rented premises. (T. Ex. 50) Dr. Morgentaler and Dr. Smoling also had their position regarding the need for a clinic put before the jury in T. Ex. 43.

[See also the passage from Dr. Morgentaler's testimony quoted in paragraph 11(d) of "Evidence to be Referred to in Oral Argument" in which Dr. Morgentaler stated that he felt a "moral obligation" to bring a needed medical service to Ontario in order to diminish suffering. (Vol. 17, p. 3698 l. 21 to p. 3682 l. 15)]

80. Dr. Roy, the elected head of the medical profession in Quebec, described Dr. Morgentaler's earlier battles with the abortion law, noting that abortion is now a "settled matter" in Quebec. He also stated that there is no medical reason for the committees. (Vol. 16, p. 2460 l. 10 to p. 3464 l. 25) Dr. Watters described the system in Ontario as "bad, bad medicine" and the therapeutic abortion committee as medically contra-indicated. Women denied abortion are in effect sentenced to mandatory motherhood. Dr. Watters emphasized that committees are judging a "living, breathing female, human being" and that "to arbitrarily say she can have it for this ground but not for that ground, the grounds don't measure the stress experienced by the woman who is trying to wrestle with this decision." (Vol. 16, p. 3539 l. 5 to p. 3540 l. 1; p. 3560 l. 10 to p. 3561 l. 15; p. 3582 l. 3 to l. 26)

81. Dr. Hodgson described the committee requirement in Canada as "bizarre", noting that a woman may be required "to go through a 20 year commitment period on the basis of these strangers making this decision." She described the situation of women being refused abortions and of being forced to wait for salines or travel out of the country as "intolerable." (Vol. 17, p. 3613 l. 20 to p. 3614 l. 1; p. 3607 l. 12 to p. 3608 l. 25)

Dr. Sacks stated that the medical profession is "not doing the best we can" in the area of abortion. (Vol. 16, p. 3421 l. 15 to p. 3422 l. 8) Mrs. Orton described the committee system in existence in Ontario as a terrible and totally unacceptable way to deliver health care. (Vol. 16, p. 3535 l. 1 to p. 3536 l. 15) Rosemary Christianson testified that in her opinion the committee system "facilitates only the humiliation of women", it "denies equal access to women", and women who don't have access are "punished", in some cases punished by bearing unwanted children. (Vol. 15, p. 3362, l. 20 to p. 3363 l. 5)

(c) No Legal Way Out

82. Dr. Morgentaler testified that he has tried since 1967 to have the law changed through lobbying efforts. (Vol. 17, p. 3640 l. 10 to l. 25; T. Ex. 50, pp. 16-19; T. Ex. 61) Dr. Roy testified that the abortion law is no longer enforced by the Quebec government. He stated that politicians try to evade the issue as, "in general, politicians are gutless." Dr. Roy said that politicians are scared to touch the issue, even though "everybody knows that it should be changed." The Canadian Medical Association has been asking for the removal of therapeutic abortion committees since 1971 because "they serve no purpose", are "very hypocritical" and "very discriminatory." (Roy, Vol. 16, p. 3470 l. 10 to l. 27) Dr. Watters testified that he has lobbied the government to change the law without success. (Vol. 16, p. 3540 l. 1 to p. 3541 l. 5; T. Ex. 57) He also testified that the findings of the Badgley Report were never discussed in Parliament, but the problem was simply handed to the provinces. (Vol. 16, p. 3556 l. 10 to l. 25) Maureen Orton also testified as to her unsuccessful lobbying efforts. (Vol. 16, p. 3510 l. 27 to p. 3512 l. 10)

83. The C.C.H.A. felt no need to monitor, review or attempt to improve access, despite its concern with good medical outcomes and the fact that the C.C.H.A. is one of two gatekeepers to abortion services. Indeed, Dr. Murray testified that the C.C.H.A. doesn't even want the responsibility in s. 251 of the Criminal Code which was thrust upon it by Parliament.

(Vol. 12, p. 2732 l. 4 to p. 2784 l. 16) Similarly, Mr. Walker, from the Ministry of Health (who was totally unfamiliar with government briefs and statistics indicating a need for abortion services), testified that the Ministry has no involvement in ensuring that hospitals provide abortions. He was ignorant of proposals to change the law or of many requests to have a clinic approved by the Minister to provide abortion services. Mr. Walker testified that the Minister will approve institutions operating in compliance with the Criminal Code. (Vol. 13, p. 2847 l. 5 to p. 2869 l. 20) However, in T. Ex. 9, introduced by the Crown, an excerpt from Hansard contains a statement of the then Minister of Justice, the Hon. Mark MacGuigan, indicating that the federal government regards the approval of new facilities as a provincial matter. (T. Ex. 9; see also at Vol. 28, p. 5851)

84. Dr. Morgentaler attempted to open his clinic in Toronto in compliance with the law. In T. Ex. 4, introduced by the Crown, Dr. Morgentaler asked in a letter to the Ontario Minister of Health, the Hon. Larry Grossman, to approve the Toronto clinic within the meaning of s. 251 of the Criminal Code. Dr. Morgentaler suggested that the clinic be a "pilot project for similar clinics to be established across the province just like in Quebec." No response was received from Mr. Grossman, although in T. Ex. 21 Mr. Grossman stated in a letter that he would not approve any new private hospitals. Dr. Morgentaler also appealed to the federal and provincial Attorneys-General, the Hon. Mark MacGuigan and the Hon. Roy McMurtry, to refrain from prosecuting, telling them he was going to set up a clinic with the best techniques available to provide a needed service for Ontario women. He pleaded with the Ministers and invited representatives of the Ministry of Health to inspect the clinic, but got no response. (Vol. 17, p. 3651 l. 26 to p. 3656 l. 23)

85. In addition to the evidence summarized above (paras. 73-85) that hospitals were not meeting the need for abortion services (thereby refuting Mr. Grossman's position), there was testimony from Dr. Grimes, Dr. Roy, Dr. Sacks and Ms. Christianson that hospitals cannot meet the demand because of

institutional limitations and bureaucratic obstacles, and therefore free-standing clinics are necessary. (Grimes, Vol. 15, p. 3247 l. 23 to p. 3248 l. 23; Roy, Vol. 16, p. 3439 l. 13 to p. 3441 l. 11; Sacks, Vol. 16, p. 3410 l. 23 to l. 30; Christianson, Vol. 15, p. 3361 l. 10 to p. 3367 l. 5)

86. Dr. Murray testified that for a hospital to become accredited by the C.C.H.A. (and therefore permitted to perform abortions), it must be open for 12 months, and must have at least 5 physicians on staff to meet the C.C.H.A. requirement of 2 doctors in addition to the 3 required on the committee. Therefore, he agreed that if three doctors wanted to open a hospital to perform abortions they could not get C.C.H.A. approval. (Vol. 12, p. 2754 l. 7 to p. 2756 l. 13)

87. During cross-examination, Dr. Morgentaler testified that his hands were tied and it was necessary to open the clinic. He also maintained that the clinic was for women who could not get into the system, and insisted under cross-examination that his guidelines were followed on this point (at Vol. 17, p. 3670 l. 17 to p. 3674 l. 2 and quoted at length in paragraph 11(g) of "Evidence to be Referred to in Oral Argument"). In Exhibits 8, 33 and 34, many consent forms were introduced by the Crown in which women declared that they were unable to obtain an abortion in an accredited hospital within a reasonable period of time. This evidence was uncontradicted.

(d) Proportionality

88. Dr. Grimes testified that there is no need for abortions to be performed in hospitals. Abortions can be performed in clinics at a lower cost, and the surroundings tend to be more sympathetic with experienced counselling available. He suspects that physicians who work in clinics are more skilled at abortions than those who provide them in hospitals, thereby

making them safer. Dr. Grimes also noted the additional benefit that women who have had an abortion tend to be better contraceptors afterwards. (Vol. 15, p. 3246 l. 20 to p. 3250 l. 11)

89. Dr. Roy testified that the Quebec experience has also shown that clinic are safe, efficient and desirable places to have abortions. Women obtain treatment quickly, and more abortions are done in clinics and doctors' offices than in hospitals. Over 25,000 abortions were paid for by Quebec Medicare in 1983 and this number did not include abortions performed in community clinics by salaried physicians. (Vol. 16, p. 3435 l. 5 to p. 3467 l. 20, and p. 3498 l. 20 to p. 3499 l. 5) Dr. Hodgson stated that clinics are preferable places to perform abortions. Standards are maintained by the National Abortion Federation and counselling can be done effectively. Since legalization of clinics in 1973, great improvements have been made in abortion services in the United States. (Vol. 17, p. 3595 l. 10 to p. 3615 l. 23)

90. Ms. Christianson testified that hospitals, on the other hand, are quite unsuitable for counselling and present an unsympathetic and often hostile environment for women. (Vol. 15, p. 3347 l. 22 to p. 3364 l. 25; see also Watters, Vol. 16, p. 3549 l. 12 to p. 3569 l. 23) Mrs. Orton testified as to the importance of counselling and the fundamental social work principle of self-determination. (Vol. 16, p. 3511 l. 22 to p. 3517 l. 25; T. Ex. 56) Janis Tripp gave evidence that women were often not treated well at hospitals, while the follow-up reports from women who go to clinics in Buffalo and Montreal "are always positive." (Vol. 15, p. 3301 l. 10 to p. 3302 l. 11) Marilynn Buckham's description of the efficient and supportive atmosphere of the Buffalo clinics supported Ms. Tripp's testimony. (Vol. 15, p. 3184 l. 7 to p. 3191 l. 6)

91. Dr. Morgentaler also testified as to the advantages of clinics, especially the Toronto clinic. He described the counselling available, the avoidance of delays and the avoidance of women having to travel long distances, and the providing of abortions in safe, sympathetic surroundings

for women who need the procedure. He also testified that his clinic would have the best equipment and that he complied with National Abortion Federation standards. Dr. Morgentaler noted that from a business point of view the clinic did not make sense; moreover, he said he dropped his fee when women were unable to pay. He also drew an analogy to the 1960s when many physicians prescribed contraceptives to patients in violation of the law, yet no one was prosecuted because it was a good medical practice. (Vol. 17, p. 3639 l. 20 to p. 3682 l. 30; T. Ex. 50) See also T. Ex. 7, containing clinic guidelines which include the fact that no one will be turned away for inability to pay, and that the D & E method is used at the clinic, and see exhibits 2A-2Y, 8, 13, 20, 25, 26, 43, and 45-49 regarding the advantages and positive aspects of the clinic. Additionally, exhibits 6, 18, 27, 33 and 34 indicate the need the Toronto clinic was meeting.

C. JURY ADDRESS AND JUDGE'S CAUTION

92. The Appellants refer the Court to paragraph 12 of "Evidence to be Referred to in Oral Argument" for excerpts from the trial judge's charge to the jury regarding defence counsel's address.

ALL of which is respectfully submitted at Toronto, this 1st day of December, 1986.

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