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See No Evil

The Case of the Women's Medical Society

Philadelphia

An Ontario Overview

Guidelines, Oversight and Transparency?

Respectfully submitted

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Introduction

In Murder in Plain Sight, a previous report produced by Alliance for Life Ontario, it was proposed that an individual such as Kermit Gosnell could operate in the same manor he did in Pennsylvania in any jurisdiction which failed to provide stringent, effective, transparent oversight and regulation of all of its abortion facilities. This finding was vital, as it underlined the importance of the Grand Jury Report into the Women's Medical Society beyond the borders of Pennsylvania. The following report examines the current status of regulation of the eight known free-standing abortion facilities in Ontario, in other words facilities of the same nature as the Women's Medical Society.

In the absence of the resources and ability to compel testimony the Grand Jury enjoyed whilst investigating Kermit Gosnell and the authorities of Pennsylvania, this report has instead utilised existing evidence and information. Three documents are used to form as complete a picture of the regulation of freestanding abortion facilities in Ontario as possible. The majority of this evidence deals with Independent Health Facilities, as described under the Independent Health Facilities Act 1990. The research for this report has discovered that this was the only statute applicable to the oversight of free standing abortion facilities until 2010, when a change was made to the provincial Medicine Act 1991. Further investigation has been carried out into this and other recent developments. The findings and the results are also included in this report.

Based solely on the research findings of this report, Alliance for Life Ontario believes that it would have been possible for Kermit Gosnell to operate in Ontario in the same manner he did in Pennsylvania. It is also plausible to conclude that that another individual may have operated in this manner over the past 20 years in Ontario, and even possible that the person could be operating this way now.

Section 1

The Annual Report of the Auditor General of Ontario 2004

The following section refers to the Annual Report of the Auditor General 2004, tabled in the Legislative Assembly of Ontario on November 30th 2004. The following description is taken from the official website of the Office of the Auditor General of Ontario;

"The main body of the Annual Report consists of matters arising from individual value-for-money audits of ministries and agencies. It includes the audits' significant findings, observations, and recommendations, as well as ministry and agency responses to the recommendations. It also includes a chapter of follow-up reviews of all the value-for-money audits from the Annual Report published two years previously. Furthermore, the Annual Report includes observations resulting from the attest audits of the Public Accounts, certain information required by statute, and reports on the Office's operations and on the activities of the Standing Committee on Public Accounts."

Chapter 3.08 deals solely with Independent Health Facilities.

The report is available in full at: http://www.auditor.on.ca/en/reports_2004_en.htm

All page references refer to this report.

Unlicensed Independent Health Facilities

The first major finding of the Office of the Auditor General is that several free-standing abortion facilities were known to be operating without being licensed under the Independent Health Facilities Act (p222). This apparently was due to a loophole in the Act which allows an Independent Health Facility to operate without a license so long as it is not paid a facility fee. However, the facility is then exempt from the quality assurance processes to which facilities licensed under the Independent Health Facilities Act are subject. This is of great concern to the Office of the Auditor General, leading it to recommend,

"*The Ministry should also determine what legislative or other actions should be taken regarding unlicensed facilities that are performing surgical and other procedures that are generally performed in hospitals or licensed independent health facilities*".

While this refers to all Independent Health Facilities, and rightly so, it should be noted that the only evidence of unlicensed activity presented was with regard to abortion facilities. Information about these abortion facilities was taken from a Government of Ontario report noted in the Annual Report of the Auditor General 2004.

The Ministry of Health and Long Term Care was given the chance to respond to these claims and recommendations. The Ministry simply reiterated that this was the fault of the language in the Independent Health Facilities Act and that a major change to the Act would be needed to address this concern (p223). The Ministry's level of support for such change is hard to measure by its response, in which it states, "*The Ministry supports the consideration of this issue under a policy review of the Act and the inclusion of amendments, subject to policy approval, if/when the Act is open for amendment*".

Number of Assessments

The Office of the Auditor General reported on the number of assessments carried out on licensed Independent Health Facilities, using figures from the 2004 report as well as those from a similar review in 1996 (p226). The earlier report reveals the astonishing state of assessment of licensed Independent Health Facilities in the mid-nineties, when *"assessments of the quality of services provided had not been performed on two-thirds of the facilities licensed under the Act and that only 47 of the 336 facilities whose licences had been renewed had been assessed*".

'Improved' findings are reported for 2004, where "the Ministry was assessing over 85% of facilities at least once within the period of a licence, which is generally five years."

This evidence raises several points which must be discussed. Despite the 'improvement' sometime between 1996 and 2004, the figures from 1996 point to at least six years where hundreds of Independent Health Facilities went without assessment. Even in 2004 the 15% still not assessed refers to nearly 150 facilities. During a period where licensed abortion facilities numbered five, it is not hard to imagine some, if not all of them, escaped assessment despite being licensed.

It must also be noted that for a facility to be included in the 85% which were considered sufficiently assessed, only one assessment had to be carried out every five years. This implies that a period of five years without any physical observation of an Independent Health Facility is adequate and does not endanger those using the facility. **In a single five year period Kermit Gosnell and the Women's Medical Society perforated a young women's uterus, left a patient with parts of an aborted child still inside her and caused the death of Semika Shaw. In a separate five year period Gosnell caused the stillbirth of a 30 week term baby, killed a child following birth and caused the death of Karnamaya Mongar.**

It should also be taken into account that in the 30 years the Women's Medical Society was operating, it was visited by various bodies on ten separate occasions, an average of once every 3 years. Since the breaking of the story of the Women's Medical Society in the media, the government of Pennsylvania has mandated annual assessments of each of its 20 free standing abortion facilities. It hardly seems sufficient protection for Ontario patients in light of this, where one assessment every five years is apparently viewed as being adequate.

Though included in the 2004 Annual Report of the Auditor General, these figures received no response from the Ministry of Health and Long Term Care and are discussed no further in the materials used for the investigation conducted for this "See No Evil Report".

Unannounced Assessments

The Office of the Auditor General notes that the Independent Health Facilities Act has permitted unannounced assessments since 1996. However, as of March 2004 none had been carried out (p226). The Office of the Auditor General clearly saw this as an important tool in ensuring patient safety in Independent Health Facilities, stating

"This would enable assessors to directly observe on a surprise basis the quality of the services provided and to ascertain whether procedures are being performed by qualified staff".

In its initial response the Ministry appears open to addressing this shortfall, announcing that discussions had begun to implement a change to the existing protocol.

Time Frames for Reporting Issues

The Office of the Auditor General raised several concerns regarding this issue (p227). It is noted that there is still no established timeframe for assessments to be forwarded to the Director of the Independent Health Facility Program, despite this being raised in the 1996 report and the Ministry agreeing with the recommendation to address this at that time.

Whilst in 1996 facility staff of an Independent Health Facility which failed an assessment would meet with the assessors to discuss the shortfalls within two months, this practice had been halted by 2004. Instead Independent Health Facilities which failed an assessment would forward information to the assessors, detailing how they proposed to address these issues. However, there was no time frame for doing this. The Office of the Auditor General saw this as a worrying practice, adding that it had

"reviewed assessment reports for facilities that the Ministry had concluded had significant concerns but that were not suspended—for the period between April 1, 2000 and March 31, 2003 and found that, in most cases, the College did not receive the information on what action had been taken until four to six months after the assessment date".

This concern was compounded by the attitude of the Ministry, which in the words of the Office of the Auditor General,

"indicated to us that a four-to-six-month time frame for receiving information about action taken in response to non-life-threatening problems was reasonable, we could not determine the basis for this conclusion".

Despite this, the Office of the Auditor General made the recommendation that time frames be implemented for both the submission of reports to the Director of the Independent Health Facilities Program and for the submission of plans by an Independent Health Facility to address issues raised in an assessment.

Despite its earlier assessment, that the current timeframes were acceptable, the Ministry responded by reporting that new timeframes were already being discussed, with a greatly reduced lapse in time between an assessment being made and action being taken (p228). Such action to address an outstanding issue must be applauded. However, the previous attitude to this problem and the danger the public was put in whilst the old time frames were allowed raises several questions about the commitment of those involved to the health and safety of the residents of Ontario.

Negative Assessment Outcomes

The Office of the Auditor General had numerous concerns regarding the effectiveness of the action taken after a negative assessment. It observed that even when there was evidence of a serious risk to public health and safety discovered during an assessment (which is a prosecutable offence that could result in the loss of the Independent Health Facility's license), an average of 3 months would pass between the assessment and action being taken (p229). During this period the Independent Health Facility could continue operating as if the assessment had never taken place and, as discussed in a previous section, even once the license was revoked it could continue operating without any further oversight from the Office of Independent Health Facilities.

The Office of the Auditor General was also troubled by the lack of procedure for dealing with a facility which continued to offend following a negative assessment (p229). This shortfall was noted in the 1996 report, when it was also recorded that 60% of facilities with issues during an assessment would still have significant problems when reassessed. In the 2004 report it was noted that for the period between 2000 and 2004 this figure was reduced to 20%. However, despite this improvement, it still equated to a rate of re-offence of one in five. The Office of the Auditor General suggested that a suitable response to a re-offending facility would be to revoke its license.

Since 1996 the Independent Health Facilities Act has allowed the Ministry to charge a facility the cost of the reassessment, in the hope that this would provide further incentive to the owners and operators of an Independent Health Facility to ensure they are operating according to standards. The Office of the Auditor General noted that as of the 2004 audit this has yet to be implemented (p229).

Concluding this section of the audit report, the Office of the Auditor General detailed its concern that the results of an assessment are not made available to the public, even if the outcome was negative (p229).

This included Independent Health Facilities which had offended to the extent of having their license revoked. The Office of the Auditor General summed this up perfectly with the following;

"Although facilities whose licences have been suspended or restricted due to quality assurance problems cannot bill for facility fees during the period of suspension or restriction, potential patients and physicians who refer patients to the facilities may not be aware that quality assurance issues have been identified".

For the above issues the Office of the Auditor General made the following recommendations, that the Ministry should; "*have a formal policy on suspending facilities with serious quality assurance issues, especially when the same issues arise on reassessment", "consider charging facilities for reassessments"* and *"should consider appropriate public disclosure of serious quality assurance problems at independent health facilities".*

The Ministry appears to have responded favourably, indicating it would instigate formal policy to revoke the license of repeat offenders and write "*options papers"* on charging for reassessments and disclosure of licensing action. However, there is no reference here to the three month gap between an assessment and the revoking of the Independent Health Facility's license, and further concerns are raised regarding the effect of publishing assessment findings, particularly with regards to the effects on the owners and operators of Independent Health Facilities (p230).

Concerns Regarding the Assessors

The Office of the Auditor General raises serious concerns regarding the methodology used in the assessment of Independent Health Facilities (p231). It explains that this task was delegated to the College of Physicians and Surgeons of Ontario. All previous references to "the assessors" in this piece refer to the College. The chief concern of the Office of the Auditor General was evidence that the College was not following its own guideline requiring the review of a minimum of ten cases per speciality provided by the facility, nor was it providing a reason for not doing this.

There is also a record of some assessors from the College allowing the staff of the facility under assessment to select the records and cases used. College policy on this requires random sampling to ensure the integrity of each assessment. In light of these issues the Office of the Auditor General recommended that all assessments consist of a sufficiently large sample size and that the sample be selected independently.

The Ministry responded to these recommendations by agreeing to discuss these issues with the College and to establish these guidelines in a Memorandum of Understanding (p231).

Clarity of Assessment Results

In the 1996 report the Office of the Auditor General was concerned that the result of an assessment was not clearly stated in the reports of the College to the Ministry (p232). This is especially worrying in cases where action was required as a result of the assessment. Despite the Ministry agreeing to address this issue in 1996, the Office of the Auditor General reported that the problem still persisted in 2004. It did note that a Facility Review Panel was set up in September 2003, to support the Director of the Independent Health Facilities Program in making decisions on assessments. However, the audit was concluded too early to make an assessment of its success.

No further recommendation was made by the Office of the Auditor General on this issue, and no comment was made by the Ministry. This issue is not discussed again in this investigation.

Assessment Tracking System

The final concern raised by the Office of the Auditor General which is relevant to this report relates to the tracking of assessments. The Office of the Auditor General found it worrying that an extensive database was not in operation which would allow the user to view an overall timeline of the facility in relation to assessments. This is deemed necessary to identify lasting or reoccurring issues within each facility and to allow anyone making a decision on a facility to view all relevant information. To this end, the Office of the Auditor General recommended that the Ministry employ a system which "*is structured to link all data relating to a specific facility"* (p233).

The Ministry responded to this by stressing that improvements had been made since the previous audit, that the current system was compliant with the needs of the Independent Health Facilities Act and that, although the proposed upgrade would enhance the system, the Ministry "*must balance the value of these enhancements against available resources"* (p233).

Section 2

Standing Committee on Public Accounts

Following the submission of the Annual Report of the Office of the Auditor General, committee hearings were held into the findings. On February the 24th 2005, the Standing Committee on Public Accounts met to discuss section 3.08, Independent Health Facilities. This committee consists of Members of Provincial Parliament from the three major parties of Ontario. The report includes excerpts from the original Office of the Auditor General report. However, this section will focus only on what the committee hearings added to these issues. If any previously mentioned issue is not covered in this section it was not included in any of the Committee's responses.

The committee meeting and subsequent report dealt solely with Independent Health Facilities.

The report is available in full at: http://www.ontla.on.ca/committee-proceedings/committee-reports/files_pdf/IndependentHealthFacilities-English.pdf

All page references refer to this report.

Unlicensed Independent Health Facilities

On this issue the Committee simply reiterated the excuses of the Ministry, stating *"The structure of the [Independent Health Facilities Act] is such that the definition of an [Independent Health Facility], and the problems and penalties associated with operating an unlicensed facility, all hinge on charging a facility fee as defined in the legislation. Facilities that forgo charging fees do not require licensing under the [Independent Health Facilities Act] and are not subject to its quality assurance provisions"* (p7). It also echoed the willingness of the Ministry to address this issue in the upcoming policy review of the Independent Health Facilities Act, expected to be completed in late 2006.

Unannounced Inspections

The Committee reported that conversations had begun between the College and the Ministry regarding unannounced inspections (p12). When the Ministry was questioned by the Committee about the lengthy delay on this practice being implemented the Ministry cited concerns for 'teams of professionals' travelling long distances to assess a facility only to find it closed or only operating some of its services. This reasoning seems to suggest that the convenience of the assessors at the College rather than the health and safety of the public of Ontario, was the priority for both the Ministry and the College. The Committee disagreed with this reasoning. It believed that the 'major roadblock' was a lack of further training to facilitate unannounced assessments. Under the heading 'Supplementary Information' a requirement was added that the proposal for unannounced assessments be finalised by March 2005 and implemented in 2005/06, with an expectation that one quarter of assessments carried out each year would be unannounced. The Committee requested in its recommendations that it be updated on this issue by the Ministry.

Time Frames for Reporting Issues

The Committee reiterated the response of the Ministry, stating that discussions were already underway to establish far more appropriate time frames for reporting issues (p13). At this stage it estimated the implementation of the new policies by early 2006 at the latest.

Negative Assessment Outcomes

On the issue of the lack of policy for handling repeat offenders, the Committee simply stated "*The Ministry will develop a policy establishing circumstances under which licensing action will be taken for repeat quality assurance problems where the deficiency does not constitute a health and safety risk or an immediate threat"* (p14).

Although it claimed to support consideration of charging facilities for reassessments, and requested an 'options paper' be drafted, the Committee seemed less than convinced on the issue (p14). It fretted over the change to the Independent Health Facilities Act which would be required, as well as questioning if such a policy, while an obvious incentive to those operating Independent Health Facilities to do so correctly, would be worth the trouble for "*a fairly small return".*

The Committee supported the call of the Office of the Auditor General to publish negative assessment outcomes (p15). However, it did hold some reservations, including how to approach suspensions under appeal and how long to post the information. Legal concerns, regarding the release of such information, was also discussed, although this was dismissed as an issue under the section 'Supplementary Information'.

Concerns Regarding the Assessors

The Committee seem as concerned as the Office of the Auditor General regarding the reporting practices of the College whilst performing assessments (p16). It recommended that these issues be addressed in the Memorandum of Understanding which was being 'negotiated' at that time. However, the time lines involved here are very worrying, with completion of the Memorandum of Understanding expected in "2005 or 2006".

The position of the College as assessors is also discussed briefly in the report (p12). When asked if another body could conduct the assessments, the Ministry responded by claiming that the Independent Health Facilities Act requires the College to conduct them, and that any change to this would require a change to the Act.

Clarity of Assessment Results and Assessment Tracking

Both of these issues were raised by the Office of the Auditor General and are included in the Committee report, Clarity of Assessments in section 5.5 (p16) and Assessment Tracking in section 5.6 (p17). However, the Committee did not feel the need to comment further on these issues.

Section 3

The Annual Report of the Auditor General of Ontario 2006

The following section refers to the Annual Report of the Auditor General 2006, tabled in the Legislative Assembly of Ontario on December 5th 2006.

In any given annual report, the Office of the Auditor General dedicates space to revisiting issues covered in the annual report published two years prior.

Chapter 4.08 of the 2006 report deals solely with a follow up to the 2004 section on Independent Health Facilities.

The report is available in full at: http://www.auditor.on.ca/en/reports_2006_en.htm

All page references refer to this report.

Unlicensed Independent Health Facilities

The Office of the Auditor General reported that the proposed review of the Independent Health Facilities Act, originally due to be completed by the end of 2006 and which would also include investigating the possibility of addressing the issue of unlicensed Independent Health Facilities, had been halted to allow the impact of the impending Local Integrated Health Networks on the Act to be assessed (p303). This move appeared to baffle the Office of the Auditor General, as Independent Health Facilities were initially seen as exempt from the Local Integrated Health Networks planning process.

Unannounced Assessments

The Office of the Auditor General reported that the Ministry, along with College, had implemented unannounced assessments in January 2006 (p305). However, such assessments were limited to repeat offenders and facilities receiving a complaint. This system was due for review at the end of the 2006/07 fiscal year.

Timeframes for Reporting Issues

The Office of the Auditor General reported that the new policies on timeframes for reporting issues raised in an assessment had been implemented. However the originally proposed 10 day deadline for the College to pass reports to the Ministry appeared to have been broadened to a window of 3 to 20 days instead (p305). The precise deadline within this window is described as driven by *'potential impact of the concerns noted'*. However, how this is measured is not reported.

Negative Assessment Outcomes

The Office of the Auditor General reported that the Ministry was still in consultation with the College regarding a policy for dealing with repeat offenders, charging facilities for reassessments and the public disclosure of negative assessment outcomes (p305). Completion was expected during the 2006/07 fiscal year.

Concerns Regarding the Assessors

The Office of the Auditor General reported that a new policy had been implemented in November 2005, requiring a minimum sample size and that the sample be independently selected (p306). However, neither the size of a minimum sample, nor the manner in which the policy was to be executed was discussed. If, like before, the new policy was communicated through a Memorandum of Understanding, then the following question must be asked - What makes the new Memorandum of Understanding more binding than the previous one the College was found to ignore?

Clarity of Assessment Results and Assessment Tracking

Once again, despite being included in the 2004 annual report, the clarity of assessment results was not discussed in the 2006 report. Assessment tracking was discussed however, with the Office of the Auditor General reporting that despite placing this as a low priority, some modifications had been made to allow the tracking of timelines for each facility (p306). However, the details of these modifications were not discussed.

Section 4

Further Information

Following our investigation of the above material, research was carried out in an attempt to acquire further relevant information. On several of the issues already discussed, such information has been found, and follows.

Unlicensed Independent Health Facilities

The Ministry's website contains a report of all licensed Independent Health Facilities in Ontario. In the latest version of this report five abortion facilities are listed[1]. After an extensive search, it is the belief of those conducting the research for this report that at least three further free-standing abortion facilities do operate in Ontario. These are the Women's Care Clinic[2], the Mississauga Woman's Clinic[3] and the Bloor West Village Women's Clinic[4]. All three appear to be operational and one, the Women's Care Clinic, is sponsored as a trusted location by the National Abortion Federation[5]. This appears to suggest that close to seven years after the original findings of the Office of the Auditor General, which were based on information from the Ministry itself, the practice of allowing free-standing abortion facilities to operate without the oversight and regulation of the Independent Health Facilities Act continues today.

A further, somewhat confusing development on this issue came in early 2010. An amendment was made to the Medicine Act 1991, which allowed for the creation of the Out of Hospital Premises Inspection Program[6]. While the stated purpose of this amendment was to "*ensure the safety of patients who undergo cosmetic surgery*"[7], there is no reason why it would not apply to the three unlicensed free-standing abortion facilities in Ontario.

Although amending a statute to address a shortfall in another statute may seem to be an odd approach to legislative drafting, any reform to improve the health and safety of the Ontario public visiting these facilities must be applauded. However, there are some significant concerns remaining. Regardless of this change, unlicensed free-standing abortion facilities were still allowed to operate in Ontario without regulation until 2010. The eventual end to this neglect appears to have been nothing more than a side effect of a move to protect a separate service.

The inspections detailed in the Out of Hospital Premises Inspection Program are also carried out by the College, so any prior concerns about the College must also apply here. Moreover, no public record exists of the facilities covered under this program. When contacted, the College only answered that facilities not covered by the Independent Health Facilities do fall under the Out of Hospital Premises Inspection Program. However they would not confirm specific facilities, even when provided the names of the three free-standing abortion facilities believed to be operating without a license[8]. When pushed to explain this reluctance the College replied that "there is currently no provision in either the statute or by-laws which govern the College to permit the College to make public details regarding a particular facility" [9].

Unannounced assessments

In the 2006 Annual Report the Office of the Auditor General noted that unannounced assessments had commenced in January 2006. When contacted in May 2011, the Independent Health Facilities Program stated that since that time approximately 72 such assessments had taken place[10]. This is considerably fewer than the roughly 50 unannounced assessments per year discussed in 2004.

Negative Assessment Outcomes

During the course of our communications with the Independent Health Facilities Program in May 2011, the current status of guidelines regarding the publishing of negative assessment outcomes was requested. The response from the office of the IHFA was that discussions on the issues, in which 'relevant stakeholders' were included, were now in the final stages[11]. These 'final stages' come almost seven years after the Office of the Auditor General raised the issue, and four years after the target deadline given in the 2006 Office of the Auditor General Annual Report.

Concerns Regarding the Assessors

In order to gain more information on this issue, a request was made to the Independent Health Facilities Program for the Memo Of Understanding between the Ministry and the College regarding the concerns raised by the Office of the Auditor General of Ontario. This was met with instructions to lodge the request with the Information and Privacy Commissioner of Ontario[12]. This is now being considered by Alliance for Life Ontario.

Conclusions

This report aimed to examine the possibility of an abortion facility being able to operate in the same manner as the Women's Medical Society of Philadelphia, only here in Ontario. The bar by which we measured the possibility were the findings in our May 2011 report "Murder in Plain Sight". That report came to the conclusion that only the certainty of transparent and effective oversight of abortion facilities would prevent a similar situation occurring in Ontario. The evidence provided by the researchers for this particular report, drawn in most part from existing government reports, suggests that we cannot be complacent in Ontario. It appears that free-standing abortion facilities have been allowed to operate **unlicensed and without oversight of any kind**. The number of assessments deemed appropriate, even when a facility is licensed, is highly questionable particularly in light of developments in Pennsylvania. It is fair to speculate that some licensed free-standing abortion facilities have operated for years without any assessment at all, and will continue to operate without assessment indefinitely.

Serious concerns exist regarding the policies and practices of both the Ministry and the CPSO. Repeated suggestions of improvements to the Independent Health Facility Program have been rejected or stalled, often out of a greater consideration for the convenience of the College or the preferences of free-standing abortion facility operators. This prioritisation comes at the expense of safety of the women of Ontario. Throughout this investigation relevant information has been withheld from our researchers, including both the results of assessments and information on whether a facility has been assessed at all.

It is most concerning that all of the information the researchers have obtained has been obtained from government of Ontario sources or other sources readily accessible by the government of Ontario.

None of this information is new, and on more than one occasion those in a position to address these issues have sat together, met in committees, and discussed the concerns, yet, failed to act.

In light of the evidence presented by this investigation, it is the belief of Alliance for Life Ontario that oversight of free-standing abortion facilities in Ontario is neither stringent, nor effective nor transparent.

This leads to the conclusion that a physician such as Kermit Gosnell could have established and operated a facility such as the Women's Medical Society here in Ontario, for as long as he did in Pennsylvania, if not longer. It is our deepest hope that this scenario will not be discovered to be a reality, and that immediate, decisive action will be taken by the Ministry of Health and Long term Care, the Independent Health Facilities Program and the College of Physicians and Surgeons of Ontario to ensure that this will cease to be a possibility in the province of Ontario.

References

[1] Facility Report by Location available at http://www.health.gov.on.ca/en/public/programs/ihf/docs/ihf_assessment_report.pdf
[2] http://womenscareclinic.ca/
[3] http://www.mwclinic.com/contact.php
[4] http://www.bloorwestwomensclinic.com/
[5] http://www.prochoice.org/pregnant/find/province.asp?strState=ON
[6] The Medicine Act 1991 available at http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_940114_e.htm
[7] The Out of Hospital Premises Inspection FAQs, available at http://www.cpso.on.ca/uploadedFiles/members/OHPIPfaqMay42010.pdf
[8] Email correspondence with the Sr. Communications Coordinator of the CPSO, dated June 28th 2011
[9] Email correspondence with the Sr. Communications Coordinator of the CPSO, dated July 11th 2011
[10] Email correspondence with the A/Program Manager of the Independent Health Facilities Program, dated May 11th 2011
[11] Email correspondence with the A/Program Manager of the Independent Health Facilities Program, dated May 11th 2011
[12] Email correspondence with the A/Program Manager of the Independent Health Facilities Program, dated May 11th 2011

All listed emails will be made available on request
All resources listed above are available on request
All Websites were last accessed on August 1st 2011