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As stated in the introduction to the main body of the Report of the Review of Abortion Procedures at Stanton Yellowknife Hospital, although there was concurrence in the recommendations by all four Committee Members, there was one dissent to the text of the report.

The main report touches on many elements of the situation at Stanton Hospital and makes valuable comments. However, it still seems to beg the question "What really did happen and how did it continue until we found ourselves in this situation?"

That question has been put to me regularly since my appointment to this committee was announced. Women in airports and restaurants have asked me. People on the street have expressed the same concern. Until the hearings were finished and all the information gathered, this was a question no one was in a position to answer. Until I had a chance to listen to and learn from my colleagues on the committee, I didn't completely understand what I was hearing or what the larger picture showed.

Now that all the parties have been heard it feels important to me to clearly share the knowledge gained.

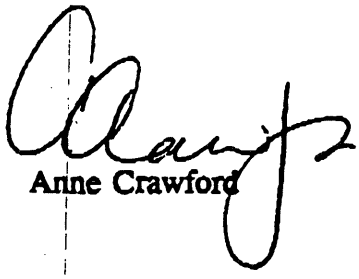
Other committee members have told me that this supplementary material is merely a repetition of what is said, in a more round-about way, or with less detail, in the main report. That may be the case. But there is value in presenting the information in a way which doesn't require second guessing or reading between the lines. People have a right to the knowledge.

Knowledge is essential to any progress we might hope for, in the North, for women, or for anyone anywhere. It is important to clearly acknowledge what has happened for several reasons:

Firstly, knowledge guards against repetition - by knowing how something happened we can use that information to identify and apply to other situations and generally to improve our lot as women and as a society;

Secondly, knowledge is power - by clearly understanding a process and how we got into it, we begin to have the power to change it;

Finally, knowledge is affirmation. Many people knew what is in this report, or at least knew the part of this which affected them. Those people have wondered if they were crazy or simply imbalanced. They weren't. And this report attempts to confirm that truth.



Anne Crawford

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1. IN SUPPORT OF STANTON HOSPITAL

An honest assessment of abortion procedures at Stanton Hospital can begin with an assertion of what went right.

It should be said that the four physicians performing abortions at Stanton Yellowknife Hospital have provided prompt and consistent access to abortion procedures for women from across the Northwest Territories for many years.

This has not been easy, and it would have been simple for them to refuse to perform abortions altogether. No one would have condemned or challenged them for such a decision.

If they chose not to provide this service, all women in the NWT would have been forced to travel South for the procedure, with the predictable and inevitable result of greater delays and more women slipping from the system or falling into logistical cracks.

Wherever we travelled in the North women have not reported any unnecessary delays in obtaining an abortion procedure once they contacted a physician at Stanton.

This access is substantiated, in part, by physicians in various regions of the Territories who report that there are few to no incidents or records of self-inflicted abortions.

In the past, one of the Stanton physicians, entirely on his own initiative, brough forward issues of access to abortion. He wrote to the Department and Minister of Health, and initiated discussions with the Status of Women Council on the poor access from the South Slave Region. That commitment should be acknowledged.

The mortality and morbidity rates for the abortion procedure at Stanton are within normal ranges. A number of appropriate protective medical procedures have been instituted.

One Stanton physician showed consistant use of appropriate analgesia, and no complaints of excess pain were received which identified this physician. A second physician was identified by support staff and patients as being supportive and caring in what they felt were very difficult situations.

The fact that a group of four physicians in a community the size of Yellowknife, and a medical community the size of the Northwest Territories, would be prepared over a period of years to consistently provide coverage for this procedure speaks well for them.

2. THE ISSUE OF PAIN

It is clear from the witnesses appearing in front of the committee that firstly, different physicians at Stanton provided different levels of pain relief to patients, and secondly that different patients perceived the pain involved in the abortion procedure differently.

Some patients gave no complaint and no indication of pain because they did not feel excessive pain. Two patients came forward to the Committee who described the pain as not being a problem. One woman who defended the procedure and who, in the event that there was a need, would choose to have the procedure again without any analgesia, described it as follows: "It hurt like hell - but for the time it took I'm glad he didn't put me under. It was over quickly, the staff were supportive."

More than 10 patients came forward in person to the Committee and described the procedure as being intolerable. In addition women provided written complaints. Common descriptions of the pain from by these women included, "more painful than child birth"; "the worst pain of my life - ever" and "the worst five minutes of my life". Several women described subsequent nightmares and flashbacks to the pain and fear, and likened the experience to torture. Hearing or reading the stories of these women was a moving experience.

At closed hearings medical personnel at Stanton acknowledged that the procedure, as it was performed, resulted in some patients who experienced very substantial pain. Estimates of the number of patients with extreme pain ranged from the highest estimate of 1 in 8, through 1 in 10, to the lowest estimate of 1 in 25.

In addition, some medical personnel reported that approximately 1 in 2 patients indicated or expressed that they were experiencing heightened levels of pain through the procedure.

Finally, some women, in particular aboriginal women, indicated that they had suffered extreme pain but that they had refused to acknowledge or indicate the pain to medical staff.

Some physicians acknowledged that a few patients were in sufficient pain that they required physical restraint by nursing staff to safely complete the procedure. Patients also reported,

and physicians acknowledged, they had screamed, cried and yelled for the physician to stop the procedure.

The following is an extract from a closed hearing where the subject of patient pain is being discussed:

COMMITTEE MEMBER: ...What kinds of signs are you getting?
PHYSICIAN: If they are moaning or you can hear them breathing, hyperventilating, or something like this or gritting their teeth or squirming a little.

COMMITTEE MEMBER: Are there other physical signs?
PHYSICIAN: If they are having pain they could very well be squirming. These are the ones you do not want to have happen and this does happen on rare occasions.

(page 272-3)

COMMITTEE MEMBER: Patients describe that they were screaming and thrashing. Is that consistent with your memory?
PHYSICIAN: It is extremely rare that someone would be screaming and thrashing.

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It seems clear that these actions and indications of pain constituted complaints made directly to the physicians, even if they were not "complaints" in the conventional sense. They are also a confirmation that the procedure was indeed, very very painful for a significant number of patients.

3. COMPLAINTS TO PRIMARY CARE GIVERS

Given that there was this level of pain, and even assuming that the operating physicians did not respond to it, the question arises: why didn't women complain to someone else if it was that serious?

The answer lies in the nature of the procedure itself, and the need for privacy and the unwillingness of individuals to "take on" established power figures, in particular, medical practioners who are at the top of the medical hierarchy.

To obtain appropriate feedback, it is important that an internal complaints system is viewed by an institution or a system as a means to ensure satisfaction and to monitor and promote quality. When people bringing forward a complaint or concern are seen as individuals who have taken the time to contribute important information, a system is likely to learn of and correct problems.

In visiting a variety of health care facilities, the comment was made that nursing and support staff, including maintenance and cleaning staff, were among the most common recipients of patient complaints.

Remembering that individuals who do not consider themselves powerful are unlikely to complain to those in positions of power, a good complaints procedure will ensure that all staff are familiar with the means to convey a complaint, and that all sources are given the respect they are due.

It does take considerable strength to complain, in particular to complain to a physician. A number of patients stated that they did complain to their primary care givers following the abortion, that is to the original referring physician or nurse.

It was interesting to note that some patients reported complaining to a particular physician, but the same physician subsequently stated that they had not received any complaints. It appears that the analogy of "not being heard" extended beyond the operating room.

Physicians interviewed from Yellowknife consistently did not recall receiving information from physicians from other hospitals, from patients or from other health care providers about a lack of pain control.

The Committee received an affidavit from the Chief Executive Officer of the Baffin Regional Health Board which stated that physicians in Iqaluit had received complaints about lack of pain control during abortion procedures at Stanton Yellowknife Hospital.

The Executive Director of the Mackenzie Regional Health Service stated that to his knowledge, physicians providing services through the MacKenzie Regional Health Services have not received complaints. He also stated that since this controversy arose several members of the public have raised this issue with nursing staff, but that these comments were not complaints or even negative comments.

The Executive Directors of the H.H. Wiliams Memorial Hospital and the Fort Smith Health Centre stated that no complaints on the topic of pain control during abortions were reported by their physicians, medical or nursing staff.

In contrast, the Chief Executive Officer of the Inuvik Regional Health Board stated that he was advised that the Director of Patient Care Services in Inuvik had conveyed patient concerns about pain in abortion procedures to the Chief of Staff in December 1991 or January 1992 and that these concerns were in turn conveyed to a physician in Yellowknife who performs abortions in or about January 1992. The following conversation took place in the closed hearings with that physician:

COMMITTEE MEMBER:	Okay, what about when the complaint came from the physician in Inuvik?
PHYSICIAN:	That is very vague, I cannot just remember what the situation was. It seemed to me it was more just something in passing.
COMMITTEE MEMBER:	Did you, for instance, take the issue to one of the hospital committees that dealt with those things? Did you compare notes at that point with other physicians, were they receiving complaints?
PHYSICIAN:	No, not with relation to that one. It was just a comment in passing. It was not a complaint, it was a comment made.

Again, it appears that complaints were made but not "heard".

4. COMPLAINTS TO STANTON HOSPITAL

In June 1986 Stanton Yellowknife Hospital implemented a quality assurance program designed to improve patient care through ongoing assessments and corrections of identified difficulties. The program was designed to provide the Hospital Board with information on a monthly basis concerning the quality of care provided.

As part of this process, each patient was given a questionnaire to provide feedback on the services received. This was viewed as an informal means to keep track of patient concerns. The Executive Director described the responses as being exceptionally positive.

One patient who appeared in front of the Committee stated that she had filled out a patient questionnaire. She complained about severe pain and remembered specifically using the term "barbaric". She also provided her name and address. When questioned, the Quality Assurance Coordinator did not recall any negative comments about pain control, and in any event the comments were not responded to or passed along to the Board.

The Executive Director stated that the Hospital's records revealed only three patient complaints regarding abortion practises between 1989 and 1991. The following are excerpts from a synopsis she prepared:

> "The first had...come to the ...unit manager of the surgical unit., [who] reviewed the events which had transpired with the patient who complained severely about the procedure and associated discomfort. Nothing further was heard from this patient following discharge.
>
> [The second was in] October 1990, one verbal complaint had come directly to the [Assistant Executive Director] from an individual who had undergone this procedure. This complaint was investigated and followed up with the individual...The complaint was not received in writing, although this was also suggested when it was apparent that the issue could not be resolved over the phone.
>
> At no point in this [second] review was there any indication of anything inappropriate occurring, nor had anything occurred different from what was the routine.

[The third was a] written complaint: There had been one written complaint received by the facility in the fall of 1991. This had been from a patient who had undergone a D & C for a miscarriage. The Executive Director had asked the chairperson of the Anaesthetic Committee to draft a response in regard to this complaint. Regrettably we now realize this response did not reach the patient and Stanton Yellowknife Hospital was totally unaware of this."

It is regrettable that these complaints, although "received" by the system, were again, not "heard".

5. INTERNAL COMPLAINTS

Stanton Yellowknife Hospital received information from staff that there were problems. Staff told the committee that there was an attempt to deal with the issue of pain through the Operating Room Committee, in October 1991. Minutes of the meeting do not record this.

Whether or not they knew earlier, once this controversy became public, Administration was given clear information that staff had concerns about levels of pain.

On May 19, 1992, the following exchange took place in a closed session, regarding patients who indicated extreme pain:

Committee Member: You are a nurse and you are trained to respond to what physicians are telling you. But, you are also trained to respond to what patients are telling you. How do you deal with this?

Hospital Staff: It is really difficult. A lot of times we would just sit down and cry. There does not seem to be anything happening. We would say what we though was awful, but the reply would be that it is just such a short procedure that we do not bother giving anything...

The next day this exchange took place with a more senior staff person:

Committee Member: Did any nursing staff approach you with concerns about pain control or the lack of pain control for patients in this procedure?

Hospital Staff: ...I met with the staff to basically get the feeling of where they were coming from and were there any issues they wanted to discuss and where did they stand.

Committee Member: What came as a result of that meeting?

Hospital Staff: They stated that, yes, there were patients in pain during the procedure. And they stated they had also brought to it to the attention of physicians during the time.

Committee Member: And in turn, what were you able to do with that information?

Hospital Staff: ...all the information I gleamed from those meetings I then relayed back to [the Executive Director].

Committee Member: Do you know the approximate date of that meeting?

Hospital Staff: April 8th [1992].

The same evening, May 20, 1992 the Committee met with the representative of the Stanton Yellowknife Hospital Board of Directors who said:

Committee Member: So far as you know, the expressions of concern in this whole issue have been raised external from the Hospital rather than internally in the Hospital?

Board Representative: That is right. There is no question. That is the case.

Earlier in the hearings on May 6, 1992 the Executive Director had been invited to comment on the contrasting versions of events:

Committee Member: One of the things that we are struggling with as a committee is that there are a number of complaints that indicate a great deal of suffering, pain, concern, [and] anxiety, on the part of the patient. We just started speaking with physicians and yourself as a representative of the hospital, where there is an equally clear indication that there was no knowledge of the existence of these problems and you can imagine that we are trying to find where there is a link between these two very different concepts. Can you help us in any way?...

Executive Director: That is one we have been struggling with too...In the information at our quality assurance meetings we had exceptionally good responses to our patient questionnaire.

From these conversations it appears that the Hospital has an issue of internal "hearing". Firstly, the administration did or should have known of this problem before the complaints were raised externally. Secondly, the Board and the Committee did not appear to be receiving all the information available to the Administration.

Specifically, the Board and the Administration were assuring the public and the Committee that there was no problem, when the Administration knew that people within the Hospital were concerned about levels of pain being experienced.

6. RESPONSE TO COMPLAINTS

In the course of the hearings, at least one example was brought forward of how Stanton Hospital did acknowledge and respond to complaints.

A Stanton physician identified a case where there had been a problem with anaesthetic for another obstetrical procedure - cesarean sections - and showed how quickly the Hospital was capable of responding:

PHYSICIAN: The nurses on the surgery ward follow up with each patient. "How did it go? Any problems?" And the patients fill out a satisfaction questionnaire. And there were two cases, I believe where the patients said "I could feel them operating on me. I remember parts of that, and it scared me."

And when that happens red lights flash and blink, and it comes back very quickly. It precipitated a chart review of those two particular cases and a review of the type of anaesthetic which was given for those two cases....Then the information went to the Anaesthetic Committee and between the different anesthetists who practise, the cases were discussed and the concerns that had been raised were addressed. And it was recommended by the Anaesthetic Committee as a whole that the procedure be changed.

It appears that the behavior of the abortion patients also resulted in physicians responding to the pain shown. Regrettably, the physicians appeared to be in a logical box. They believed that there should be no pain, and as a result tried to remove themselves from the pain rather than addressing it. The following excerpt from a closed session explains how one physician saw the procedure:

PHYSICIAN: I do not think we wanted to deal with what happens when the person loses control and we feel badly about that. We perceive there is a problem. But we have had trouble dealing with..addressing...that.

One coping mechanism was that physicians arranged the operating room so that they were not able to see the face of the patient:

PHYSICIAN: Through all the operations it has been standard ritual to put up a barricade. In other words the drape is pulled up around the IV poles on either side so that there is a cloth wall between the patient and the operator.

Physicians also coped by creating emotional distance from patients. This was commented on by patients who described physicians as "cold" or "distant". This distance was demostrated by a physician who generalized about patients in the following way and then corrected himself:

PHYSICIAN: We have seen a lot of patients who are pretty unfriendly; very unco-operative and we try to roll with that. There are some people who arrive drunk and some who arrive belligerent and hostile and in the face of what we perceive as a helpful caring process, they are abusive.

COMMITTEE MEMBER: But there are probably another 95% of the patients who do not fall into this category.

PHYSICIAN: Most patients are no problem.

A particular effort was made by physicians to speed up the procedure in order to reduce the time that the patient felt pain. Two Stanton physicians were careful to point out that they attempted to complete the procedure quickly to avoid pain:

PHYSICIAN #1: ...The actually painful procedure, the suction part, I am sure, would last less than two minutes.

PHYSICIAN #2: ... most of the operations that I have done over the last 15 years have been completed within 60 seconds...

This is in contrast to the evidence of two physicians who have performed many abortions in southern Canada:

Dr. A.: Give us an idea of the duration of the procedure.

Dr B.: It varies of course, depending on the length of the pregnancy, of gestation and the skill of the individual doctor. Any procedure below 14 weeks, in my hands, goes about four or five minutes. Other doctors would take maybe seven or eight minutes or so. The procedure where we use laminaria--and we use them only after 14 weeks--may take 10 to 15 minutes, depending on the case.

Dr. A.: That is the sort of time we were talking about but we came up with more interesting times here. In other words, we were talking 60 seconds to two minutes which seemed unusually fast...

Dr B.: I think that even the best doctor could not do a good job that way.....It is important for the doctor to take his time, and for him to take his time, it is extremely important that the patient be as comfortable as possible.

In addition to creating physical and emotional distance there was a certain rationalizing or denial or the pain. Physicians were convinced that the pain being expressed was largely emotional rather than physical pain. The following is an example of that belief, as expressed in the open sessions by a physician who appeared as a hospital spokesperson:

PHYSICIAN: I think that the pain women experience with abortions goes far, far beyond the physical pain and there is a strong degree of emotional pain, which physicians attempt to address to various degrees, but we cannot fully. We just cannot.

The issue of emotional pain does present a legitimate problem. Patients may express grief and sadness following an abortion, including in cases where their physical pain has been addressed. The following comment was made in a closed session for the information of the non-medical participants:

> **Dr. A.:** I should mention for those people who do not go into operating rooms much...that even with a general anaesthetic, patients can wake up screaming ..., crying and weeping their hearts out, just beside themselves....

Physicians at Stanton suggested that the pain expressed was emotional pain and this dictated their response to it. They believed that there should be no physical pain. This position is illustrated in the following exchange, in which a southern physician also identifies the potential physical source of pain:

> **PHYSICIAN:** ... Not perceiving that there was a major problem. We proceeded with what we perceived was a reasonable operation.
>
> **DR. A.:** There is not a lot of downside in local anaesthesia or paracervical block, when skillfully and gently done.
>
> **PHYSICIAN:** The traditional thinking is that the cervical block [only] helps the dilation process. [The way we do the procedure using laminaria] the cervix has already been dilated.
>
> **DR. A.:** That is true and in an article I have written I have actually stated that myself five or six years ago. I found over the years ... there is an instrument going up and down past [the cervix] stimulating the contraction somewhat and stimulating the pain ... now I find that anaesthestic block improves the situation.

In hindsight, these attempts to avoid the pain resulted in more pain for patients, more avoidance for physicians, and in the end, more women who were given an additional emotional burden to carry at a time when they were already burdened.

In contrast, the one physician performing abortions at Stanton Hospital who was not identified in any complaints the Committee received, addressed the pain issue in this manner:

COMMITTEE MEMBER: Physicians have said to us that they could see there was pain but this was emotional pain; that the patient was emotional, as opposed to having physical pain and therefore I was just able to carry on, recognizing that this was simply an emotional reaction.

PHYSICIAN: Pain is pain isn't it.?...if a patient is having pain, it is pain, whether it is emotional pain or whatever it is. My procedure is that I will respond to it...If a person has difficulty then they deserve some support.

In this instance, the practical response enabled the physician to see his way clear of the logical contradiction. "Scientific" knowledge told him there was no pain, and his experience showed patients suffering. He chose to listen to the patients.

CONCLUSION

Pain is pain. Women can and do bear considerable pain in the course of their lives. Within modern medicine we anticipate that, as much as is possible, we will be spared unnecessary pain.

Where that doesn't occur we are right to seek an answer. Where the system doesn't hear the complaint, we are right to speak more loudly. If we keep saying what has happened, in a way that doesn't require second guessing or reading between the lines, then we may have started towards solving the problem.

I would like to reiterate that I support the recommendations set out in the main report of the Committee.