

**SILENCED ENCOUNTERS:
AN AFFECTIVE HISTORY OF ACCESSING ABORTION IN
ALBERTA, 1969-1988**

SHANNON LA REE INGRAM
Bachelors of Arts (Honours), University of Lethbridge, 2014

A thesis submitted
in partial fulfilment of the requirements for the degree of

MASTERS OF ARTS

in

HISTORY

Department of History
University of Lethbridge
LETHBRIDGE, ALBERTA, CANADA

© Shannon Ingram, 2020

SILENCED ENCOUNTERS:
AN AFFECTIVE HISTORY OF ACCESSING ABORTION IN ALBERTA, 1969-1988

SHANNON INGRAM

Date of Defense: June 25th, 2020

Dr. Carol Williams Thesis Supervisor	Professor	Ph.D
---	-----------	------

Dr. Heidi MacDonald Thesis Examination Committee Member	Professor	Ph.D
--	-----------	------

Dr. Kara Granzow Thesis Examination Committee Member	Associate Professor	Ph.D
---	---------------------	------

Dr. Carly Adams Chair, Thesis Examination Committee	Associate Professor	Ph.D
--	---------------------	------

DEDICATION

To Dr. George Jacobson, Dr. Meredith Simons, Dr. Jean Harrowing, and Professor Irene Sisson. Thank you for sharing your memories with me.

ABSTRACT

This thesis is an affective history of abortion as told through the memories from four individuals; two retired medical practitioners who sat on Therapeutic Abortion Committees (TACs) and two women who accessed abortion services in Alberta between 1969 and 1988. Further, my analysis of access to abortion focuses not only on the convoluted history of reproductive services in Alberta but also draws attention to the communities of affect that circulate between individual agents such as between the medical practitioner and the female patient, the narrator and the interviewer, and also the dialogue that often ensues in casual encounters where the topic of abortion is discussed. Through focusing on the complex emotions that circulate within the four oral histories of abortion, I aim to challenge the binary of either grief or relief that is often equated to narratives of abortion.

ACKNOWLEDGEMENTS

There is a community of people that have supported me over the past four years. I will not be able to list every single individual but to those who are not mentioned, please know that our interactions at the University and within the community have been so meaningful.

First and foremost, I would like to thank my supervisor, Dr. Carol Williams, who encouraged me to pursue this M.A. Carol has supported me with her time, feedback, and encouragement when I did not think it would be possible to finish. Thank you, Carol, for the numerous occasions that you invited me to share my research in classes, at conferences, and in publications. It has meant so much to me. I would also like to thank my committee members, Dr. Heidi MacDonald and Dr. Kara Granzow. Heidi, thank you so much for hiring me during my second year of my undergraduate degree which helped tremendously by instilling confidence in my ability as a researcher and a scholar. You are missed by so many at the University of Lethbridge for your scholarly accomplishments and your genuine kindness. Kara, thank you for agreeing to be on committee. Although we may not have had as much interaction throughout my time writing my M.A., I appreciate all of the critical feedback and words of encouragement throughout this process. Thank you, Dr. Carly Adams and Dr. Darren Aoki, for the opportunity to work on the *Nikkei Memory Capture Project*. The experience gave me invaluable insight into the practice of oral history and the importance of active listening. Most importantly, I would like to thank the individuals who agreed to share their memories with me. Without your experiences and candor, this thesis would not be possible.

I also wish to thank: Anastasia Sereda, Jasmine Saler, and Elaine Toth, for supporting me emotionally throughout the whole grad school journey. Anastasia, you have been so understanding of those fragile moments involving both laughter and tears. Jasmine, I am so fortunate to have met you. Thank you for our chats and *slow* walks with Roxy. And to my dear friend, Elaine Toth. The past four years has been an emotional rollercoaster and I am honoured to have witnessed your durability and perseverance. My life is richer for having met you. Thank you for your support and your unceasing strength.

I would also like to thank my parents, Carl and Chris Ingram, for pushing me to finish this thesis, and for the limitless resources that you have provided. To my beloved cat, Gracie; thank you for beginning this journey with me. It deeply saddens me that you are not around for the last few months of this long process, but your presence has been felt nonetheless.

And lastly, thank you to my brother, Dwayne. I do not know if our paths will cross again but you have taught me the true meaning of unconditional love and the importance of human connection. Wherever you may be, thank you for sharing your life with this world.

TABLE OF CONTENTS

Dedication.....	iii
Abstract.....	iv
Acknowledgements.....	v
List of Abbreviations.....	viii
Introduction.....	1
Chapter 1- Physicians Reflect on Therapeutic Abortion Committees.....	15
Chapter 2- ‘And yet, it’s an important part of your history’:..... Accessing Abortion in Alberta, 1969-1988	54
Chapter 3- How <i>should</i> I Feel?:..... Methods for Incorporating Emotion into the Histories of Women’s Reproductive Health	85
Epilogue.....	96
References.....	99
Appendix 1.....	106
Appendix 2.....	110
Appendix 3.....	111

LIST OF ABBREVIATIONS

AHS	Alberta Health Services
BCFA	Birth Control Federation of America
CMA	Canadian Medical Association
CNCMH	Canadian National Committee for Mental Hygiene
OBGYN	Obstetrics and Gynaecology
PAS	Post-Abortion Syndrome
PTSD	Post-Traumatic Stress Disorder
RJ	Reproductive Justice
RCSW	Royal Commission on the Status of Women
TAC	Therapeutic Abortion Committee
UFWA	United Farm Women of Alberta
WPAA	Women-Protective Anti-Abortion Argument

Introduction

In 1983, historian Diane Sands authored and published “Using Oral History to Chart the Course of Illegal Abortions in Montana.” The article focuses on oral histories from women who accessed illegal abortions in Montana from 1880 to 1973. Despite being published over 35 years ago and focusing on the experiences of, primarily, white lower-middle class women from the United States, the article touches on themes that emerged in the oral histories that I conducted with women and medical practitioners who obtained or facilitated therapeutic abortions in Alberta during the period between partial decriminalization, 1969, and full decriminalization, 1988, of abortion in Canada. One relevant excerpt from the Montana-based oral history project includes a statement from a woman who recalled her interaction with and memory of the individual, to which she refers to as, ‘the abortionist’, “He told me that it was going to be very painful, and, but that if I screamed, that he would immediately stop the procedure and throw me out. You know, he said, ‘If you want this, you know, you’d better be quiet.’”¹ For this particular woman, at the time of the procedure, the fear of the potential consequences of vocalizing her physical pain during the abortion procedure silenced her. Indeed, in this thesis I argue that the historic consequences that inhibited many women, such as the woman describing her abortion above, from speaking out about the complex emotions surrounding abortion continues today. Sands addresses the lack of historical focus on women’s experiences of accessing abortion, stating, “The realities of reproduction, or at least potential reproduction, and the desire to control it are shared by all women. But, in proportion to the importance

¹ Diane Sands, “Using Oral History to Chart the Course of Illegal Abortions in Montana,” in *Women’s Oral History: The Frontier Reader*, eds. Susan H. Armitage, Patricia Hart, and Karen Weathermon (Lincoln, Nebraska: University of Nebraska Press, 2002), 213.

of these issues present and past, relatively little historical examination has occurred.”² And while the stigma surrounding speaking out about abortion continues, there is a growing body of scholarship that aims to dismantle this stigma.³

Throughout the twentieth-century, there was a documented increase in women attempting to control their own bodies, specifically as it pertained to their reproduction. Historian Linda Gordon argues that the organizational history of contraception went through four phases throughout the late nineteenth-century and for the entirety of the twentieth-century in the United States.⁴ Beginning first in 1870 with the slogan; “voluntary motherhood,” a term that would later resurface in the latter twentieth-century amongst feminists arguing for a woman’s right to choose or not choose motherhood, proponents of the first phase of the movement condemned contraceptives and advocated for long periods of abstinence for heterosexual couples to limit pregnancies.⁵ The second phase (1910-1920), where the term, ‘birth control,’ was first used saw the organization of the American Birth Control League.⁶ In the United States, feminist Margaret Sanger led the second phase of the Birth Control movement that began organizing around 1915.⁷ Although arguing for women’s reproductive autonomy was one element of this second phase, the movement

² Sands, 213.

³ One of the more popular pro-abortion American campaigns, “Shout Your Abortion,” began in 2015 as a reaction to U.S. Congress’s efforts to defund Planned Parenthood. Similarly, “The Abortion Diary Podcast” by Melissa Madera features stories of women from countries around the world who narrate their experiences of having an abortion. Within Canada, historian and activist, Shannon Stettner, along with feminist scholars, Colleen MacQuarrie and Tracy Penny Light organized the first ever international conference on abortion in Canada in 2014, which was held in Charlottetown, P.E.I. At the time of the conference, there were no abortion providers in the province. This has since changed.

⁴ Linda Gordon, “Introduction: Birth Control, the Moral Property of Women,” in *The Moral Property of Women: A History of Birth Control Politics in America*, (Chicago, Illinois: University of Illinois Press, 2002), 4.

⁵ Gordon, 1.

⁶ Gordon, 1.

⁷ David M. Kennedy, *Birth Control in America: the Career of Margaret Sanger*, (New Haven, CT: Yale University Press, 1970), 72.

garnered more support amongst individuals focusing on limiting reproductive freedom for working-class, differently abled, and Black and Latino folks.

One such example of this early eugenic ideology was circulated in a newspaper advertisement for the first American Birth Control Conference held in New York City from November 11th to November 13th, 1921: “Some of the themes to be covered [at this conference] are: the medical and social aspect of birth control and its relation to national health; the amendment of the present laws governing the use of contraceptives, which make it a criminal offence to give this information; over-population and its relation to war; individual family problems of economy and health”.⁸ One of the principle speakers at the conference, that would also establish the American Birth Control League, was Sanger. Indeed, a significant element of the second phase of the movement equated ‘maternal health’ with ‘national health’. Under the guise of maternal health, and by extension access to contraception, Social Darwinist ideology that argued for reproductive privilege for select individuals was able to flourish.⁹

The movement that largely began in Britain, and later increased in force in the United States, also continued throughout Canada in the twentieth-century. Historian Erika Dyck analyzes how provincial eugenic attitudes formed and were implemented throughout Canada during the twentieth-century. With the formation of the Canadian National Committee for Mental Hygiene (CNCMH) in 1918, national support for the expansion of eugenic ideology thrived.¹⁰ And while most provinces in Canada “entertained eugenic

⁸ Anonymous, “A birth control conference” *Women’s Journal* vol. 6, no. 11 (1921), 20.

⁹ Susanne M. Klausen, “Eugenics and the Maintenance of White Supremacy in Modern South Africa,” in *Eugenics at the Edges of Empire: New Zealand, Australia, Canada, and South Africa* eds. Diane B. Paul, Hamish G. Spencer, and John Stenhouse (New York, NY: Palgrave Macmillan US, 2017), 291.

¹⁰ Erika Dyck, “Eugenics: Choice, Coercion, and Context,” in *Eugenics at the Edges of Empire: New Zealand, Australia, Canada and South Africa*, eds. Diane B. Paul, Hamish G. Spencer, and John Stenhouse (New York, NY: Palgrave Macmillan US, 2017), 43.

ideas,” Dyck focuses scholarly attention on the only provinces that formally enacted sexual sterilization laws: British Columbia, from 1933-1973, and Alberta, from 1928-1972.¹¹ The overlap of the passing of Prime Minister Pierre Trudeau’s 1969 Omnibus act that would fully decriminalized birth control and partially decriminalized therapeutic abortion with Alberta’s Sexual Sterilization Act was not coincidental.¹² One might argue that Trudeau’s 1969 Omnibus act signaled a shift away from government intervention into the private lives of women.¹³ And yet, the Therapeutic Abortion Committees (TACs) that operated throughout Canada and the continuation of Alberta’s Sexual Sterilization Act (1928-1972), which remained in effect three years following the 1969 Omnibus bill, contradicted the reproductive autonomy that women held in public policy versus their private lives.¹⁴

This thesis records the experiences of two white upper-middle-class medical physicians who reviewed, approved or rejected applications for abortions as sitting members of TACs in Lethbridge and Calgary between 1969 and 1988 and of two white middle-class women, both residents of Lethbridge, who sought and secured abortions in Alberta during the 1970s and 1980s.

What I aim to convey throughout this thesis is the importance of qualitative research and to give voice to individual experiential narrative. I address the varied experiences of the two women who accessed abortion services in Alberta and the two medical

¹¹ Dyck, “Eugenics: Choice, Coercion, and Context,” 42.

¹² *Criminal Law Amendment Act, 1968-69*, S.C. 1968-69, c. 38.

¹³ Robert F. Badgley, “Appendix 3: The Abortion Law,” in *Report of the Committee on the Operation of the Abortion Law*, (Ottawa, ON: Minister of Supply and Services Canada, 1977): 472 – 474.

¹⁴ Province of Alberta, *The Sexual Sterilization Act of Alberta*, 1928, statutes of the Province of Alberta, retrieved from: <https://www.canlii.org/en/ab/laws/astat/sa-1928-c-37/latest/sa-1928-c-37.html>.

professionals involved with facilitating access to abortion services against the backdrop of an active sexual sterilization law in Alberta. It is my determination that Alberta's Sexual Sterilization Act privileged certain bodies such as white, Anglo-Saxon, cisgender heterosexual women, as shown through the oral histories from all four participants, while simultaneously restricting bodily autonomy of Indigenous and differently abled people.¹⁵ Further, for many Indigenous women and men as well as differently abled individuals, choice and consent was not included within the vernacular concerning their bodies and their rights. As historian Erika Dyck has discussed in, *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice* (2013), Alberta had the "largest and longest-standing sterilization policy in Canada and the only one in Canada or the United States to remove the need for informed consent."¹⁶ I agree with Dyck who further asserts that the history of abortion in Canada must also address the continuum of reproductive 'rights' and access to sexual and reproductive health services against the forty years of the Sexual Sterilization Act in Alberta that "witnessed the rise of new reproductive technologies, second-wave feminism, increased secularization, and the decriminalization of abortion."¹⁷ While the narratives from each of the four individuals I interviewed may not explicitly address the influence of eugenics or the correlation to increased access to abortion services, the vocabulary used on each application for a therapeutic abortion illustrates how medical

¹⁵ My view on the connection between the passing of the Criminal Law Amendment Act, 1968-1969, and the continuation of Alberta's Sexual Sterilization Act to promote eugenic practices is by no means original. There have been several prominent scholars who convincingly argue a similar claim. Sociologist Jana Grekul published a brief history of the eugenic boards in Alberta, "Sterilization in Alberta, 1928-1972: Gender Matters," in 2008. Similarly, scholars Claudia Malacrida and Erika Dyck have also done extensive research on the correlation of the reproductive rights movement and the continuation of sterilization in: *A Special Hell: Institutional Life in Alberta's Eugenic Years* (2015) and *Facing eugenics: reproduction, sterilization, and the politics of choice* (2013), respectively.

¹⁶ Erika Dyck, *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice*, (Toronto, ON: University of Toronto Press, 2013), 21.

¹⁷ Dyck, 21.

policies and practitioners attempted to control who had the ‘right’ to reproduce and who did not. I sample some applications for therapeutic abortions to contextualize the historical environment that each participant was situated within while attempting to navigate access to abortion services in Alberta.¹⁸

In *Abortion: History, Politics, and Reproductive Justice after Morgentaler*, historians Marion Doull, Christabelle Sethna, Evelyn Morisette, and Caitlin Scott discuss the emotional labour involved when research is both personal and political.¹⁹ They reflect on the emotional impact that researching abortion has on each researcher. Further, they state that, “autoethnography can be a suitable method of anti-oppressive research as it is intended to recognize researchers as embedded in the research process...”²⁰ In choosing to write on abortion, I had to closely analyze how women’s bodies have been historically understood. With my research into the ways in which women’s bodily autonomy was historically (and is presently) threatened, personal memories of instances of infringements on my bodily integrity resurfaced.

Set within the backdrop of the politics surrounding ‘choice’ as it pertains to one’s body, this thesis also explores the importance of self-reflexivity and the relationship between the interviewer and interviewee when conducting oral histories. Oral history theories value both the process and final result of each individual’s account. For this reason, I begin this discussion on the historical barriers to accessing abortion services in Southern

¹⁸ Dominion Bureau of Statistics, *Special Statement: Therapeutic Abortions in Canada: August 26th, 1969 to August 25th, 1970*, Catalogue number CS82-002-1970-2-eng.pdf in Statistics Canada [database online], Ottawa, ON., 1970 [accessed May 17TH, 2020], available from: http://publications.gc.ca/collections/collection_2018/statcan/82-002/CS82-002-1970-2-eng.pdf.

¹⁹ Marion Doull, Christabelle Sethna, Evelyn Morisette, and Caitlin Scott, “When Research is Personal and Political: Researchers Reflect on the Study of Abortion,” in *Abortion: History, Politics, and Reproductive Justice after Morgentaler*, (Vancouver, BC: University of British Columbia Press, 2017), 152.

²⁰ Doull et. al, 153.

Alberta from 1969 to 1988 with an explanation as to why I chose the topic of abortion. Each individual shared with me their experiences of accessing or facilitating abortions. Without this, my thesis would not be possible. To acknowledge the vulnerability involved in disclosing one's intimate history of their reproductive body to an outsider who has no experience accessing abortion services, I came to realize how this research is both personal and political.

Personally, I have never had an abortion. And while one does not have to experience having been pregnant, deciding to have an abortion, or going through with the abortion procedure to research this topic, I asked each participant to share with me intimate moments of their corporeal history. My own experience and emotions are also implicated in the space that I asked each narrator to share with me regarding their memory of abortion. In the article, "Discarded Histories and Queer Affects in Anne Carson's *Autobiography of Red*" literary scholar Dina Georgis focuses on "history's queer affective traces."²¹ Georgis describes 'queer' as not simply representing sexual orientation, but more broadly as tracing the "abject perversions of difference."²² Further, understanding the history of abortion involves analysis of individual memory and emotion through connection with other bodies. Georgis demonstrates that, "our selfhoods are always already narrated by the other and therefore implicated in the other. Our mutual dependency and vulnerability mean that we must learn to narrate each other's lives ethically, recognizing or giving attention to the other's suffering."²³ As Doull et. al have discussed, the researcher is embedded in the process of oral history and to fully engage in anti-oppressive research, such as furthering

²¹ Dina Georgis, "Discarded Histories and Queer Affects in Anne Carson's *Autobiography of Red*," *Studies in Gender and Sexuality* vol. 15, no. 2 (June 2014), 154.

²² Georgis, 154.

²³ Georgis, 141.

research on reproductive justice, it is helpful to share in moments of the narrator's suffering.²⁴ I was invited to enter a space of vulnerability as each individual I interviewed shared their memories.

I, too, would also like to invite the reader to share in my own experience of vulnerability as it has shaped my understanding of bodily autonomy. Engaging with the study of the historical barriers to accessing abortion, the themes of violation and discomfort paralleled my own history. At the age of six, I was molested by a boy following a church event at a friend's house. The first two people to whom I disclosed this information stated, "well, the next time this happens to you, just tell him, no." From a very early age, I came to understand that some experiences were meant to be shared and other, more unpleasant experiences, should remain unspoken. Further, my emotions regarding this memory and my understanding of my own body remained for many years unarticulated, confused, and shameful. Shame emerged when I spoke later about the experience. This shame was coupled with fear, as I grew aware of the possible perceived consequences that might occur from speaking out. As a child, I established my own means of strength by refusing to talk about that event for many years. Only recently have I addressed the ways in which relationships of power made my silence the appropriate reaction. Self-imposed silence absolved accountability from not only the abuser but also from the patriarchal institution that valued the abuser's experience more than mine. Just as the woman obtaining an abortion in Montana recalled the imperative of silence demanded by the 'abortionist,' I, too, experienced an imperative to be silent regarding speaking out about my body. As a child, I quickly understood my body not as my own but rather as a vessel that would

²⁴ Doull et. al, 153.

inevitably end in heteronormative marriage and motherhood. I was expected to conform to this ideology, both in practice and belief. Throughout my youth, I performed and conformed to this heteronormative construct. There was, however, an incongruity with how I portrayed myself that did not align with how I experienced my body or my history.

In disclosing this anecdote, I do not endeavor to detract from the experiences of the participants who shared their abortion narrative with me. Rather, I wish to illustrate how memory and emotions may serve as an analytic framework for any researcher who is conceptualizing autonomy in the research of abortion. Further, drawing on my own experience of my body as it relates to Georgis' definition of 'history's queer affective traces,' I aim to approach each narrative "ethically [while] giving attention to the other's suffering."²⁵ Applying a feminist lens in conducting each interview, I hoped to provide each participant with the space to explore the complex emotions in remembering their experiences with abortion. Each individual's experiences and memories are unique. Having the opportunity to listen to and witness the sharing of each narrator's history was my privilege as the oral historian.

My research is grounded in feminist theories of oral history, and in the growing scholarship on the history of emotion. Further, feminist oral historian Lynn Abrams describes how the process of studying history through oral history, "is increasingly an understanding of our selves" and therefore is affective.²⁶ Throughout each interview, each participant reflected on their emotional journey as it related to their encounters with others, whether those others be doctors, nurses, counsellors or other women.²⁷ These expressions,

²⁵ Georgis, 154.

²⁶ Abrams, 37.

²⁷ Lynn Abrams, *Oral History Theory*, (New York: Routledge, 2010), 36, 37.

both self-reflexive and relating to others, influenced how I have interpreted each narrative and come to understand each individual's history. Throughout the thesis, I incorporate how my own emotions and the emotions of each narrator shapes my understanding of the history of abortion in Alberta. In alignment with feminist approaches to oral history, I stress the importance of incorporating self-reflexivity and subjectivity as an added component of my analytic lens.

The first chapter of this thesis details the experience of two medical physicians, one a male-identified practitioner from Lethbridge, the other a female-identified practitioner from Calgary. Both served on TACs during the 1970s and 1980s. While the physicians are the primary interview subject, the implementation of regional, hospital-based, TACs not only shaped the experiences of many women in their efforts to obtain an abortion, but also, as previously discussed, is intertwined with the history of eugenics in Alberta and its effect on establishing criteria to adjudicate 'fit' and 'unfit' parents. The Sexual Sterilization Act not only influenced the response from medical practitioners involved with the TACs, as indicated in the responses from both retired practitioners with whom I interviewed, but it also impacted the lives of both men and women throughout Alberta. However, women were disproportionately more affected by the Act.

The second chapter focuses on the lived experiences of two women who had an abortion during the period of partial decriminalization (1969-1988) in Canada. The chapter also addresses the varying experiences of women's encounters with the TACs highlighting the historical memory of abortion in these decades. At the forefront of my analysis is the research question: how do I, as a historian, understand the history of access to reproductive services using an analysis of emotions? I expand on how oral history and the history of

emotion has influenced my research and analysis in a discussion on methodology and historiography in my third and final chapter.

Recruitment of Oral History Participants

All interviews were conducted in accordance with the guidelines outlined by the University of Lethbridge's Human Participant Research Committee.²⁸ The excerpts from my oral history interviews throughout this thesis do not represent all of the individuals that I interviewed while completing my research. I interviewed a total of seven individuals; however, this thesis focuses only on the experiences of four individuals: Dr. George Jacobson, Dr. Meredith Simons, Dr. Jean Harrowing, and Professor Irene Sisson, as their experiences most closely fit within the historical period of my analysis, between 1969 and 1988. The other participants, whose narratives are equally important, obtained abortions following the full decriminalization of abortion and as such, I did not include an analysis of their experiences in this thesis. I am beginning with this preface to my analysis to acknowledge that there are many voices and experiences that are not included within this thesis, but are deserving of research to more fully understand the layered barriers to accessing abortion services.

The location of each interview took place in different settings, but all followed the same protocol for conducting the oral history interview. Each individual was provided with an opportunity to review the letter of consent and questions prior to starting the recording of the interview and I invited them to change or omit any of my questions. This consent was ongoing as I frequently checked-in with each participant throughout the interview process. And while I follow a set of questions for each interview, the process was semi-

²⁸ Please see Appendix 1, Appendix 2, and Appendix 3.

structured. I was open to follow-up questions that also allowed each narrator to add or expand further on my questions. I additionally provided each participant with the opportunity to use a pseudonym. With the exception of one individual, Dr. George Jacobson, all participants opted to use their own name.

The scope of my research was limited to incorporating narratives from retired medical practitioners, specifically physicians, who sat on TACs and women who had obtained a therapeutic abortion (1969-1988). Recruitment for this thesis utilized both the snow-ball method, relying on word-of-mouth, and an intercampus letter of recruitment following a conference where I presented on the History of Women's Political and Social Activism in the Canadian West which took place in October 2016.²⁹ The snow-ball method of recruitment was by far the most effective method in recruiting participants for this thesis.

The process of recruitment was challenging not only because of the subject, but also because my research focuses primarily on the experiences of women and practitioners from rural Alberta. Women who had therapeutic abortions in rural Alberta did not, necessarily, remain in rural Alberta. Additionally, in order to obtain approval from the Human Subject Ethics Committee at the University of Lethbridge to interview medical professionals, the criteria required that doctors be retired so as to not violate patient-doctor confidentiality. After interviewing the four participants, I came to understand that the narrative on accessing abortion services in Alberta is far more complex than I had initially understood prior to the interviews. The oral histories brought forth memories of difficult conversations from each narrator, and also feelings of excitement, anxiety, pain, grief, and relief, to name only a few.

²⁹ Please see Appendix 4.

To understand the experiences from each participant, I applied a narrative-analysis technique. While a traditional narrative often has a beginning, middle, and end, the oral histories from the four participants throughout this thesis is much more complicated.³⁰ Oral historian Lynn Abrams describes two separate approaches to analyzing a narrative: “[Oral historians] can analyze the narrative shape of an oral history, and they can analyze the narrative content.”³¹ I apply both techniques to understand the experience from each participant. Meaning, although I focused on a specific event and historical period, the oral histories are fluid and ever-changing, and greatly informed by my involvement in the interview process. The ‘narrative turn,’ described by Abrams, took place in the 1970s and was embraced by oral historians and social scientists who challenged the positivist view of history, focusing on the ‘facts’ rather than the ‘meaning’ of the event to each historical actor.³² The ‘meaning’ behind accessing or facilitating an abortion changed greatly from the time of its occurrence to present date. The narrative of accessing abortion is affected by human interactions and ever-changing, as historians presently also acknowledge the experiences that were ignored and devalued at the time of partial decriminalization of abortion in Canada.

First described in the 1990s by activist Loretta Ross, addressing the experiences of women of colour, the inclusive term ‘reproductive justice (RJ)’ was coined to highlight the limitations of the Reproductive Rights movement of second wave feminism. Ross synthesizes the values of the RJ movement as follows, “Reproductive justice centers on three interconnected values based on human rights: the right *not* to have children by using

³⁰ Lynn Abrams, *Oral History Theory*, (New York: Routledge, 2010), 110.

³¹ Abrams, 124.

³² Abrams, 110.

safe birth control, abortion, or abstinence; the right to *have* children under the conditions we choose; and the right to *parent* the children we have in safe and healthy environments”.³³ As Cloder clarifies, “The RJ framework is distinct from the reproductive rights and reproductive health framework. The reproductive rights framework involves *protecting* a person’s right to reproductive health services, whereas the reproductive health framework involves the *delivery* and expansion of reproductive healthcare. On a more fundamental level, RJ uses an organizing framework to *understand* and root out reproductive oppression to achieve human rights and social justice.”³⁴

Ross’s definition of reproductive justice can also be applied to all scholarship pertaining to reproductive autonomy. I hope that this thesis will continue to insight ongoing dialogue and scholarship on the many tenants of reproductive justice.

³³ Loretta J. Ross, “Conceptualizing Reproductive Justice Theory: A Manifesto for Activism,” in *Radical Reproductive Justice: Foundations, Theory, Practice, and Critique*, eds., Loretta J. Ross, Lynn Roberts, and Erika Derkas et. al, (New York, NY: Feminist Press, 2017), 171.

³⁴ Charisse M. Loder et al., “Bridging the Expertise of Advocates and Academics to Identify Reproductive Justice Learning Outcomes,” *Teaching and Learning in Medicine* vol. 32, no. 1 (2020), 12.

Chapter One: Physicians Reflect on Therapeutic Abortion Committees

Twentieth-Century Views on Women's Bodies – Leading up to 1969 Omnibus Bill

The implementation of physician adjudicated Therapeutic Abortion Committees (TACs) across Canada allowed medical practitioners to moderate women's access to contraceptives and abortion. Similar to the first half of the twentieth-century, medical practitioners continued to establish the parameters for obtaining an abortion. Historian Wendy Mitchinson provides an overview of medical views of women's bodies during the first half of the twentieth-century. Mitchinson explores how prior to the partial decriminalization of abortion, instances of medical intervention to procure an abortion was completely dependent on life-threatening consequences if a pregnancy was carried to term. As in the first half of the twentieth-century, medical practitioners of the second half of the century established the parameters for obtaining an abortion as this chapter will show. Mitchinson discusses beliefs held by some medical professionals, "many physicians harboured the fear that if left to their own devices women would abort for frivolous reasons".³⁵ Historian Tracy Penny Light conversely argues, however, that the Canadian Medical Association's views on abortion and maternal health was also mitigated by public dialogue on abortion, "as much as Doctors shaped the discourse on abortion, they were also constrained by it."³⁶

Further adding to the conversation on the historiography of abortion prior to partial decriminalization, historian Shannon Stettner analyzes reactions from women across

³⁵ Wendy Mitchinson, *Body Failure: Medical Views of Women, 1900-1950*, (Toronto: University of Toronto Press, 2013), 184.

³⁶ Tracy Penny Light, "Shifting Interests: The Medical Discourse on Abortion in English Canada, 1850-1969," (PhD diss., University of Waterloo, 2003), 4.

Canada regarding the legality of abortion as represented in *Chatelaine*, *The Globe and Mail*, as well as articulated in the report issued by the Royal Commission on the Status of Women in 1970 (RCSW).³⁷ As these scholars demonstrate, views on abortion were articulated in national popular press, amongst medical practitioners, and by government officials; however, the experiences from women who obtained therapeutic abortions between 1969 and 1988 remains underrepresented within historical scholarship.

To challenge the dominant historiography on abortion in Canada, Stettner asserts that the inclusion of women's narratives is necessary to understand their struggle to access reproductive health services and the struggle for bodily autonomy after 1969. No one can speak to the lived experience of obtaining an abortion more accurately and profoundly as those who have navigated the complex medical network. The 1970s and the 1980s saw the implementation of TACs that were ever-changing, making it increasingly difficult for women to access abortions. Stettner further argues that, "By understanding the personal as political and accepting that individual voices can be powerful in shifting dominant understandings of the place of abortion in a modernizing society, we can suggest that women's voices in this decade were central to placing the abortion debate in the public sphere and contributing to change."³⁸ Public commentary in parliament, amongst medical professionals, and within popular Canadian magazines like *Chatelaine* politicized women's choices concerning autonomy. Women's bodies were pathologized to be suitable for motherhood or unsuitable for motherhood.

³⁷ Shannon Stettner, "Women and Abortion in English Canada: Public Debates and Political Participation, 1959-1970," (PhD diss., York University, 2011), 2.

³⁸ Shannon Stettner, "He is Still Unwanted: Women's Assertion of Authority over Abortion in Letters to the Royal Commission on the Status of Women in Canada," in *Abortion: History, Politics, and Reproductive Justice after Morgentaler*, eds. Shannon Stettner, Kristin Burnett, and Travis Hay (Vancouver: UBC Press, 2017), 98.

Identifying appropriate criteria for motherhood framed the questions asked by medical practitioners and is also reflected in the narratives from both women with whom I interviewed in the second chapter of this thesis. The undue scrutiny of women's bodies by medical professionals intensified the TAC process of accessing abortion services. This chapter reviews how medical practitioners reacted to the confusing 1969 Omnibus Bill that established TACs across Canada. The bureaucratic process, unclear guidelines, and the divisive views on abortion held across Canada and within the medical community during the twentieth-century influenced the memories of each retired medical practitioner.

Establishing Therapeutic Surveillance

Prior to its partial decriminalization in 1969, abortion in Canada was deemed a criminal act following the passing of Canada's first Criminal Code in 1892. According to the Criminal Code, anyone found in violation of Section 271, described as the "killing [of any] unborn child," was sentenced to life imprisonment.³⁹ In addition to the criminalization of abortion, women were further restricted by the state in controlling their reproductive autonomy as contraceptives also remained criminalized. Although illegal at the time, women in Canada had access to oral contraceptives as early as 1961.⁴⁰ Historian Tracy Penny Light observes that there had been a decrease from 28.2 live births per thousand women in 1957 to 18.2 per thousand in 1967; thus, illustrating the effectiveness of contraceptives since its availability to women in 1961.⁴¹ And while access to oral contraceptives existed, albeit still illegal at the time, doctors were still placed in the difficult position to either follow the Criminal Code that viewed abortion as a criminal act or defy

³⁹ Shannon Stettner, *Without Apology*, (Edmonton: Athabasca University Press, 2016), 34.

⁴⁰ Light, "Shifting Interests: The Medical Discourse on Abortion in English Canada, 1850-1969," 173.

⁴¹ Light, "Shifting Interests: The Medical Discourse on Abortion in English Canada, 1850-1969," 173.

it by medically intervening to abort on a woman's behalf. Reacting to the growing socio-political precedent within Canada that required a change to the state's stance on abortion, a group of physicians from the Canadian Medical Association (CMA) pressured legislators to reform the law. This motivation, however, was driven more out of a concern for the rights of doctors to perform a legal medical procedure rather than the rights of women to have bodily autonomy.

Although there was no uniform opinion held by all medical practitioners, the CMA reacted to the growing concern voiced by many physicians regarding the criminality of performing a therapeutic abortion to save a woman's life by pressuring the federal government to reform the laws concerning abortion. Light states that prior to the passing of the *Criminal Law Amendment Act, 1968-69*, "Doctors' discussions of their legal right to perform therapeutic abortions prompted the tabling of three separate Private Member's Bills recommending the revision of the Canadian Criminal Code with respect to abortion".⁴² The passing of the Omnibus Bill C-150, and the implementation of government sanctioned TACs across Canada, allowed the federal government to maintain a weak stance on women's right to reproductive autonomy. In an article published in 1982 chronicling the opposing views on abortion within the CMA and the Canadian government's weak response to these views, political scientist Larry D. Collins stated that, "The federal government's reaction was complex. It chose to give public symbolic support to reformers, while also giving quiet reassurance to the pro-life movement...It legitimized the doctors' *de facto* autonomy and generally tried to steer the controversy away from the

⁴² Light, "Shifting Interests: The Medical Discourse on Abortion in English Canada, 1850-1969," 172.

federal government and the governing party caucus.”⁴³ Further, given the contentious nature surrounding the discussion of reducing the legal challenges to accessing abortion, the federal government placed responsibility for controlling access to therapeutic abortions on medical professionals.

Scholarly works by Light and also other works by historian Jane Jensen focus on one aspect within the historical narrative on access to abortion in Canada prominently featured; mainly, the actions and dialogues that occurred within the CMA and amongst federal legislators. For example, Jensen argues that during the decades leading up to the partial decriminalization of abortion, “women...did not have the political resources to press their positions [about abortion] or even a language in which they could express them.”⁴⁴ Jensen’s views do not include the avenues that women did use to assert their opposition to the restrictions that would be imposed on them by the amended 1969 abortion law. Historian Shannon Stettner argues that, “Although a woman’s magazine, *Chatelaine*, is often credited with opening public discussion of abortion... subsequent public debate highlighted the place of physicians, represented by the Canadian Medical Association (CMA)”.⁴⁵ Indeed, doctors remained the default public authority concerning women’s bodies rather than women themselves.

At a press conference on May 29th, 1970, in Vancouver, BC, one year following the passing of the Omnibus Bill C-150, one woman expressed her opposition to the limitations

⁴³ Larry D. Collins, “The Politics of Abortion: Trends in Canadian Fertility Policy,” *Atlantis* vol. 7, no. 2 (Spring 1982), 3.

⁴⁴ Jane Jensen, “Getting to Morgentaler: From One Representation to Another,” in *The Politics of Abortion*, eds. Janine Brodie, Shelley A.M. Gavigan, and Jane Jensen (Toronto: Oxford University Press, 1992), 25.

⁴⁵ Shannon Stettner, “‘He is still unwanted’: Women’s Assertions of Authority over Abortion in Letters to the Royal Commission on the Status of Women in Canada,” *Canadian Bulletin of Medical History* vol. 29, no. 1 (2012), 152.

of the amended law and the subsequent impact of the law on women's lives in a meeting with then Prime Minister, Pierre Trudeau:

Well, your law simply reinforces a situation that already exists. It simply lets women go through eight doctors before they can get an abortion. That they have to beg and plead insanity before they can get an abortion...Because that law hasn't given women anymore abortions than existed before...and you haven't answered to us in any way, and we're angry. I want you in some way to give some explanation why the government thinks it doesn't even have to talk to us.⁴⁶

While this excerpt may convey the frustration and anger of one white, cis-gender woman, her voice also amplifies the anguish that many other women in Canada experienced from the time of partial decriminalization of abortion in 1969 and the implementation of TACs across Canada, until the complete decriminalization of abortion in 1988. This anger, regarding the limitations of Omnibus Bill C-150, was intensified throughout the early twentieth-century and is evident in popular Canadian print women's magazines like *Chatelaine*.⁴⁷ Conversations amongst women advocating both for and against abortion occurred in tandem with conversations shared amongst members of the CMA.⁴⁸ Under the direction of feminist editor, Doris Anderson, *Chatelaine* encouraged dialogue involving changes to the current abortion law in Canada. Anderson first became editor of *Chatelaine* in 1957. And, as historian Shannon Stettner discusses in her unpublished dissertation, "Women and Abortion in English Canada: Public Debates and Political Participation, 1959-70", *Chatelaine* was publishing articles on the partial

⁴⁶ CBC News, CBC Archive: *The Omnibus Bill doesn't go far enough*, 1970, audio from 00:48-01:37, from an interview aired on CBC, May 29th, 1970, accessed on 9th April, 2016, <http://www.cbc.ca/archives/entry/the-omnibus-bill-doesnt-go-far-enough>.

⁴⁷ Joan Finnigan, "Should Canada Change Its Abortion Law?" *Chatelaine*, October 1959, in Valerie J. Korinek, *Roughing it in the Suburb: Reading Chatelaine Magazine in the Fifties and Sixties*, (Toronto, ON: University of Toronto Press, 2000), 306.

⁴⁸ Shannon Lea Stettner, "Women and Abortion in English Canada: Public Debates and Political Participation, 1959-70," (PhD diss., York University, 2011), 72.

decriminalization of abortion as early as 1959.⁴⁹ In the 1959 article titled, ‘Should Canada Change Its Abortion Law?’ for example, freelance journalist Joan Finnigan argued for changes to abortion law but maintained the argument that medical practitioners held expertise over women’s bodies, and as such, should not be held legally liable for intervening to save a woman’s life.⁵⁰

Efforts by medical practitioners of the CMA to loosen the regulations on abortion in Canada during the 1950s were primarily motivated out of self-interest to legally protect the physician. For example, during the 1950s the CMA established the Maternal Welfare Committee to address issues of maternal health and mortality, including the topic of abortion.⁵¹ The mounting pressure within the CMA, regarding individual members’ stance on their involvement in procuring abortions, led to increased pressure on the federal government to reform the Abortion law. Consequently, in 1966, the CMA put forward support to reform the law on abortion by allowing for medical intervention to procure an abortion in certain cases. In her introduction to the edited collection, *Without Apology: Writings on Abortion in Canada*, Stettner argues that, “although reducing maternal mortality was certainly a concern, [these professional] organizations founded their support for abortion law reform primarily on the fears about the potential prosecution of doctors who were willing to risk performing therapeutic abortions, rather than on sympathy for the situation of women who sought abortions for reasons other than medical.”⁵² Indeed, physician self-interest is briefly discussed in the interviews with both retired medical

⁴⁹ Stettner, “Women and Abortion in English Canada: Public Debates and Political Participation, 1959-70,” 72.

⁵⁰ Stettner, “Women and Abortion in English Canada: Public Debates and Political Participation, 1959-70,” 72.

⁵¹ Stettner, *Without Apology*, 41.

⁵² Stettner, *Without Apology*, 41.

practitioners who sat on the TACs. Both voiced support for the loosening of barriers to accessing abortion but such access was not often welcomed amongst their peers.

In 1966 in the *Canadian Medical Association Journal*, medical practitioner, C.P. Harrison argued that, “in my opinion, there may be no law that will be effective in preventing or reducing ‘criminal abortion’ except in one circumstance namely, that no form of abortion be made illegal. However ineffective the present law may be, it is reasonably certain that any change in it cannot be expected to improve the situation materially and may, in many ways, make it worse”.⁵³ Even prior to the partial decriminalization of abortion, some medical practitioners saw the anticipated changes to the law on abortion as more inhibitive for both practitioners and for women seeking the procedure. Despite the efforts of some medical professionals within the CMA to advocate for full decriminalization of abortion, the changes to the Criminal Code in 1969 absolved the government from taking a clear stance on the legality of abortion as it pertained to a woman’s autonomy. The divisive conversations that took place during the 1960s, in advance of the omnibus bill of 1969, foreshadowed the many challenges that would be imposed on women with the establishment of TACs. Ironically, despite the limited knowledge within the medical profession concerning women’s reproduction, public debate concerning abortion prominently featured the opinions of medical professionals as the authority on matters such as sexual and reproductive health. And while medical professionals had a prominent voice concerning the parliamentary move to partially decriminalize abortion, they were by no means the only voice expressing concern about access to sexual and reproductive health services across Canada.

⁵³ C.P. Harrison, “On the Futility of Legalizing Abortion,” *Canadian Medical Association Journal* vol. 95 (1966), 360.

With vocal support from practitioners of the CMA, parliamentary debate surrounding the partial decriminalization of abortion was additionally sparked by Prime Minister Lester Pearson's establishment of the Royal Commission on the Status of Women (RCSW) in February, 1967, in reaction to pressures for gender equity made by prominent feminists and affiliated organizations.⁵⁴ Political scientist Louise Chappell states that, "women belonging to traditional women's organizations, such as the Canadian Federation of University Women, the YWCA, and the Business and Professional Women's Clubs, succeeded in pressuring the Pearson government to establish the RCSW."⁵⁵ The purpose of the RCSW was to inquire into and report on the status of women across Canada as well as make recommendations that would lead to equality with men in all spheres including, education, workplace, politics, and unprejudiced access to medical care, to name a few areas that disproportionality privileged white, male-identified individuals. Interdisciplinary scholar Benita Bunjun argues in her dissertation that the RCSW acted as both a "counter-hegemonic and a hegemonic record [in] challeng[ing] state gender oppression while [also] reinforcing processes of exclusion for marginalized groups of women".⁵⁶ In addition to the over-representation of cis-gendered, able-bodied, heterosexual women, with the exception of Lola Lange, little representation was also given to women residing in rural areas across Canada.⁵⁷ As I explore later in the subsequent chapter, the barriers for women residing in rural areas across Canada drastically impacted their access to TACs. Public commentary in parliament, amongst medical professionals, within the report published by RCSW, and

⁵⁴ Stettner, 42.

⁵⁵ Louise Chappell, *Gendering Government: Feminist Engagement with the State in Australia and Canada*, (Vancouver, BC: UBC Press, 2002), 24.

⁵⁶ Benita Bunjun, "The (Un)making of Home, Entitlement, and Nation: An Intersectional Organizational Study of Power Relations in Vancouver Status of Women, 1971-2008," (PhD diss., University of British Columbia, 2011), 89.

⁵⁷ Bunjun, 90.

within popular Canadian magazines like *Chatelaine* politicized women's choices concerning autonomy.

The growing pressure to decriminalize abortion as expressed by primarily middle-class women across Canada coupled with support from the CMA provided Prime Minister Pierre Trudeau a strong platform for the passing of the Criminal Law Amendment Act, 1968-1969. The Omnibus Bill C-150 revised the Criminal Code with the full decriminalization of contraceptives and the partial decriminalization of abortion. In April 1970, the *British Journal of Criminology* clarified some aspects of section 237 under clause 18 of the changes to abortion law in Canada:

Qualified medical practitioner[s] who in good faith use any means in an accredited hospital for carrying out his intention to procure the miscarriage of a female person, provided that it has already been stated that the continuation of the pregnancy of such female person would be likely to endanger 'her life or her health.' This last phrase...is wide enough to cover both the mental and physical health of the female person.⁵⁸

Accordingly, the criteria for pregnancies deemed to endanger the health of women varied widely based on differing makeups of TACs across Canada. Under the new federal law, TACs consisted of a minimum of three doctors who reviewed requests for therapeutic abortion on a case by case basis. Each province and territory understood federal law regarding abortion differently. Physicians who volunteered or were recommended to sit on TACs often held opposing views as to how the new law on abortion was to be interpreted and enforced. The two medical practitioners with whom I interviewed had drastically different understandings of their roles in facilitating access to abortion. What remained constant across Canada, according to the *Criminal Law Amendment Act*, was the

⁵⁸ Jay C. Prober, "The Criminal Law Amendment Act 1968-1969 (Canada)", *The British Journal of Psychiatry*, Vol. 10, no. 2 (April 1970), 181, 182.

understanding that access to abortion procedures was to remain in control of medical professionals. Therefore, the bodies and lives of women were governed by mostly male medical practitioners acting on behalf of similarly predominantly male legislators.

Remembering the TACs – Physician Memories

“In the absence of a body, is a patient truly real to the doctor?
What is a patient without [her] body?”⁵⁹

The above quotation from Swiss medical historian, Micheline Louis-Courvoisier, posits a question that can be applied to and disrupt the organization and operation of TACs. Ironically, given the invasiveness of the therapeutic abortion application, that would be submitted by a referring physician on behalf of a woman, and the intrusiveness of the therapeutic abortion process in the hospital setting, members of the TAC would likely never meet or know the female patient.

The two medical practitioners with whom I interviewed had drastically different understanding of their roles in facilitating access to abortion. Both individuals were retired medical professionals. One, a white, upper class male, Dr. George Jacobson, who immigrated to Lethbridge to practice medicine and was recruited to sit on the Lethbridge TAC.⁶⁰ The second, Dr. Meredith Simons, was born in Seattle, Washington in 1946 before moving to Montreal in the 1960s.⁶¹ The questions that I developed for each medical practitioner were designed to address their professional views of the TAC process and

⁵⁹ Micheline Louis-Courvoisier, “Qu’est-ce qu’un malade sans son corps?” in Sonja Boon, *Telling the Flesh: Life Writing, Citizenship, and the Body in the Letters to Samuel Auguste Tissot*, (Montreal, QC: McGill-King’s University Press, 2015), 25.

⁶⁰ To protect his identity, Dr. George Jacobson is using an assigned pseudonym that will be used throughout this thesis. I have also deliberately concealed the country that Dr. Jacobson immigrated from to further protect his privacy.

⁶¹ At the time of our interview, Dr. Meredith Simons was provided with the opportunity to use a pseudonym rather than her legal name. Dr. Simons declined my suggestion and will be referred to as she prefers, Dr. Simons. Additionally, I contacted Dr. Simons following my MA defense to further confirm that she was comfortable with the use of her name.

therefore differed from the questions that I asked of women who had procured an abortion.⁶² Both practitioners were provided with the opportunity to use a pseudonym and opt-out of answering any questions I posed. In spite of their differing views of their involvement on the TAC, both Dr. Jacobson and Dr. Simons maintained the opinion that abortion should be available for women.

At the beginning of all of the interviews with both the medical practitioners and with the two women, I explained that I was conducting a semi-structured interview. A series of questions guided the conversation but follow-up questions based on the participant's reply might also be asked. Additionally, at the end of the interview, I provided each participant with the opportunity to direct any question or concern towards me, the interviewer, regarding my use of their narrative.

Each discussion differed significantly; however, the interviews with both retired medical professionals, Dr. Jacobson and Dr. Simons, highlighted the inconsistencies in the operation of TACs and the subsequent frustration they experienced. The conversations between myself and each of these retired individual physicians illustrates that while the *Criminal Law Amendment Act* and the establishment of the physician mediated TACs did to some degree reform the level of restriction on women's reproductive autonomy, medical practitioners also experienced the process as impediment to practicing medicine. Both experienced confusion surrounding the uniform implementation of the Act. Further, as I discovered in the interview with Dr. Simons, she felt tangible fear surrounding the potential violent consequences from those citizens opposed to abortion. As Simons described, this fear was ever present, even within the regulated confines of the hospital and medical clinic.

⁶² Please see Appendix 1, pg.

Remembering the TACs - Dr. Meredith Simons

Shannon Ingram, (SI): And how much training did you receive in medical school on medical procedures such as therapeutic abortions?

Dr. Meredith Simons, (DS): None (laughs). Very little was mentioned, even mentioned, yet alone training. I had to get that all afterwards. After my medical school and after my residency as well.

SI: Do you ever remember a conversation where it came up in medical school or did it ever come up?

DS: (Pause). I can't really remember to tell you the truth. It's been a long time, but if it did come up, it would have been absolutely minimal.⁶³

The above exchange begins my interview with Dr. Meredith Simons. Dr. Simons attended Medical School at the University of Calgary in Alberta from 1976 to 1979, before completing a residency in Family Practice from 1979 to 1981.⁶⁴ Dr. Simons decided to practice Family Medicine as she felt compelled to choose a stream of medicine that allowed for more flexibility for her young family despite her interest in obstetrics and gynecology (OBGYN). Dr. Simons may have begun her medical practice focusing on family medicine, but she soon began to dedicate her time to improving access to reproductive health services for women. First, she was involved with the Foothills Hospital TAC in Calgary, approving abortion procedures. Subsequently, following the full decriminalization of abortion in 1988, Dr. Simons continued performing abortions as a full time practitioner at the Calgary based free-standing private, Kensington Clinic.⁶⁵

Dr. Simons' memory of her time as a member on the Calgary TAC is informed by the ways in which the change in the Abortion law affected the actions of physicians as well

⁶³ 01:50-02:50, interview with Dr. Meredith Simons by Shannon Ingram, 27th February, 2016.

⁶⁴ 00:40-01:00, Dr. Simons, 27th February, 2016.

⁶⁵ "Making Your Decision," *Kensington Clinic*, accessed on 18th May, 2020, <https://kensingtonclinic.com/making-your-decision/>.

as the expected antagonism from anti-choice activists who targeted practitioners like herself. During moments of silence during our interview, Dr. Simons struggled to recall details from the time that she served on the TAC. She did, however, recall a general consensus from colleagues who sat on the Calgary-based TAC that if a woman went through the arduous process to apply for a therapeutic abortion, they approved each application without question. For Dr. Simons, the invasive and bureaucratic process of the TAC was a trauma that women unnecessarily endured as they awaited approval from the committee for an abortion. As Simons implied, the decision to unanimously approve each application was a deliberate act from the Calgary TAC in reaction to the arbitrary operation of the TAC. Contrastingly, Dr. Jacobson received his diploma in OBGYN but never performed abortion procedures during his years in medical practice.

Remembering the TACs - Dr. George Jacobson

Dr. George Jacobson was born on 10th January 1936.⁶⁶ Dr. Jacobson was one of many doctors who immigrated to Canada following the Second World War with hopes of forging a more lucrative medical practice in Canada. His involvement with the Lethbridge TAC, located at the Lethbridge Municipal Hospital, began in 1972 and lasted just over a year. Our interview took place on Friday, October 25th, 2015 at his home in Lethbridge, Alberta. Differing perspectives of both narrators regarding their role in the operation of the TAC is apparent from both of my interviews with Dr. Jacobson and Dr. Simons. The attitudes from Dr. Simons and her colleagues diverged in meaningful ways from the views from Dr. Jacobson and the Lethbridge TAC, as is visible in the following excerpt from my interview with him:

Shannon Ingram (SI): And what can you tell me about the makeup of the committee?

⁶⁶ 01:36, Interview with Dr. George Jacobson, pseudonym, by Shannon Ingram, 23rd October 2015.

Dr. George Jacobson (DJ): As I recall it, it was usually four people. Occasionally, I think five. I think the fifth one was added as an alternate...I think we met every two weeks at lunchtime in the hospital [Lethbridge Municipal Hospital] at the library. And because of the urgency of the matter, the applications would come from doctors within the community to the hospital committee...and the committee would then form a total block on the application proceeding any further.

SI: Could you expand a little further on the what the criteria was for either accepting or blocking an [application] and what the follow-up was like?

DJ: There was no criteria laid down. The committee had to vote, 'yes' or 'no'. So, we were given...I'm sure we were given the name of the patient; the age of the patient; the parity of the patient, that is the previous number of pregnancies...the medical history of the patient and usually the social history of the patient because the referring doctor would have included all of this on the application...and the religion of the patient.⁶⁷

Throughout our interview, and briefly mentioned in the above quotation, Dr. Jacobson stressed the importance of not challenging the recommendations from the referring doctors. The excerpt of our exchange demonstrates that during the years following the partial decriminalization of abortion, practitioners like Dr. Jacobson received little guidance from legislators as to how medical professionals were to implement access to therapeutic abortions although the committee structure was highly mediated. Indeed, there is a stark contrast in the memories of both the Lethbridge TAC, shared by Dr. Jacobson, and the Calgary TAC, shared by Dr. Simons as there is almost a decade difference from both of their time on the TAC. Although it may appear as though Dr. Jacobson applied a more scrupulous approach in reviewing applications compared to Dr. Simon's, it is also important to recognize the novelty of the TAC process that was evident in the lack of clarity regarding the operation of the committees. Indeed, while both medical practitioners may have approached their roles on their respective TACs differently I believe that each

⁶⁷ 13:10-16:15, Interview with DJ, 23rd October 2015.

individual, Dr. Jacobson and Dr. Simons, were both of the opinion that women should have access to abortion services.

Enforcing the Structure of TACs

Following the passing of the *Criminal Law Amendment Act*, each governing TAC in cities across Canada was responsible for reporting on therapeutic abortions. Beginning in August 1969, in what later became known Statistics Canada, the Dominion Bureau of Statistics began a ‘monthly summary count reporting,’ a system to account for the number of therapeutic abortions performed across the country and the demographics of women receiving the medical procedure.⁶⁸ During the early years following partial decriminalization of abortion, the monthly reports merely “counted” the number of women who obtained abortions from within each province. Also reported were women from other provinces/territories receiving an abortion, and a count of abortions performed on ‘non-residents of Canada’.⁶⁹ During the first full year, from August, 26th, 1969 to August 25th, 1970, all ten provinces and the Yukon Territory submitted reports to the Domestic Bureau of Statistics (DBS), documenting the hospitals with approved TACs and accredited hospitals where therapeutic abortions were performed.⁷⁰ Within Canada, of the 1,392 hospitals, 143 had a TAC.⁷¹ Within Alberta, 18 hospitals out of a possible 164 hospitals had a TAC.⁷² Important to note, however, was the lack of qualitative data that was collected or incorporated by this system of reporting designed by Statistics Canada. And yet, in spite

⁶⁸ “History of the Therapeutic Abortion Survey,” *Statistics Canada*, last modified 21st August, 2009, http://www23.statcan.gc.ca/imdb-bmdi/document/3209_D1_T9_V7-eng.pdf.

⁶⁹ *Ibid.*

⁷⁰ Dominion Bureau of Statistics, *Special Statement: Therapeutic Abortions in Canada: August 26th, 1969 to August 25th, 1970*, Catalogue number CS82-002-1970-2-eng.pdf in Statistics Canada [database online], Ottawa, ON., 1970 [accessed May 17th, 2020], available from: http://publications.gc.ca/collections/collection_2018/statcan/82-002/CS82-002-1970-2-eng.pdf.

⁷¹ *Ibid.*

⁷² *Ibid.*

of the absence of qualitative experiences from women who sought therapeutic abortions, many TACs across Canada relied greatly on the ‘social’ history of each woman that was presented by the referring physician to approve or reject an application for a therapeutic abortion.

The ‘social history’ of each patient that Dr. Jacobson alluded to in the above excerpt from our interview was formalized officially for women applying for a therapeutic abortion beginning in 1972. From 1972 to July 1986, representatives from the federal departments of Health and Welfare, Statistics Canada, the Society of Obstetrics and Gynecologists, and the CMA created ‘an individual case report form,’ which featured the broad umbrella term of, ‘social history’ of each woman. This qualitative-based form provided greater insight into the lives women who sought abortion at this time and included: “province of residence, marital status, age/date of birth, previous deliveries [and] abortions, date of last menses/gestation period, abortion procedure [needed], sterilization [if it was part of the procedure], complications [and] days of hospitalization.”⁷³ By no means representative of the complex lived realities of many women and youth who sought access to abortion services, the qualitative information that was provided on these more extensive applications viewed by the TAC points to the problematic lens that some boards used to approve or deny a woman’s request for a therapeutic abortion.

It is significant, in my view, that Dr. Jacobson’s memory of the Lethbridge TAC notably contrasts with Dr. Simons’ recollection of the Calgary TAC and the latter’s more liberal treatment of women’s applications. With the little guidance initially given by the federal government, combined with the little to no medical training on procedures such as

⁷³ Ibid.

abortion, many practitioners like Dr. Jacobson first and foremost relied on the knowledge of the referring physicians within their network to navigate the decision making process that had been transformed by the 1969 amendments to the Criminal Code.

Dr. Simons, contrastingly, recalled ‘a more liberal’ attitude from physicians who served on the Calgary TAC. Upon further questioning, however, Dr. Simons did observe that there was still a certain degree of trust assumed by practitioners serving on the Calgary TAC towards the referring physician. They consistently believed that referring professionals would further educate women following the procedure, suggesting options for controlling their reproduction like oral contraceptives, IUDs, or other measures such as tubal ligation. This excerpt from my interview with Dr. Simons highlights not only the unanimity of their decisions but her insight about the trust they invested in referring physicians:

DS: In the Foothills hospital, our committee was a rubber stamp. It didn’t matter...if the woman wanted an abortion, the three of us were of the same mind that we didn’t bother to make any comments like, ‘oh, she needs this for her mental health or her physical health.’ If she needed an abortion, she needed an abortion. Period. And so, I was very lucky in that way. The committee was very liberal, thank goodness, and it was just a nuisance to have to meet once a week to have to sign the papers.

SI: So, you never made any recommendations for tubal ligations or sterilizations?

DS: At that point, no. We just made the abortion procedure available to the patient that needed, that wanted, one. And when the abortions were performed, it was left to the doctors and nurses performing the abortion to talk about things like contraception.⁷⁴

While Dr. Jacobson describes the ways in which the committee ensured that access to abortion was controlled, stating, ‘the committee would form a total block on the application’, Dr. Simons

⁷⁴ 07:10-08:30, interview with Dr. Meredith Simons, 27th February, 2016.

shared her frustrations with the pedantic process that took her away from seeing patients or that further restricted women's bodily autonomy.

Comparing the memories from both physicians, Jacobson, a male physician from Lethbridge and Simons, a female physician from Calgary, highlights the inconsistencies of the practitioner's attitudes towards women. As Simons noted, after going through the TAC, most hoped that additional guidance from medical professionals was given to women regarding their reproductive choices following their abortion procedure. For some women, the birth control pill was suggested. However, sterilization was also proposed as an option if physicians deemed a woman unsuitable to parent. Yet the interviews also revealed the extent of a physician's involvement in women's continued healthcare following the abortion procedure also varied greatly across Alberta. Dr. Simons, for instance, does not recall making any recommendations for contraception, stating, 'it was left to the doctors and nurses performing the abortion to talk about things like contraception.' Her role in the TAC process was compartmentalized as she allowed and trusted other medical professionals to do their assigned jobs and adhere to their ethical obligations.

As I have already implied, despite the significant history on the operation of TACs, there has been much less historical consideration of the lived experiences from women who accessed therapeutic abortions. This does not mean, however, that conversations did not occur amongst women concerning the treatment they received from physicians, some of whom were more likely to support a woman in her decision to have a therapeutic abortion. The disproportionate access to therapeutic abortions across Canada has been historically documented in 1986 by historians Angus McLaren and Arlene Tiger McLarens', *The Bedroom and the State: The Changing Practices and Politics of Contraception and*

Abortion in Canada, 1800-1980. As they noted, following the passing of the 1969 Criminal Law Amendment Act, one could argue that access to abortion had been more equitably distributed across Canada. The 1969 Bill that included the partial decriminalization of abortion and the legalization of contraceptives was touted by some within the Trudeau government as monumental in shifting the federal views on women's rights. There were, however, others such as federal Justice Minister John Turner who, upon the passing of the Omnibus Bill C-150, viewed the Criminal Code as outdated and more representative of a "nineteenth-century document" that failed to capture the current socio-political landscape in Canada during the twentieth-century.⁷⁵

This conflicting interpretation among political leadership and regional inconsistencies in implementation of the bill allowed for provincial discretion concerning TACs and women's access to abortion services. The illusion of equitable access was far from reality for women. As McLaren and McLaren argue, the apparent 'liberalization' of the abortion law in 1969 disproportionality favoured white middle-class women.⁷⁶ Adding to the stress imposed on women who did decide to travel to access a therapeutic abortion, McLaren and McLaren further argue that, "Even hospitals with committees interpreted the law in dramatically different fashions."⁷⁷ Factors such as age, geography, religion, race, dis(ability), and class all impeded women's access to those physicians willing to refer for

⁷⁵ Peter Loucks and John Turner, "Omnibus Bill: A New Era in Canada," Aug. 26th, 1969, in *The World at Six*, produced by CBC Digital Archives, <https://www.cbc.ca/archives/entry/omnibus-bill-a-new-era-in-canada>.

⁷⁶ Angus McLaren and Arlene Tigar McLaren, *The Bedroom and the State: The Changing Practices and Politics of Contraception and Abortion in Canada, 1800-1980*, (Toronto: McClelland and Stewart Limited, 1986), 137.

⁷⁷ McLaren and McLaren, 137.

a therapeutic abortion and these characteristics of the applicants were also flagged by some TACs, influencing whether an application was more or less likely to be approved.

The history of eugenics and the manner by which eugenic views intersect with the implementation of TACs is debated by medical historian Erika Dyck who argues that some women with access to financial means and social support traveled to Alberta for therapeutic abortions. This interprovincial travel, she suggests, was a reaction to the lack of hospitals willing to perform therapeutic abortions in neighboring provinces: “39 per cent of the abortions in 1972 were performed on women who lived in the Northwest Territories, 33 per cent on women from British Columbia, and 23 per cent from women from Saskatchewan.”⁷⁸ As her analysis implies, eugenic views remained intertwined with the results of TACs as each physician and committee interpreted the application for the procedure based on their personal belief of who was ‘fit’ and ‘unfit’ to parent. Further, physicians’ interpretation of the law was additionally influenced by policies on eugenics that circulated throughout the late nineteenth and early twentieth-century. As Dyck states, the decades leading up to the partial decriminalization of abortion and following the establishment of TACs, “persistent concerns about intelligence, maturity, mental health, and suitable motherhood remained a part of these [physician] debates and continued to justify abortion and sterilization policies aimed at women who were marginalized or had mental and intellectual disabilities.”⁷⁹ These eugenically derived ‘concerns’ adopted by physicians surfaces in the below excerpt from my interview with Dr. Jacobson:

SI: And what was included in the patient’s social history? Was it just demographics, more or less?

⁷⁸ Dyck, 203.

⁷⁹ Dyck, 202.

DJ: Um, details of the...attachment or the occasion or the reason for the pregnancy occurring. In that particular person, living common law, um, a matter of rape. Um, the previous history would be given with regard to pregnancy...but you asked about the social side. Um, we would normally be given, it was actually up to the referring doctor, almost entirely general practitioners but not totally because psychiatrists would send us some cases because they had been the earliest contact...The pregnancy test had been positive and that was known to us at the time. We did not interview the patients. We did not communicate with the patients. The...I don't actually know how the patients got to know. Yes, the patients must have been contacted through their doctors because the answer would go back to the doctor and the doctor would be responsible for conveying that information.... Um, so descriptions of people's social situation. They were, might be that they had an unfavorable childhood themselves, their marital status would be known, their ethnic origin, whether they were foreigners or indigenous, um, Indian people, for example, whether there was drugs or alcohol, these would be referred to or communicated to us, but not in every case.⁸⁰

Although it is not possible for me to fully understand why Dr. Jacobson was unable to remember the 'social histories', which formed a strong case for refusing or approving a woman's application for an abortion, it is possible to consider the detachment that was required of medical professionals who held the power to make decisions that had a profound impact on women's lives.

In the above response, Dr. Jacobson highlights a prevalent issue discussed by those who theorize the methodologies and value of oral histories: the frequency of, 'memory blocks.' Historian Lynn Abrams theorizes on the importance of not only the spoken word, but times when an interview subject struggles to articulate meaning and identity of events, as exemplified by Dr. Jacobson's struggle to speak on the 'social history' of the women.⁸¹ Abrams states that, "the important part here is that memory is not just a source; it is the narrator's interpretation of their experience and as such [the memory of each interviewee] is complex, creative, and fluid."⁸² Oral historians rely on the narrator's memory as a

⁸⁰ 16:50-19:45, interview with Dr. Jacobson, 23rd October, 2015.

⁸¹ Abrams, 104.

⁸² Abrams, 105.

primary source. Each individual narrative shapes the subject's understanding of the past as it relates to their identity. A memory block may then act as a form of self-protection for the narrator to assert control in the interview process.

During my interview with Dr. Jacobson, what was not explicitly discussed, but was ever present, was the long reach of Alberta's eugenically informed Sexual Sterilization Act. Passed in 1928, Alberta's Sexual Sterilization Act remained in place until 1972.⁸³ Alberta, having the most active role in controlling reproduction of both men and women deemed 'unfit for parenthood,' used institutionalization and forced sterilization to prohibit individuals from having children. Dyck has stated that during the years between the passing of the Sexual Sterilization Act in 1928 and the repeal of the act in 1972, "the Alberta eugenics program recommended sexual sterilization surgeries for 4,725 individuals, and ultimately performed operations on 2,822 people."⁸⁴ Alberta stood out amongst other Canadian provinces and territories for its eugenic views and attempting to establish a hierarchy that favoured white Anglo-Saxon, mostly Protestant, individuals. Although eugenic views circulated across Canada during the nineteenth and twentieth-century, they were far more palpable across the Canadian prairies. Tracing the historical development of these views, Dyck argues that during the early twentieth-century, "religious movements erupting in western Canada also helped to fuel the anti-'Other' rhetoric that lay at the heart of eugenic values... Gradually these voices harmonized in a chorus of political support for more stringent restrictions on immigration policy, along with a narrowing focus on controlling the existing population."⁸⁵ These eugenic values resurfaced amongst public

⁸³ Erika Dyck, *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice*, (Toronto: University of Toronto Press, 2013), 4.

⁸⁴ Dyck, 4.

⁸⁵ Dyck, 10.

discourse around conversations of women's bodies leading up to and following the 1969 partial decriminalization of abortion. Dyck explains how these earlier language and circumstances were redeployed during the 1970s and the 1980s:

Rather than usher in a new era of language describing reproductive rights and choices, the public discourse on abortion returned to an older set of attitudes that refocused the blame on women, combined elements of sexuality with accusations of immorality, and questioned the viability of abortion for middle-class women while sanctioning them along with the sterilization of women considered to be less desirable mothers, including those who were either young or disabled.⁸⁶

It is my contention, in concert with Dyck, that eugenic values prevailed and influenced the actions of some physicians in approving or denying a woman's application for a therapeutic abortion.

Additionally, in some cases, approving a therapeutic abortion was contingent on women's adherence to the referring physician's recommendations that she control her fertility post procedure. And while it may seem fitting to scrutinize individual medical practitioners, it is perhaps more accurate to understand how these views existed within the medical profession where paternalism and the influence of eugenics dominate attitudes towards women's bodily autonomy during the twentieth-century.

Dr. Jacobson, having obtained his medical degree and education in Britain, was also privy to the operation of TACs before they were implemented in Canada. Published in 1966 in the *British Journal of Psychiatry*, the "Royal Medico-Psychological Association's Memorandum on Therapeutic Abortion" was released and contained many similar guidelines that would also be adopted in Canada, following the passing of the 1969 omnibus bill.⁸⁷ Within the Memorandum, several guidelines were outlined by the Royal

⁸⁶ Dyck, 25-26.

⁸⁷ "The Royal Medico-Psychological Association Memorandum on Therapeutic Abortion," *British Journal of Psychiatry* vol. 112, (1966): 1070-1073.

Medico-Psychological Association that greatly adhered to eugenic beliefs salient within the twentieth-century, such as: measures to reduce “population growth...[reducing the likelihood of a child to be] born seriously handicapped...young parents who, because of their genetic constitution, face a heavy risk of producing an abnormal child...when a severely subnormal woman, or one who is suffering from severe chronic mental illness, becomes pregnant”.⁸⁸ Indeed it is more fitting to understand Dr. Jacobson’s attitudes as more symptomatic of the problematic views within the medical profession and his early exposure to these values as motivating the operation of TACs in Britain.

Perhaps influenced by her experience in medical school or perhaps influenced by her upbringing in Montreal, Dr. Simons’s recollection of using abortion and sterilization for eugenic purposes sharply contrasts with the memory and values of Dr. Jacobson. And while both narrators were of the opinion that access to abortion was medically ethical, during and after her interview, Dr. Simons did convey a liberal socio-political consciousness following the conclusion of our interview that, perhaps, influenced her role on the Calgary TAC.⁸⁹ Applications for therapeutic abortions, Dr. Simons’s stressed, were screened for situations when, or if, women were potentially coerced into having an abortion:

SI: So, can you tell me a little bit more about the committee? The dynamics of the committee...people on it?

DS: We were three family docs. My partner, whose practice I joined when I started family practice, another family doc, another woman who was also very interested in women’s health. She, by the way, ended up becoming a low-risk obstetrics specialist. And, so the three of us were just totally of the mind that women should have reproductive choice. I remember one day; this is a little bit of an aside but it’s interesting. One day, I delivered a baby in the morning, went to my office for a

⁸⁸ Ibid, 1071-1072.

⁸⁹ Dr. Jacobson did not discuss with me his political beliefs, I was, however, of the opinion during the interview that he aligned more closely with a liberal leaning.

couple of hours, did my shift at the abortion clinic in the afternoon, and delivered another baby that night. It was all about the woman's choice and what was best for her. So anyway, our committee was very liberal. We didn't worry as to whether she is really mentally capable of this, carrying a pregnancy, it wasn't an issue. It was just sign off. If she wants an abortion, she deserves to get an abortion.

Dr. Simons's continues:

DS: And that wasn't the case with other committees. By hearsay, I was aware that it certainly wasn't the case with other places but in Calgary, we had no compunctions. We had no negative feelings. If a woman wants an abortion, they get an abortion.

SI: Did you ever look at the applications?

DS: Oh, yes. You had to...just to make sure that abortion was wanted. Was she allergic to anything, you know, all of the medical health things.⁹⁰

In addition to Dyck's scholarship on the influence of the Sexual Sterilization Act on the interpretations held by physicians appointed to Alberta's TAC, other scholars such as sociologist Claudia Malacrida have drawn closer attention to the lived experiences of individuals affected by the lingering effects of eugenic policies practiced in Alberta. Malacrida conducted extensive oral histories with individuals institutionalized in the Red Deer Michener Institute as well as interviews with individuals that held positions of institutional power, such as former Board members and nurses, between the years from 1965 to 1985.⁹¹ The institutional life and forced sterilization of patients, or 'inmates,' as Malacrida characterizes them at the Michener Institute, demonstrates the brutal effects of the eugenic social hierarchy.⁹² And while her analysis of these topics is important, little scholarly attention has been given to the direct role of medical practitioners involved with

⁹⁰ 09:00-11:00, interview with Dr. Simons, 27th February, 2016.

⁹¹ Claudia Malacrida, "Contested Memories: Efforts of the Powerful to Silence Former Inmates' Histories of Life in an Institution for 'Mental Defectives,'" in *The Canadian Oral History Reader*, ed. by Kristina Llewellyn, Alexander Freund and Nolan Riley, (Montreal, QC: McGill-University Press, 2015), 321.

⁹² Malacrida, 319.

TACs in smaller cities such as Red Deer or Lethbridge. Yet Dyck observes that, “the number of women demanding such operations (such as hysterectomies) spiked in somewhat unlikely settings such as Lethbridge, where a surgeon’s reputation for performing hysterectomies gained momentum and the number of women receiving them blossomed overnight.”⁹³ Individuals with a social history highlighted in Dr. Jacobson’s response above would most likely be given a recommendation for sterilization by some TACs or before the application was viewed by a referring practitioners. The ‘medical action’ that was recommended following the abortion would be given to the referring doctor and women would also be advised of a number of birth control options and in some instances, sterilization would also be suggested or encouraged.

The referring physician and the TAC was profoundly influential in the lives of many women accessing therapeutic abortions. And yet, despite the monumental decision that referring physicians and members of the TAC were left with, following the passing of the 1969 Bill, most practitioners had received little to no medical educational training other than understanding the criminal implications of therapeutic abortions. Both narrators confirmed that they received little education on the practise or ethics of abortions as a procedure within their medical school.⁹⁴

Indeed, the medical profession did little to prepare young medical professionals entering a workforce where the social, ethical and political discussion of therapeutic abortions would become so salient. While Dr. Jacobson was in school to become a doctor, therapeutic abortions still remained criminalized in Britain. Discussions surrounding the topic of abortion centered around the illegality of the procedure and the potential

⁹³ Dyck, 23.

⁹⁴ 2:02, interview with Dr. Jacobson, 23rd October 2015.

implications for medical professionals who participated in the termination of a pregnancy. The years that Dr. Simons completed her schooling and residency overlapped with the 1969 Bill. Many medical practitioners were confused by process and application of the TACs and unaware of the significance that physicians would play in facilitating access for some women while denying access to others. Evidently, Dr. Jacobson and Dr. Simons received little to no knowledge on abortion attending medical school; therefore, in their efforts to avoid pregnancy, many women relied on their own knowledge or the shared consciousness of women's health shared by activists to terminate unwanted pregnancies rather than on healthcare professionals. Medical historian Wendy Mitchinson has analyzed the views of medical practitioners towards female bodies from the years 1900 to 1950 and argued that, "Much of the information physicians had about attempted means of abortion came from the women patients."⁹⁵

Prior to the partial decriminalization of abortion in 1969, it was widely reported that women self-administered a number of different abortifacients, "quinine, castor oil, ergot,...salts, [and] lead pills" as well as inserting foreign objects into their vagina as a means of controlling their own reproduction.⁹⁶ And while women have always exercised control over their bodies, the attention women's reproductive healthcare received from physicians regarding women's reproductive lives increased during the twentieth-century. For some physicians, the TACs represented legislated permission to surveillance women's bodies, granting them greater authority in controlling women's autonomy. Indeed, the

⁹⁵ Wendy Mitchinson, *Body Failure: Medical Views of Women, 1900-1950*, (Toronto, ON: University of Toronto Press, 2013), 165.

⁹⁶ Mitchinson, 165.

power relationship between the male physician and the woman patient was often unequal, as demonstrated in my interviews.

According to Mitchinson, the early twentieth-century increased the medicalization of the female body in Canada. Mitchinson argues that, "For feminists, medicalization of women's bodies refers to the ways in which physicians have made the female body problematic...When a woman patient faced a male physician who saw her body as 'other,' she was in a less powerful position than a male patient would have been; the societal context, in which both the physician and the female patient lived, invested status to men over women."⁹⁷ Important to note within her statement is Mitchinson's focus on the male physician and female patient relationship. The ways in which Dr. Simons's regarded each woman and her involvement in facilitating an abortion stands in contrast to the way that Dr. Jacobson viewed his role as a physician in mediating a woman's access to abortions. Although neither practitioner self-identified as feminist, some of the insight that Dr. Simons shared about the TAC and her concern for her female patients within her medical practice following the full decriminalization of abortion in 1988 suggests that she had a heightened feminist awareness.

Prior to her application reaching the TAC at the Lethbridge Municipal Hospital, a woman's circumstances might be deliberated on several times before a decision was made. The decision was conveyed to her by the referring medical practitioner. A woman or teenage girl would first make an appointment with either a general practitioner, or in some cases with a psychiatrist. Either would build a case on her behalf before sending the application to the accredited hospital with an active TAC. The application would then be

⁹⁷ Mitchinson, 9.

reviewed by the hospital administrative staff before going to be deliberated on by the three practitioners appointed to the TAC. When I asked Dr. Jacobson to recall any memories that stand out on specific cases, he responded as follows:

DJ: I don't have very many, or any that particularly stand out. It was all academic almost. There was not any person involvement. Like I said...almost 50% of the patients were Roman Catholic...Um, any particular cases?...Yes, I can remember a refusal. Yes, I can remember a few of refusals that we made on the grounds of repeated, um, repeated applications...we felt that we should be responsible and put some kind of gate on the accessibility of this...⁹⁸

Unfortunately, Dr. Jacobson did not elaborate further on what information was included on those applications that his Committee refused. He informs us that some women may have requested more than one therapeutic abortion and would, in his view, not receive an approval from the Lethbridge TAC. Many male physicians involved with facilitating a woman's abortion, perhaps including Dr. Jacobson, potentially viewed a woman's reproductive autonomy as problematic.

This perspective agrees with Malacrida's analysis of the ways in which individuals in positions of power, such as physicians, psychiatrists, nurses, and hospital administrative staff justified or characterized operations like sterilizations as routine in provincially funded institutions like the Michener Institute. Malacrida argues that to perform such life altering operations with routine efficiency, the individuals holding positions of power dehumanized the patients. They justified sterilizations as a means to keep order.⁹⁹ Malacrida's examination of the Michener Institute's treatment of women and men deemed unsuitable to reproduce provides an extreme example of twentieth-century views of

⁹⁸ 22:23-23:00, interview with Dr. Jacobson.

⁹⁹ Claudia Malacrida, "Bodily Practices as Vehicles for Dehumanization in an Institution for Mental Defectives," *Societies* Vol. 2, No. 2 (December 2012), 287.

problematic bodies. And yet, Dr. Jacobson's responses show a more insidious presence of these views. The task of reviewing, and subsequently either approving or blocking an application, and recommending medical actions was routinized and required individuals like Dr. Jacobson to distance himself—marking a distance between his role as a physician, holding a position of power, and the woman's role as a recipient of his decision. When a woman's application was refused, as Dr. Jacobson articulated in the above passage, this refusal was based on the belief that the physicians on the TAC were authorized to this life changing decision on behalf of the woman concerning her reproductive autonomy.

One way in which Dr. Jacobson reinforced the distinction between his empowered role and the disempowered subject of the request for the abortion was by correcting himself whenever he employed or said, "the woman." His responses were self-corrected to substitute the term, "the patient" to replace, "the woman".¹⁰⁰ When Dr. Jacobson received a woman's application for a therapeutic abortion, intimate and private details from her life were exposed. Details that she may not have known were potentially included on the form by the referring doctor. Dr. Jacobson did reveal that the names of the patients were included on the application. His sustained use of, "the patient" rather than "the woman" demonstrated one way, perhaps, that Dr. Jacobson distanced himself from the significant and life altering impact that he had on the women's lives.

Lynn Abrams writes on the role of subjectivity and memory in oral history, "It is precisely the relationship between subjectivity and discourse that engages the oral historian, who understand that the creation of memory stories can only be undertaken by calling upon certain sets of ideas, interpretations and presentations which are meaningful

¹⁰⁰ 15:10, interview with Dr. Jacobson, 23rd October 2015.

to the narrator, which help make sense of an often disparate and disconnected set of memories and experiences."¹⁰¹ Dr. Jacobson's responses enlist twentieth-century views of male physicians and female patients and multiple other details from our interview to narrate his memories of the Lethbridge TAC and the construction of his professional identity. The manner by which a subject forgets specific events or answers questions with a certain degree of reticence on a topic importantly highlights how identity is shaped or affirmed in oral history. Abrams further asserts that, "In the interview situation the oral historian is a facilitator; we ask questions, provide prompts or cues, demonstrate interest and empathy, all in order to encourage a respondent to access their memory and convert their memories into a narrative."¹⁰²

In my interview, Dr. Jacobson struggled with my follow-up question regarding the social history of the women whose applications were reviewed that was used to approve, or reject, a request for a therapeutic abortion. His answer took a series of turns before he finally articulated, in just a few sentences, prevalent views of how women might be deemed 'unfit' for motherhood. This shift in his narration fits with Abrams view on the process of how the interview participant accesses a memory, "It is sometimes possible to literally 'see' or hear a person accessing their memory store; when asked a question they are not expecting they will have to search around in their memory to have to find an answer."¹⁰³ Indeed, when I inquired as to how women found out whether they were approved or denied for a therapeutic abortion, Dr. Jacobson took a brief detour in his response as he rhetorically replied, "We did not interview the patients. We did not communicate with the patients.

¹⁰¹ Abrams, 65.

¹⁰² Lynn Abrams, *Oral History Theory*, (New York, NY: Routledge, 2010), 104.

¹⁰³ Abrams, 104.

(Pause) I don't actually know how the patient got to know."¹⁰⁴ His reflection might, perhaps, indicate that something within his memory was triggered in the process of answering my question or it might mean that his influence on the women's lives impacted him more than he was comfortable articulating.

Oral historian Lenore Layman has analyzed the importance of the interviewer acknowledging the significance of reticence in the interviews they undertake. She argues that, "Using reticence to curtail or close off topics from discussion is primarily an assertion of narrators' authority."¹⁰⁵ Dr. Jacobson easily demonstrated the areas that he was comfortable discussing with ease, such as expanding on the meanings of certain medical terms that I did not fully understand or talking about his time as a doctor in England. The lapses in his recall that seemed to occur were the more unfamiliar and uncomfortable such as the social circumstances of a patient's life. I argue that this response demonstrates one way in which physicians necessarily distanced themselves from the direct impact of their involvement on TAC and the impact that the process had on those individuals who sought an abortion through the TAC system. Dr. Jacobson's response is important as it conveys one of the many problematic features associated with the operation of the TAC. That is, the level of intrusiveness of the process into women's private lives. The smaller hospital setting of the Lethbridge TAC recollected by Dr. Jacobson stood in stark contrast to Dr. Simons's memories of the Calgary based TAC. I believe the actions of Dr. Meredith Simons and the Calgary TAC were atypical to the predominant views from other physicians

¹⁰⁴ 18:25-18:42, interview with Dr. Jacobson, 23rd October, 2015.

¹⁰⁵ Lenore Layman, "Reticence in Oral History Interviews," *The Oral History Review*, Vol. 36, No. 2 (Summer-Fall, 2009), 210.

on TACs across Alberta. Indeed, Dr. Simons's recognized the exceptional attitude of the Calgary TAC in relation to other committees across Canada.

The one similarity that did occur in my interviews with both Dr. Simons and Dr. Jacobson was the way in which each narrator directed our conversation to focus my attention on the areas that they deemed important to understanding the history of accessing abortion in Canada. My interview with Dr. Simons primarily focused on her involvement as an abortion provider following the complete decriminalization of abortion in Canada. Unlike my interview with Dr. Jacobson, that occurred in his home after having met with him once, my interview with Dr. Simons took place at my office which I shared with two other graduate students. Dr. Simons lives in Calgary; however, our interview took place after she guest lectured in a class at the University of Lethbridge.¹⁰⁶ This lecture affirmed her interest in women's health as an area of focus within her medical practice. Despite making the decision to specialize in Family Practice, Dr. Simons expressed a commitment to actively improving reproductive care and access for women while attempting to eliminate the stigma surrounding abortion. Her move to become an abortion provider began first with her involvement on the Calgary TAC informed by the knowledge that she acquired when abortion was partially decriminalized.

DS: I had asked the head of OBGYN after I had been practicing for a few years if I could be trained to provide abortions. This would have been after the decriminalization by the government...And [he] basically said, family practitioners don't do that. So, then, I joined the TAC at the hospital in Calgary. My partner, my family practice partner at the time, was also on the committee so I got on quite readily.

SI: Did he give a reason at the time as to why family practitioners were not...?

DS: Family practitioners didn't poke around in uteri. It wasn't something that they had any experience with us doing. Abortions were done by several of the gynecologists

¹⁰⁶ 00:30-00:40, interview with Dr. Meredith Simons, 27th February, 2016.

there who had, in fact, been trained when therapeutic abortion was against the law. And they had seen the result of it. They had seen women die of infections and massive hemorrhages...so the few of them at the Foothills who did abortions had had that experience. But, they just didn't think that it was appropriate for family doctors...What did happen, if I can continue, is a few years later, and I think it was after the need for the committee...After we didn't need a committee anymore and after those gynecologists were retiring then the head of OBGYN came and asked if I would still want to be trained because we don't have enough gynecologists to provide the procedure anymore.¹⁰⁷

Dr. Simons's memory of becoming an abortion practitioner also provides insight into one of the main obstacles continuing to limit women's access to abortion services. There was a lack of access and a limited number of physicians willing, or available, to perform surgical abortions. This absence of willing abortion providers became **more pronounced** following the full decriminalization of abortion in 1988.

During the period when TACs regulated access to abortions, Erika Dyck argues that for many, "Alberta became an attractive destination for women seeking abortion from other, less well serviced areas."¹⁰⁸ Three years following the partial decriminalization, the Alberta Hospital Services Commission reported that in 1972, twenty-three hospitals were performing abortions.¹⁰⁹ By tabulating the number of hospitals that performed therapeutic abortions in Alberta, one might assume that the existence of TACs did not restrict women in their efforts for bodily autonomy. When compared with access today, there was indeed a higher number of hospitals that performed therapeutic abortions during the period between partial decriminalization and full decriminalization. Following the full decriminalization of abortion in 1988, the number of hospitals that provided abortions and the number of medical practitioners performing abortions dropped precipitously. That lack

¹⁰⁷ 02:50-05:06, interview with Dr. Meredith Simons, 27th February, 2016.

¹⁰⁸ Erika Dyck, *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice*, (Toronto: University of Toronto Press, 2013), 203.

¹⁰⁹ Erika Dyck, 203.

of service continues to date. Current information from Alberta Health Services (AHS) cites Calgary and Edmonton as the only two cities where surgical abortions can be performed outside of a hospital setting.¹¹⁰

On January 28th, 1988, in *R. v. Morgentaler*, the Supreme Court ruled that section 251 of the Criminal Code requiring TACs to approve a woman's application for an abortion was struck down.¹¹¹ As her interview reveals, Dr. Simons was one of the few physicians who sat on a TAC and later transitioned into performing abortions following the full decriminalization. With the Supreme Court ruling that fully decriminalized abortion in 1988, physicians like Dr. Simons could perform abortions in private clinic settings and without the approval of a TAC. For anti-abortion opponents, this ruling was a major defeat. The existence of TACs protected physicians both legally and, in some instances, physically from anti-abortion opponents. Dr. Simons's memory of her work at the Kensington Clinic in Calgary involved a heightened awareness of the anti-abortion extremist reactions against abortion providers that occurred more frequently and aggressively after 1988. Dr. Simons's described to me how she reacted to these views in her work:

SI: Did you ever feel that during your time on the TAC, or even later once you practiced at the Kensington Clinic, that either you or your family's safety was compromised because of your involvement with abortions?

DS: I never felt it was but, still, I thought about it. It was a concern. When I was on the TAC, it wasn't out in the open. We went to a room someplace in the hospital. I don't even remember where it was. It wasn't advertised and it wasn't out in the open very much that we were the three doctors signing the papers for the women to have the abortions. Of course, the gynecologists and the anesthesiologists who were doing the procedures would see who it was...But then later, when I started doing abortions myself. (Pause) I performed abortions only in the hospital. I was invited by another gynecologist who I had met during my training, who started the Kensington Clinic. And after he had been going for a few years, he had asked me

¹¹⁰ "Abortion Services: Information for the Public," *Alberta Health Services online*, last modified 2018, <https://www.albertahealthservices.ca/info/Page14011.aspx>.

¹¹¹ *R. v. Morgentaler*, 1956 SCR 30 (1988).

if I wanted to join him. And I, at the time, I was too nervous about being an abortion provider. There was too much going on in the States and even in Canada, there was some shootings of abortion providers so I did not want to be in the private clinic.

She then goes on:

DS: But other than that, I never felt personally threatened but I was cautious. Me and my family did not talk about the fact that I was an abortion provider... There was a possibility of danger. Like I said, I didn't feel personally threatened but I was definitely aware of it. Actually, we have a big picture window in the front of my house and I didn't sit in front of it. (Pause) Especially at night. (Pause) There were some doctors who got special insurance, even, but I never did that. It was available to have special insurance because you were an abortion provider.¹¹²

In reaction to the ruling fully decriminalizing abortion, violence from anti-choice extremists began to grow and instilled a sense of fear in abortion providers like Dr. Simons. Political scientists, Paul Saurette and Kelly Gordon discuss the growing discontent amongst opponents of abortion in, *The Changing Voice of the Anti-Abortion Movement*. Although not as extreme as the opposition to abortion in the United States, Saurette and Gordon argue that, "As the number of defeats grew for the anti-abortion movement, frustration intensified in certain sectors of the movement. In this context, some activists began to advocate and employ more extreme protest tactics, and a small minority of extremists resorted to violence."¹¹³ After deciding to leave the hospital and continue as an abortion provider at the Kensington Clinic, Dr. Simons discussed the ways she initially avoided drawing attention to her work:

DS: And then by the time that I started to be comfortable enough with it and things were starting to be a little more liberal in society, I had the opportunity to join the Kensington Clinic and I jumped at the chance. (Pause) I used to, at first, the first couple of years working there, I never parked in their parking lot. I parked around the corner and walked into the clinic. And when Dr. Jackson (pseudonym) retired. You might not want to use his name, but he's so out there... When he retired and I was invited to be the Medical Director, the Calgary Herald did a front page story saying that he was retiring. He was very open about his clinic. There were always

¹¹² 13:30-16:10, interview with Dr. Simons, 27th February, 2016.

¹¹³ Saurette and Gordon, 134.

protesters across the street. So, the paper asked me if I would be okay to be interviewed, because I was taking over as Medical Director and could they put my picture in the paper and I actually said, yes, but please put it on the second page. (Laughs) Not right on the front with him. I learned from him, to just relax. And then my role became to just normalize the procedure for women. And I'm still trying to do that. (Pause) By doing things like talking to you. (Laughs)¹¹⁴

Fear became an underlying emotion that governed the actions of Dr. Simons in reaction to the violence of others opposed to her work as an abortion provider. Feminist scholar Sara Ahmed discusses the ways in which emotions like fear circulate within and between bodies, "Fear, like pain, is felt in an unpleasant form of intensity. But while the lived experience of fear may be unpleasant in the present, the unpleasantness of this fear also relates to the future. Fear involves an *anticipation* of hurt or injury."¹¹⁵ Applying this understanding of fear, for abortion providers like Dr. Simons, the potential of violence prevented her from initially joining the Kensington Clinic. Fear was a salient emotion that impacted her behavior at work, by parking away from the clinic, and fears lingered in her private life. The more insidious way that access to abortion was controlled was through the barrage of anti-abortion ads, vocabulary, and violence from those in opposition to women's autonomy. This tactic was indeed a powerful method to deter medical practitioners from improving access to abortion services. As Ahmed argues, fear also involves the '*anticipation* of hurt or injury' and relates to the future. For Dr. Simons's, the potential for violence that dominated the discussion of abortion following the decriminalization in 1988 was internalized as a possibility of harm or injury. This anticipatory fear affected how she practiced as a physician, the conversations that she shared (and didn't share) with her family and colleagues, and also physically limited the areas of her home where she could

¹¹⁴ 16:30-17:44, interview with Dr. Simons, 27th February, 2016.

¹¹⁵ Ahmed, 64.

sit to enjoy her view of the acreage without fearing for her safety. The most direct impact from our interview of the fear of potential violence was articulated by Dr. Simons regarding her behavior at home, “There was always a possibility of danger... Actually, we have a big picture window in the front of my house and I didn’t sit in front of it. (Pause) Especially at night (Pause).”¹¹⁶ Analyzing the ways in which emotions shaped the actions and reactions of individuals like Dr. Simons on issues like abortion, historians are provided with an additional analytic lens to understand the complexities of the history of abortion in Canada and the impact changing legislation had on women’s lives. Indeed, the varied responses from both retired physicians in this study confirms that no TAC operated the same. Likewise, no woman experienced the same journey to obtain an abortion.

¹¹⁶ 13:30-16:10, interview with Dr. Simons, 27th February, 2016.

Chapter Two:
‘And yet, it’s an important part of your history’: Accessing Abortion in Alberta, 1969-1988¹¹⁷

As I have shown in the previous chapter, both Dr. Simons and Dr. Jacobson seemed unaware of the direct impact of the TAC on the lives of women; perhaps even how they experienced treatment from referring physicians, or how each woman was treated by other medical practitioners while obtaining a therapeutic abortion. To understand the lived experiences of having therapeutic abortions during the period between partial decriminalization and full decriminalization, I asked Dr. Jean Harrowing and Professor Irene Sisson to recall their memories.

This chapter addresses the narratives of these two well educated white middle-class professionals from Southern Alberta, both of whom obtained therapeutic abortions during the period between partial decriminalization and full decriminalization (1969 to 1988). Dr. Jean Harrowing obtained an abortion in Lethbridge during the early 1970s. Irene Sisson obtained two abortions at different periods in her life, both in Calgary. The first abortion Sisson obtained in the early 70s, the second in the mid-1980s.

The questions that I designed for each narrator provide insight into the emotional and physical journey each woman encountered during their respective experiences of seeking and securing an abortion. What emerged from both accounts, and what perhaps is indicative of the historical understanding of many women’s experience of accessing reproductive health services during the twentieth-century, is a complex narrative of pain.

¹¹⁷ In the practice of shared authority and ongoing consent, I contacted each participant following my MA defence to re-confirm their decision to disclose their identity. Irene Sisson (pseudonym) decided that she would feel more comfortable concealing her identity.

Feminist scholar Sara Ahmed explores “The Contingency of Pain” in her book *The Cultural Politics of Emotion* arguing that, “Rather than assuming that pain is unrepresentable [one must ask] how does the labour of pain and the language of pain work in specific and determined ways to affect differences between bodies.”¹¹⁸ This chapter addresses how pain is manifest in each woman’s memory relative to not only their abortions, but also in their struggle for autonomy and access to reproductive health services throughout their lives. At the time of their abortion, however, the decision to terminate the pregnancy was not always necessarily personally viewed as a political act. For the two women whom I interviewed, the decision to terminate their pregnancies was deemed a necessity given their then lack of financial and social resources. Only later, reflecting on their experiences, did each individually articulate the impact that public political debate surrounding abortion had on their decision to terminate their pregnancies. The varied reactions of support from some and judgement from others also profoundly impacted the memories of each narrator.

Shame and abortion

I entered the interview with a list of predetermined questions, as is standard to the preparation of most oral historians. Retrospectively, I believe I also arrived with a preconceived expectation of how each woman might answer my questions regarding their individual experiences of obtaining a therapeutic abortion. My perspectives were influenced by contemporary scholarship that report women’s experiences as either one of relief or internalized shame. Yet the interviews with both Professor Sisson and Dr. Harrowing illustrate to me that the individual emotional experience is fluid and evolves

¹¹⁸ Sara Ahmed, *The Cultural Politics of Emotion*, (New York: Routledge Press, 2012), 22-23.

over the course of the individual's life, and resists this limiting binary. To understand the development of contemporary feminist scholarship that contests the labelling of abortion as 'shameful', I needed to accept the insidious ways through which anti-choice narratives in Southern Alberta that shame women for obtaining an abortion, perhaps, clouded my understanding of the historical experience of obtaining a therapeutic abortion.

Alberta has a proactive anti-choice movement that, following the decriminalization of abortion in Canada in 1988, has implemented an aggressive marketing campaign on billboards, at bus-stops, and at various locations in public spaces to shame women for having abortions. The "Pregnancy Care Centres" are deceptively clever in advertising support for women experiencing unplanned pregnancies, who might also be considering abortion; however, the Centre's support is limited **only** to providing support for a continued pregnancy.¹¹⁹ Within Alberta, there are currently 17 "Pregnancy Care Centres," two of which are located in Lethbridge.¹²⁰ Advertisements for these Centres frequently appear at the University of Lethbridge and throughout the city. In a blog post on the Lethbridge Pregnancy Care Centre's website, titled, "After an Abortion," a commentary reads, "No two people feel the same after an abortion and no one can tell YOU how to feel. Some women feel relief after an abortion, while other women experience strong negative emotions".¹²¹ Disguised as a welcoming and safe place for women to freely navigate the complex emotional terrain that sometimes follows an abortion, the Pregnancy Care Centre

¹¹⁹ "Crisis Pregnancy Centres in Canada," *Canada Adopts! Canada's adoption meeting place*, accessed May 23, 2020, <http://www.canadaadopts.com/adopting-in-canada/crisis-pregnancy-centres-canada/>.

¹²⁰ Ibid.

¹²¹ "After an Abortion," *Lethbridge Pregnancy Care Centre*, accessed May 23, 2020, <https://lethbridgepregcentre.com/after-an-abortion/>.

monopolizes on the trauma that some women experience regarding their bodies and their reproduction.

The development of the Pregnancy Care Centres occurred during the 1980s in the United States just as the extreme, and at times violent, tactics of the anti-choice movement faced strong resistance, even from supporters opposing abortion.¹²² Saurette and Gordon argue that the rise of the “Woman-Protective Anti-Abortion Argument (WPAA)” coincided with the rise of the “crisis pregnancy centres” in an attempt to shift the traditional, god-fearing, pro-fetus, and anti-woman foundation of the anti-choice movement to garner more support amongst its critics.¹²³ Saurette and Gordon further claim that during the same decade where the emergence of the diagnosis of Post-Traumatic Stress Disorder (PTSD) began to gain therapeutic credence, the anti-choice movement also coined the term, “post-abortion syndrome (PAS)” that was argued to have similarities to PTSD and inflicted women following abortion.¹²⁴ Although PAS was not recognized as a medical diagnosis, and has since been discredited by scholars and medical professionals, the anti-choice movement co-opted the multifaceted emotional landscape that women experience related to their relationship with their bodies in an effort to shame women who had abortions.

Sara Ahmed describes shame as, “[a] double play of concealment and exposure”.¹²⁵ Through the historical absence of women’s lived experiences of having abortions, the procedure is stigmatized as something that carries shame. Ahmed further states, “Shame

¹²² Paul Saurette and Kelly Gordon, *The Changing Voice of the Anti-Abortion Movement: The Rise of ‘Pro-Woman’ Rhetoric in Canada and the United States*, (Toronto, ON: University of Toronto Press, 2015), 298.

¹²³ Saurette and Gordon, 299.

¹²⁴ Saurette and Gordon, 299.

¹²⁵ Ahmed, *The Cultural Politics of Emotions*, 104.

can also be experienced as *the affective cost of not following the scripts of normative existence*".¹²⁶ In choosing to control one's own reproduction through abortion, women have historically and are presently shamed by anti-choice supporters for not prescribing to heteronormative constructs of womanhood. To resist this labelling, and to assert a more nuanced historiography of women's experiences with abortion, both Dr. Harrowing and Professor Sisson shared their memories of obtaining an abortion with me.

The Emotional Landscape of Memories

Throughout Professor Sisson's interview, a history emerged shaped by interactions with dance instructors, family physicians, and with her long-term partner. The experiences that Professor Sisson shared with me did not align with my own perhaps generational expectation going into the interview.¹²⁷

On the other hand, Dr. Harrowing remembered enjoying being pregnant during, after she initially received confirmation of a positive pregnancy to when she obtained an abortion and the time that the procedure occurred. Both interviews, however, addressed how few birth control options were available to them after the complete decriminalization of contraceptives and the partial decriminalization in 1969. Additionally, as is explored in more depth later in this chapter, the negative side effects experienced by Professor Sisson that led to lifelong bodily damage from early contraceptives is indicative of the lack of medical research and legislative support for women's reproductive lives that existed throughout the twentieth-century.

¹²⁶ Ahmed, *The Cultural Politics of Emotions*, 107.

¹²⁷ As I explored above, the anti-choice movement is pervasive across Southern Alberta. And while I am resistant to the narrative of the movement, I must also entertain the possibility that aspects of the contemporary movement may have coloured my expectations going into the interviews.

Each interview evoked memories connected to lasting physical and psychological impacts of their respective complex reproductive histories. Professor Sisson recalling the ‘shaming’ of her noticeable weight gain, a side effect from her prescription for early oral contraceptives, while studying dance in New York. Nonetheless, the weight gain was a minimal side effect when compared to her memory of the painful insertion and lasting complications that arose after receiving one of the earliest hormonal IUDs known as the Dalkon Shield. For Dr. Harrowing’s memory of her experience of receiving a therapeutic abortion at the Lethbridge Hospital centered around the anesthesiologist’s moral judgment of her the moment before she was anesthetized for the procedure. Both narratives expand on the scholarship of women’s struggle for reproductive autonomy while weaving an emotional landscape shaped by actions and reactions to the responses of others to their circumstances.

Navigating the Medical Maze: Dr. Jean Harrowing

My interview with Dr. Jean Harrowing, an Associate Professor in the Faculty of Health Sciences at the University of Lethbridge, took place in her office and was the first interview that I conducted after receiving ethics approval. As I prepared and later arrived for the interview, I was overwhelmed with fear and uncertainty. I could hear every sound and picked-up on every movement in the office. Perhaps because it was my first interview, I entered the office with fear, unsure of how the interview would unfold and nervous that I would react poorly to the memories shared by Dr. Harrowing. This insight, or rather this emotion, represents one unique aspect indicative of the precariousness of the oral history process and the vulnerability needed, by both interviewer and interviewee. Further, the encounter provided a symbolic reminder for me, the interviewer, of the fear that many

women also encountered as they entered an office environment prior to their pursuit of abortion during the era when it required such effort and argument to gain approval. The process of seeking a therapeutic abortion required a woman to enter a space of uncertainty and vulnerability, often revealing intimate details from her past, and to build a convincing case to a medical professional, who held a position of greater authority, that would ultimately be responsible for either supporting or denying her request for an application for the procedure. Indeed, this disproportionate power dynamic continued as the application was then sent to a TAC and the woman was left to anxiously wait for the Committee's decision. Soon after beginning the interview with Dr. Harrowing, I realized that one of the many stark differences between my own experience and the experience that she and many other women encountered is that I found myself in an environment where my own nerves from the stiffness of the interview process soon dissipated into a conversational dialogue. Dr. Harrowing further demonstrated that the trepidation that I initially experienced was by no means similar to the continual unease she experienced as a young woman seeking approval within the convoluted process of securing a therapeutic abortion prior to 1988.

As she explained, Dr. Harrowing was eighteen years old and beginning her academic career when she first discovered she was pregnant. The thought process and first feelings after confirmation of her pregnancy are unequivocally recalled:

Shannon Ingram, (SI): What can you tell me about when you first found out you were pregnant?

Jean Harrowing, (DH): I was in my second year of University. It was probably late March, early April and I realized I had missed my period. I had that confirmed and I was a little overwhelmed...At the time, it was not something that I had planned. I guess, I was concerned about what would happen to my University career. How my life would change...Yes, I was just overwhelmed with all of the decisions that would have to be made and the changes I would have to consider.

SI: Do you remember your first feeling?

DH: Oh my gosh! This can't be happening! (laughs)¹²⁸

As this excerpt of our exchange shows, for Dr. Harrowing, the possibility of a pregnancy was indeed daunting. Although she eventually decided to have an abortion, it was not her original desire. After revealing the news of the pregnancy to her partner of the time, she recalled that it was, however, his immediate reaction for her to have an abortion. She remembers feeling surprised concerning his conviction, later reflecting, however, that she was not in an economic or emotional position where she wanted to go through with the pregnancy. Further strengthening her decision to pursue a therapeutic abortion was that the lack of social and financial resources to have and raise a child.

Contrary to her vivid memory of first discovering she was pregnant, Dr. Harrowing's recollection of the interview process for the therapeutic abortion is less certain. Following her decision to proceed with an abortion, she necessarily began to navigate the medical web associated with the implementation of the TACs. Dr. Harrowing's first consultation with a doctor was at the University of Lethbridge's Health Centre and she described that interaction as follows:

SI: What can you remember about the process of having an abortion?

DH: It's all kind of blurry at this point. It was a long time ago...I would have a forty-something year old child by now (laughs)...I remember going to the health clinic here at the University and the physician there said that if he was the last doctor on the planet, he was not prepared to do the procedure. He was a GP [General Practitioner] so it's not like he would do it, but because of his own religious beliefs he would not engage in that but would refer me to someone who would.¹²⁹

¹²⁸ 00:25-01:21, Interview with Dr. Jean Harrowing by Shannon Ingram, 2nd March 2017.

¹²⁹ 03:35-04:16, Interview with Dr. Harrowing, 2nd March 2017.

The reaction from the above medical practitioner, mediated by his personal religious conviction, highlights the ways in which some doctors asserted power over women's bodies through the use of their medical authority to block her efforts to obtain an abortion.

Historians Frances E. Chapman and Tracy Penny Light discuss the conflicts among the medical professionals during this era after the partial decriminalization of abortion and regarding their roles in regulating reproductive health services for women. Additionally, by revealing their religious beliefs on abortion to patients, some doctors, like the individual that Dr. Harrowing consulted, attempted to distinguish themselves within the profession and amongst their colleagues. As Chapman and Penny Light determined, "In the case of abortion, doctors believed that it was their duty to ensure that their patients did not stray from the moral prescriptions for women at the time (that they were made to be mothers), and in so doing, could separate themselves [from practitioners] who were willing, or were perceived willing, to perform the procedure."¹³⁰ And while this quotation specifically addresses practitioners who performed abortions, it may also be applied to doctors who were the initial contact for women those, like Dr. Harrowing, who sought a therapeutic abortion.

Social Scientist, Gail Kellough argues that, "contemporary academics do not always agree about the degree to which women have historically had access to the means of fertility control, but within this discontinuity is an intersection of law and medicine."¹³¹

And while my previous chapter shows the ways in which medicine and law intersected, I

¹³⁰ Frances E. Chapman and Tracy Penny Light, "Functionally Inaccessible: Historical Conflicts in Legal and Medical Access to Abortion," in *Abortion: History, Politics, and Reproductive Justice after Morgentaler*, eds. Shannon Stettner, Kristen Burnett, and Travis Hay (Vancouver: UBC Press, 2017), 186.

¹³¹ Gail Kellough, *Aborting Law: An Exploration of the Politics of Motherhood and Medicine*, (Toronto, University of Toronto Press, 1996), 43.

would further argue that Kellough's research might be expanded with greater consideration of the importance of religion, particularly within the historical context of Southern Alberta, as Dr. Harrowing's experience demonstrates.

Although I did not explicitly discuss religion in my questions for either participant, the topic arose on several occasions throughout my interviews, both with the women who had a therapeutic abortion and with the physicians who served on the TACs. As previously discussed, Dr. Jacobson recalled that many referring physicians included mention of a woman's religious affiliation on her application for a therapeutic abortion before sending it to the Lethbridge TAC. Dr. Harrowing further remembered how her brief initial encounter with the University's clinician to be influenced by religion and who earnestly conveyed his moral condemnation of abortion. The memory from Dr. Harrowing's encounter illustrates how some women directly encountered the blurring of religious convictions with medical authority. Without a doubt, some referring physicians refused to assist women in their pursuit of a therapeutic abortion.

Following the referral from the general practitioner at the University of Lethbridge's Health Centre, Dr. Harrowing was referred to two more medical specialists before her application for a therapeutic abortion advanced to the Lethbridge TAC. After the clinic visit, Dr. Harrowing's pregnancy was confirmed by a gynaecologist; following which, she was referred to a psychologist who would question her motivations and submit a request on her behalf to obtain an abortion. The specificities of the questions were not clearly remembered, but Dr. Harrowing does recall highlighting her emotional state as 'depressed' when speaking with the psychiatrist. Dr. Harrowing describes her memory of her appointment at the psychologist's office:

DH: I'm not sure exactly how I was told, but I was told that I had to see a psychologist. I remember going to that appointment and...knowing that I had to convince that person that I was depressed [that] abortion was in my best interest from a medical perspective...I wasn't depressed about the pregnancy. It was kind of exciting in a way.

SI: What kind of questions were you asked by the psychiatrist?

DH: I'm not sure. I wasn't a health care provider at that time so I wasn't familiar with the healthcare system. I just felt like I was being sent here and then being sent there. I wasn't sure why I was having to answer all of these questions. It all seemed a bit ridiculous...I imagine it was a standard psych assessment for depression...I don't know...I can kind of see his face, sitting in a chair, but that's all I remember of the encounter.¹³²

Despite acknowledging that she knew very little about the process on which referring physicians relied on to either approve or 'block' a woman for a therapeutic abortion, Dr. Harrowing quickly ascertained the appropriate answers to the questions asked by the psychologist that would most likely lead to an approval for a therapeutic abortion.

In 1983, the position of the CMA concerning the criteria for a therapeutic abortion was published in popular newspapers including in *The Globe and Mail*. The Globe reported the CMA's consideration of the broad category of 'social history' as being a key determinant for granting approval for abortion. As the paper reported, a meeting held by the CMA in Halifax discussed the general council's views on therapeutic abortion where members were divided but ultimately voted in favour, "[that] the CMA recognizes there is justification on non-medical social grounds for the deliberate termination of pregnancy."¹³³

Ultimately, the implementation of TACs provided a lens through which women's bodies were scrutinized by medical practitioners for their suitable match to a racialized, ablest,

¹³² 04:45-05:59, Interview with Dr. Harrowing, 2nd March 2017.

¹³³ Joan Holloban, "2,000 MDs Polled on Abortion by Association Studying Policy," *The Globe and Mail*, Wednesday, January 12th, 1983.

and heteronormative vision of the nation. Split opinions from members of the CMA, as reported in the *Globe*, paralleled public dialogue on women's bodies and abortion.

Historian Erika Dyck analyzed the policy record of hospitals located in Alberta including at the Calgary Foothills Hospital, where as noted in the previous chapter, Dr. Simons served on the Therapeutic Abortion Committee. In an internal memo released shortly following the partial decriminalization of abortion, administrators of the Foothills Hospital defined what they deemed a threat to a woman's health. As Dyck observed, "the memo stipulated that social, economic, or humanitarian grounds alone were insufficient reasons for an abortion without further close scrutiny of family history."¹³⁴ As a result, a woman's social history or "family history" was interrogated prior to, and as required for, approval of the abortion procedure. These broad definitions of 'social', 'economic', and 'humanitarian' causes were used by referring doctors and TACs to classify women as fit or unfit for motherhood. Although Dr. Harrowing did not recall being questioned about her family history in the interview with the psychiatrist, my interview with Dr. George Jacobson illustrates how physicians defined the broad 'socio-economic' criteria that would grant or prevent women from accessing a therapeutic abortion.

What stood out to me in Dr. Harrowing's memory of having a therapeutic abortion is the encounter with medical professionals at the hospital during the procedure. Despite acknowledging that she did not fully remember the interview process or how she came to find out that she was approved for an abortion, Dr. Harrowing specifically remembers the psychologist's face 'sitting in a chair' during the interview. This instance evoked the strong feelings experienced in her encounters with specific medical professionals. Asking her

¹³⁴ Erika Dyck, *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice*, (Toronto: University of Toronto Press, 2013), 209.

about this treatment at the hospital, Dr. Harrowing recalled moments of uncertainty, loneliness, and pain. In the following passage, Dr. Harrowing remembers her interaction with the psychologist as being procedurally routine as well as void of affect:

SI: So, how were they in terms of handling, being empathetic or compassionate? Do you remember any...?

DH: I don't get it. I don't recall any sense of that from that particular individual...Later on in the process, I remember being scolded.¹³⁵

Later in the interview, Dr. Harrowing remembers the time that she spent at the hospital from the moment of arrival, following admission, and while awaiting the procedure in the operating room. Perhaps the most profound, and disturbing, interaction she described with a medical professional was her encounter with the anaesthesiologist in the operating room. Dr. Harrowing recalls being strapped to the operating table, surrounded by medical equipment and nurses. Moments before completely losing consciousness, the words from the anesthesiologist still resonates nearly forty years after her procedure.

SI: How were you treated at the hospital?

DH: Hmm. Not so well, I would say. It was done as an outpatient procedure so I presented myself to outpatients at the appointed time. I was put in a corner. It was kind of a ward with beds and it was where I was going to be sent to recover...I was put into a corner and pretty much ignored and after the initial assessment was done...I was left there to wait. No time was given as to how long I would have to wait before I went for the procedure.

SI: So, you were alone?

DH: I was alone, yes. I was alone. When I went up to the OR [Operating Room] what I recall quite vividly was as the anesthetist was doing their thing, [they] said to me just as I was going under, you know they ask you to count backwards from ten...[they] said, 'Now, you won't get yourself into this pickle again, will you?!' So, I was scolded for my errant ways, I guess.¹³⁶

¹³⁵ 06:05-06:28, Interview with Dr. Harrowing, 2nd March, 2017. To further protect the identity of the anesthesiologist, I have removed altered the pronoun.

¹³⁶ 10:06-11:59, Interview with Dr. Harrowing, 2nd March, 2017.

Beginning with her initial contact with the University doctor to the above encounter with the anesthesiologist, Dr. Harrowing's response highlights the economies of affect that influenced the process of obtaining an abortion an individual might experience. Feminist scholar Sara Ahmed defines 'affective economies' as "feelings [that] do not reside in subjects or objects, but are produced as effects of circulation."¹³⁷ Dr. Harrowing's encounter with the anaesthesiologist was memorable as she mentioned some aspect of that encounter at least four times throughout our interview. Dr. Harrowing's feeling of being 'scolded' led her to specifically mention this twice.

Dr. Harrowing's understanding of the memory of her abortion is unique as she was, at that time, studying to become a health practitioner and subsequently practice at Chinook Hospital Lethbridge where the abortion took place. Years following her abortion, as a nursing student, Dr. Harrowing remembered hearing the name of the anaesthesiologist broadcast over the hospital intercom. This reminder of her encounter jarred her memory of the profound feeling of judgement she experienced in an intensely vulnerable moment when seeking her abortion.

Interactions with medical professionals shaped the way that Dr. Harrowing remembers her abortion but also influenced her own ethics as a medical professional in her treatment of patients. The words articulated by the anesthesiologist in the operating room left a significant impression on Dr. Harrowing. It might be argued therefore that Dr. Harrowing's experience exemplifies the ways in which emotions shape the surface of interaction between medical professionals and women who seek an abortion. Further, her experience illustrates how abortion is not only experienced but also remembered and felt.

¹³⁷ Sara Ahmed, *The Cultural Politics of Emotion*, (New York: Routledge Press, 2012), 8.

This experience shared by both professionals and the individual obtaining an abortion evokes a history of judgement and paternalism.

Recognizing the ways in which she experienced discomfort as a patient and the ‘impression’ left by the anesthesiologist’s judgement, Dr. Harrowing changed the community of affect that she adopted within her own nursing practice. Sara Ahmed’s theorizing has helped me to understand the concept and circulation of communities of affect. As Ahmed states, “If the object of feeling both shapes and is shaped by emotions, then the object of feeling is never simply before the subject. How the object impresses (upon) us may depend on histories that remain alive insofar as they have already left their impressions.”¹³⁸ Dr. Harrowing actively shifted her own professional methods in order to leave a different ‘impression’ on those she cared for. I suggest that this can only occur if someone holds an understanding of the complexity of emotion. And second, a practitioner must understand how ‘economies of affect’ are created and sustained through action and reaction to others. After becoming a registered nurse, Dr. Harrowing internalized the memory of her treatment by medical professionals using her personal experience to not only influence care towards her patients, but also to inform her own insight into the complexity of individual experiences of pain. The following statement reveals how Dr. Harrowing conceptualized the pain of others:

SI: So, can you speak a little bit further about how it impacted your career as a Registered Nurse? How that experience in the hospital...?

DH: Well, I think I have been pretty careful to never judge people, at least not openly. I always wonder what the story is of any person that I come across. I’ve worked with many people who were dying because my work was palliative care for many years...and I did a lot of symptom control, including pain management...So, I was often asked to consult on patients who were experiencing pain, and who were not necessarily dying...I resist labelling and I don’t know if it has anything to do with

¹³⁸ Ahmed, *The Cultural Politics of Emotion*, 8.

my experience having had an abortion...What stands out for me about the abortion process was the process of appearing in front of all of these people and having to prove my case. I just didn't think that was right...that I should have someone wagging their finger at me in the OR room. It just seemed very disrespectful and degrading. Maybe that did influence my practice...Anyway, I think I was able to give better care to people who came in with stories that affected how they address their own health issues.¹³⁹

While I do not imply that any one individual's experience of pain is identical, I argue throughout this chapter that pain is central to many women's experiences with and understanding of their reproductive body. Further, the historiography of abortion in Canada shows how pain shaped women's experiences. Ahmed explores the meaning of pain in relation to personal connections to others and the 'circulation' of emotion. Ahmed describes, "pain [as] not simply the feeling that corresponds to bodily damage. Whilst pain might seem self-evident...the experience and recognition of pain *as pain* involves complex forms of association between sensations and other kinds of 'feeling states'."¹⁴⁰ Ahmed's conceptualization of pain is not limited to a bodily sensation it also applies to feelings directed towards others.

Applying Ahmed's insight, I believe the anesthetist's judgement directed at Dr. Harrowing symbolically illustrates how some medical practitioners 'other' the female reproductive body as a means to exert professional authority. By so doing, any women's experiences of abortion may become the object of disapproval. This disapproving gaze may cause memories of pain.

In *The Body in Pain: The Making and Unmaking of the World*, Elaine Scarry divides pain into three categories which she views as three 'concentric circles'.¹⁴¹ These

¹³⁹ 18:05-21:46, Interview with Dr. Harrowing, 2nd March, 2017.

¹⁴⁰ Sara Ahmed, *Cultural Politics of Emotion*, (New York: Routledge Press, 2012), 23.

¹⁴¹ Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World*, (New York: Oxford University Press, 1985), 3.

three circles are divided as follows: “*first*, the difficulty of expressing physical pain; *second*, the political and perceptual complications that arise as a result of that difficulty; and *third*, the nature of both material and verbal expressibility.”¹⁴² Pain, in Scarry’s model, is the intersection within these ‘concentric circles’ where concrete experiences and expression reside. Dr. Harrowing’s experience exemplifies how the pain associated with her memory of abortion caused her to reformulate her practice as a registered nurse. Pain, as exemplified by Dr. Harrowing’s capacity to empathize with others, can be transformative.

To gain an understanding of the historical narrative of accessing abortion services, I was invited to listen to and witness as Dr. Harrowing made sense of her own experience and history. Similarly, Dr. Harrowing also applied narrative within her career to understand the history of each of her patients. What emerged from my interview with Dr. Harrowing was not only the memories connected to obtaining an abortion but also how the event informed her nursing career by way of her interactions with individuals in pain. While Dr. Harrowing recalled the pain of being judged as a result of her interaction with the anaesthesiologist, the overall process of obtaining an abortion was, more generally, a very solitary experience. In my second interview with Professor Sisson, her memory of two abortions was shaped by her relationship with her partner. The differing memories of initial feelings concerning terminating their respective pregnancies demonstrates the historical importance of individual narrative to shed light on the complexities surrounding access to abortion services.

¹⁴² Scarry, 3.

The Poster-Child for Choice: Irene Sisson

My interview with Professor Irene Sisson was the final interview that I conducted for my research. Over the course of our two-hour conversation, Professor Sisson recalled her experiences of two therapeutic abortions. As she compared the varied memories of both, my understanding of the history of access to abortion is fraught with incongruities expanded leading me to conclude that there is no singular narrative of the experiences of abortion, even within the lifetime of a single individual. Professor Sisson recalled her first memory of her first therapeutic abortion as follows:

SI: What can you tell me about when you first found out you were pregnant?

IS: Okay, well there are two incidents here. When I first found out I was pregnant, I mean really, my first thought was that I would have an abortion. I was 18 at the time. I had an ongoing partner and he was in agreement with it, to terminate the pregnancy. We were both really young... We were just going to have adventures. We weren't going to have children. I wasn't going to tell my parents. I wasn't going to tell anyone, really.¹⁴³

Adding to her memory of her decision to terminate that first pregnancy, Professor Sisson recalled being invited to participate in a public service announcement on access to abortion:

IS: I just wanted to say that before this, I can't remember how this happened and I was going to bring you the picture, I had been approached by somebody doing a public service announcement about access to abortions when I was 16 or 17? And they asked if I would pose for a photograph in a playground or a field, I can't remember, I have the photograph deep in my archives because it was pretty strange. The caption on the photograph was, 'To be every child, a wanted child and every mother, a willing mother.' So, before I had really even entered adulthood, I was apart of an advertising campaign for access to abortion.¹⁴⁴

This phrase attached to the campaign Sisson recalls, 'Every mother a willing mother, every child a wanted child,' became a hallmark of the pro-choice movement and most commonly

¹⁴³ 00:30-01:40, Interview with Irene Sisson by Shannon Ingram, 26th October, 2017.

¹⁴⁴ 01:30-02:00, Interview with Irene Sisson, 26th October, 2017.

associated with Dr. Henry Morgentaler's plight for the full decriminalization of abortion.¹⁴⁵ As a participant in the campaign arguing for reproductive autonomy for women this experience implicated Professor Sisson in the larger dialogue on 'suitable' motherhood.

The public service announcement reveals how public conversation concerning abortion also endeavoured to editorialize about controlling teenage pregnancies. The announcement juxtaposed a teenager, Professor Sisson, alongside the catchphrase specifically focusing on her age. As a high school student at the time, the caption drew attention to Professor Sisson age at the time, implying that her youthfulness disqualified her as a suitable, or prepared, candidate for motherhood. This small detail conveyed Sisson memory of a campaign focussed on reducing teen pregnancy triggered my thoughts on how the history of advocacy for access to birth control, or, earlier for voluntary motherhood, in Alberta converged with the history of eugenics as documented by Erika Dyck and Amy Kaler. Further, a history of women's struggles for reproductive autonomy in Alberta would not be complete without an acknowledgment of the influence of the United Farm Women of Alberta (UFWA).

Founded in 1915, the UFWA was established as a "women's auxiliary to the UFA, a populist, agrarian farmers' organization that became a political party".¹⁴⁶ Focussing on the development of the UFWA, Kaler documents how the exclusively women-led organization was able to push eugenic ideals throughout Alberta during the beginning of the twentieth-century that strengthened support for Alberta's Sexual Sterilization Act.¹⁴⁷

¹⁴⁵ "Obituary of Henry Morgentaler: Canadian Safe Abortion Crusader," *BMJ* online, 7th September, 2013, <https://www.bmj.com/bmj/section-pdf/737987?path=/bmj/347/7923/Obituaries.full.pdf>.

¹⁴⁶ Kaler, 81.

¹⁴⁷ Amy Kaler, "Mothers' Duties: Eugenics, Sterilization, and the United Farm Women of Alberta," in *Baby Trouble in the Last Best West: Making New People in Alberta, 1905-1939*, (Toronto, ON: University of Toronto Press, 2017), 85.

Further adding to this analysis, sociologist Jana Grekul argues that, “From today’s vantage point, it is perhaps easier to understand women’s involvement in the birth control movement during this time because this movement’s objectives on the surface at least represent a move toward greater female control of their own bodies. However, birth control advocates did not all share the same objectives and many were also eugenicists”.¹⁴⁸ The inconsistencies that some may equate with an organization that was led by women who advocated for greater reproductive choice for some while simultaneously limiting the same freedoms for others was the foundation of eugenics during the twentieth-century in Alberta. The female members of the organization applied the tenants of maternal feminism, asserting their authority to address issues concerning women’s reproduction within Alberta, “because they were mothers and gave birth[; moreover,] they claimed the social organization of birth as their moral terrain”.¹⁴⁹ Indeed, as is asserted by Kaler, “Sterilization happened, I argue, because the social imaginary of early-twentieth-century Alberta permitted both the construction of social problems and the definition of solutions to these problems in ways that favoured public intrusions into private reproductive lives”.¹⁵⁰ This observation by Kaler may also provide one explanation as to why Professor Sisson was targeted for the public service announcement on access to abortion.

Professor Sisson’s memory of her involvement within the pro-choice movement through the advertisement campaign in Calgary is significant as it, perhaps, confirms the scholarly discussion that teenage girls were disproportionately targeted to control their reproduction. Erika Dyck argues that, “Throughout the 1970s, as abortion attracted media

¹⁴⁸ Jana Grekul, “Sterilization in Alberta, 1928 to 1972: Gender Matters,” *Canadian Review of Sociology* vol. 45, no. 3 (August 2008), 250.

¹⁴⁹ Kaler, 86.

¹⁵⁰ Kaler, 78.

and public attention, the debate about parenthood refocused on women: their bodies, once again, came under medical and public surveillance as the site of contest over reproductive morality. Some women celebrated the steps taken towards greater autonomy...Others—pregnant teenagers and those considered mentally incapable of autonomous living and responsible parenthood – instead encountered greater scrutiny.”¹⁵¹ Jana Grekul further suggests that within the history of sterilization in Alberta, “several subgroups, including women, Aboriginals, and teenagers and young adults [were] overrepresented in cases sterilized by the Eugenics Board and its affiliated mental health institutions”.¹⁵² And while age was minimal in my interviews with Dr. Simons or Dr. Jacobson, both Professor Sisson and Dr. Harrowing mentioned their age as a personal deterrent for carrying on with the pregnancy. Professor Sisson’s role in the public service visual campaign, although arguing for choice, also implicitly reinforced a criterion for ‘responsible parenthood’.

The history of access to abortion services in Canada also highlights the complexities surrounding the language of ‘choice’ during the 1970s. Dyck further asserts that, “The issue of choice in this sense effectively absorbed an essential grain of eugenics philosophy and continued to rely on the authority of the medical profession to determine who made good parents, either biologically or socially.”¹⁵³ Clearly, as Professor Sisson’s experience exemplifies, age factored as a socially constructed qualification for a woman’s (or youth’s) choice in terminating the pregnancy.

¹⁵¹ Dyck, 205.

¹⁵² Grekul, 249.

¹⁵³ Dyck, 207.

Prior to obtaining her first therapeutic abortion, Professor Sisson recalled the judgement directed towards her by a general practitioner when inquiring about birth control options. She recalled that interaction as follows:

LD: And this is all confused to in my mind, that history, probably forgotten because it was really a drag...I think my first IUD [intrauterine device] was the Dalkon Shield, and I don't know if you know anything about the Dalkon Shield. There was a lawsuit. It was a spikey looking thing. I can't remember the sequence of events. If I got pregnant and the device was still in there...that might have been a factor. I had a lot of yucky things happen because of that IUD...It was a big problem dealing with birth control. I'm moving on, but if you want to talk about barriers (chuckles)...I had gone to my family doctor, who was an older man, when I came home...and so I asked him about birth control and he said, 'no. You should abstain.'...He was the one who put the Dalkon Shield in, so I'm quite sure he was inexpert and he did it unwillingly...Really, what he was saying was, 'Okay. I'll do this but really you shouldn't be doing this at your age.' I might have been 18 at the time.¹⁵⁴

Both memories shared by Professor Sisson focused on age as an additional criterion used to mediate or control women's sexual activity. The above excerpt from our interview, however, only briefly describes the complicated and traumatic history that Professor Sisson shared with me about her reproductive history.

Prior to becoming pregnant with her first pregnancy, Professor Sisson was training as a professional dancer in New York. Bodily scrutiny and the societal pressure for women to remain thin was intensified for Professor Sisson because of the standards expected of her within the dancing profession. Professor Sisson recalled taking 'the pill' from a very young age:

IS: I was on birth control very early. I had taken, you're going to laugh, but in New York City, I was a poor, starving dancer and I went to the Margaret Sanger clinic and I was put on some sort of trial for the pill so I didn't have to pay anything. I didn't have a doctor [in New York City] so I took the pill and I put on a whole lot of weight, which was horrible for a dancer. I had just ballooned! I had these boobs and this big butt. When I went back to the dance program, one of the kind instructors

¹⁵⁴ 07:45-10:30, interview with Irene Sisson, 26th October, 2017.

came up to me and said, ‘you know, this isn’t a good thing. You need to lose weight.’ And so, I went off the pill and got an IUD instead.¹⁵⁵

Professor Sisson’s memory of her struggle to obtain accessible and affordable birth control while studying dance in New York City flags the side effects that accompanied the early version of ‘the pill’.

Unlike many Canadian women, Professor Sisson was able to access birth control in the United States before it was fully decriminalized in Canada after 1969. Her experience, unlike Dr. Harrowing’s, merges some aspects of the history of birth control in the United States with the history of birth control and therapeutic abortion in Canada. The first iteration of ‘the pill’ was approved by the US Food and Drug Administration in 1960, and later approved by the Supreme Court, for married women, in 1965.¹⁵⁶ Pharmaceutical contraception would only become legal for all citizens, regardless of marital status, in 1972.¹⁵⁷ Professor Sisson was able to receive oral contraceptives as a client within a drug trial, at a time when the side effects of the early pill were much more severe than subsequent doses.

Prior to its approval by the FDA in the United States and its decriminalization and availability to white middle-class women, preliminary trials for oral contraceptives such as Enovid were conducted. Latina women in Puerto Rico and Black women in the United States, and Haiti, were the initial trial subjects for Enovid beginning in 1956.¹⁵⁸ These early

¹⁵⁵ 07:00-07:59, interview with Irene Sisson, 26th October, 2017.

¹⁵⁶ Kirsten M.J. Thompson, “A Brief History of Birth Control in the U.S.,” *Our Bodies, Ourselves Online*, 14th December, 2013, <https://www.ourbodiesourselves.org/book-excerpts/health-article/a-brief-history-of-birth-control/>.

¹⁵⁷ Ibid.

¹⁵⁸ Suzanne White Junod and Lara Marks, “Women’s Trials: The Approval of the First Oral Contraceptive Pill in the United States and Great Britain,” *Journal of the History of Applied Sciences*, vol. 57, no. 2 (April 2002), 124.

doses of Enovid contained extremely high levels of hormone levels that led to nausea, dizziness, weight-gain (most prominently remembered by Professor Sisson). More serious side effects like blood clots led to death in some cases.¹⁵⁹ In some ways, being a white woman protected Professor Sisson from the experiences of Black and Latina women in the United States as documented by historians White Junod and Marks. In other ways, because of her youthful age and economic instability, Professor Sisson was another demographic of the birth control movement in the United States.

Margaret Sanger, the woman most commonly ‘idolized’ as the “mother of birth control” in the United States, founded the American Birth Control League in 1921, later forming the Birth Control Federation of America (BCFA) in 1939.¹⁶⁰ Sanger’s ambition to develop and legalize pharmaceutical contraceptives increased women’s reproductive autonomy and helped to decrease the number of pregnancy-related deaths. Just as the history of access to therapeutic abortions is fraught with incongruities, so too is the history of the birth control movement in the United States and Canada. Legal scholar Dorothy Roberts argues in, *Killing The Black Body: Race, Reproduction, and the Meaning of Liberty*, that Sanger’s “original feminist vision of voluntary motherhood” soon coalesced with America’s concern for “fiscal security and ethnic makeup.”¹⁶¹ Prior to being available to single women like Professor Sisson, the pill and its numerous negative side effects were first experimented on women of colour who were disenfranchised economically and socially.

¹⁵⁹ White and Marks, 146.

¹⁶⁰ Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, (Toronto, ON: Random House of Canada limited, 1999), 57.

¹⁶¹ Roberts, 58.

The birth control movement that began as a means to allow women greater reproductive autonomy soon focused, similar to Alberta's Sexual Sterilization Act, on limiting those understood as "unfit" mothers from becoming pregnant. The birth control movement, Roberts argues, "veered from its radical, feminist origins towards a eugenic agenda [where] birth control became a tool to regulate the poor, immigrants, and Black Americans".¹⁶² Roberts further comments that, "The career of Margaret Sanger demonstrates how birth control can be used to achieve coercive reproductive policies as well as women's liberation."¹⁶³ Opponents of the legalization of birth control overemphasized the possibility of death and long term health concerns while proponents of birth control, many of whom argued for population control, underemphasized the discomforts of the pill.¹⁶⁴

U.S. feminist historian Linda Gordon analyzes efforts by women to control their reproduction prior to and following the decriminalization of oral contraceptives. Beginning in 1967 in the United States, the pill 'dropout' began before the side effects of oral contraceptives became publicly exposed by women's health movement activists. Gordon argues that for women who initially chose to take oral contraceptives, the decline in use occurred not because of advice received from doctors to discontinue use, but rather women were acting "on their own initiative" while seeking better alternatives to avoid pregnancy.¹⁶⁵ Indeed, Gordon's point about women exercising authority over the method of birth control they chose, alongside the vocal activism of the women's health movement

¹⁶² Roberts, 58-59.

¹⁶³ Roberts, 58.

¹⁶⁴ Linda Gordon, "The Folklore of Birth Control," in *Reproduction and Society: Interdisciplinary Readings*, eds. Carole Joffe and Jennifer Reich (New York: Routledge Press, 2015), 25.

¹⁶⁵ Gordon, 25.

of this era may have influenced Professor Sisson's decision to switch from an oral contraceptive to the Dalkon Shield. Her initial decision to obtain an IUD was in part because of its increased efficacy in reducing pregnancy, but more significantly, it was her attempt to avoid the noticeable weight gain that resulted from the high doses of estrogen in the earlier versions of 'the pill'.

Professor Sisson recalled returning where her partner resided during her summer break. She travelled back to New York during the fall/winter seasons for dance. She expressed an ongoing concern that the IUD was working effectively:

IS: I had to do it [re-insert the IUD] every couple of years and it was really tricky. I did it right up until I was in my late twenties. Because that was what they said that you should do. It was always painful and it was always horrible...not painful like that first one where I was told that I shouldn't be doing what I was doing. I shouldn't even be asking for it...But, my partner and I really felt that it was the right way to go. We didn't believe the other methods would prevent pregnancy.¹⁶⁶

The side effects that Professor Sisson had experienced from taking oral contraceptives were adverse enough for her to seek alternative options. As mentioned in the above excerpt, Professor Sisson recalled the reluctant decision of her family doctor to insert an IUD. Early medical versions of the IUD marketed by pharmaceutical companies included the Dalkon Shield. Scholars Carole Joffe and Jennifer Reich classify the Dalkon Shield in the category of "first generation [IUDs] which were very controversial because of numerous injuries they caused and in the case of the Dalkon Shield, even some deaths."¹⁶⁷ Additional side effects of early IUDs like the Dalkon Shield included "pain and bleeding, pelvic inflammatory disease, septic abortions, uterine perforations, anemia, embedding, and even

¹⁶⁶ 10:59-11:39, interview with Irene Sisson, 26th October, 2017.

¹⁶⁷ Carole Joffe and Jennifer Reich, "Contraception and Sterilization," introduction to *Reproduction and Society: Interdisciplinary Readings* (New York: Routledge Press, 2015), 13.

fragmentation of the devices.”¹⁶⁸ Indeed, this history relates to Professor Sisson’s history with the Dalkon Shield and the pain that she incurred as a result of the device.

The end of restrictions on birth control as well as the increased and partial access to abortion services in Canada between 1969 and 1988 was no more liberating than the previous half of the twentieth-century. Procedural protocol may have slightly changed regarding access to medical interventions to control reproduction, but during the decades from 1969 to 1988, women were subjected to discomfort and judgement from the medical system. These effects were further compounded by the complex emotions women experienced throughout their search for methods to control their reproduction.

For Professor Sisson, the emotions she experienced with her second pregnancy varied greatly from her first pregnancy. Like Dr. Harrowing, during the second experience of seeking a therapeutic abortion, Professor Sisson did not remember exact details of the referral process nor how she found out she was approved for an abortion. She recalled that approval for the second abortion was relatively easy for her to secure, remembering that the screening process was less intense than for the first abortion. Whereas Professor Sisson received her first abortion at the Foothills Hospital in Calgary, her second abortion was performed at the Holy Cross Hospital, also in Calgary. In the quest to obtain her first abortion, Professor Sisson recalled answering a long slate of questions pertaining to her mental health, her age, the stability of her relationship, and her family history. These questions were all deemed ‘necessary’ to secure an approval for an abortion. Just as Dr. Harrowing remembered highlighted how distraught she was by her pregnancy, Professor Sisson also highlighted the negative emotional impact that carrying a pregnancy to term

¹⁶⁸ Gordon, 25.

would have on her life. Her familiarity with the criteria used by medical professionals to get to the approval stage allowed Professor Sisson, as it did Dr. Harrowing, to assert some degree of self-awareness and control over the process. Regarding women's relative empowerment in the process, historian Tracy Penny Light discusses the relationship between medical practitioners and women patients, stating that, "While it cannot be argued that women have had control or absolute power over their own bodies historically (or even today), their ability to question or reshape the medical view to suit their own situation is apparent."¹⁶⁹ And while Penny Light fails to address the influence of eugenics in preventing many women, primarily Indigenous women and differently (able)ed people, of their right to control their own bodily autonomy during the twentieth-century, both Professor Sisson and Dr. Harrowing, white, middle-class, educated cisgender women, possessed an awareness of the medical screening for the woman's susceptibility to depression and suicide. This awareness allowed each woman to, as Light suggests, 'reshape the medical view to suit their own situation.'¹⁷⁰

Ten years after her first abortion, when Professor Sisson was beginning her first year of her Master's degree, she and her partner experienced greater indecision about termination of the pregnancy. During her first pregnancy, Professor Sisson and her partner's decision was, according to her, 'the obvious choice'. Whereas she remembers the procedure as less formidable for her second abortion, making the decision to terminate more challenging. The challenges deciding to terminate for the second time had to do with age, her partner's expectations, and timing of motherhood as her observation reveals:

IS: I think there was a lot of judgement on the first one because I was so young and must have been so stupid. Just like my family doctor [said], 'you shouldn't be doing

¹⁶⁹ Light, "Shifting Interests: Medical Discourse on Abortion in Canada, 1850-1969," 10.

¹⁷⁰ Light, "Shifting Interests: Medical Discourse on Abortion in Canada, 1850-1969," 10.

this'. There was a lot of shaming but I think I was just really protected by my partner's attitude...And the second one, I think I was just so wrapped up in my realization about how sad my partner was that I didn't realize what was going on in the hospital. If I contrast that with my ectopic pregnancy, when I went in...the level of care and nurture in that situation was enormous.

SI: And how was your partner with emotional support during the second abortion?

IS: I think it was okay. I think it was a more difficult time...It was okay. We had to work harder at it. I think we named that one. We named that baby (small laughter). You know, sort of in a joking way. So that stays with us as an important moment where we made the decision, 'Okay. So we are going to have children.'...He supported me but I remember sometimes afterwards going out for dinner and actually talking about it...I think he was just sad and wished things were otherwise. I don't know, if I'm really honest, if I wished things were otherwise at that point. In retrospect, I think I do. I don't regret the abortion parse but I think that was really key to my idea that, 'oh. Well, actually having a kid with this person would be pretty great.'¹⁷¹

In a recent study published in 2018 by health scholars Kathryn J. LaRoche and Angel M. Foster examine the language used by medical professionals towards women who had multiple abortions is examined as perpetuating women's internalized stigma of the procedure. Their study traces the experiences of over 300 women who had more than one abortion over their lifetime.¹⁷² LaRoche and Foster state that, "women consider abortions to be unique life events, even if more than one abortion occurs in similar circumstances. [none] of our participants talked about their abortions as being a repeat of a previous experience, and instead discussed their experiences in a variety of ways, noting both similarities and differences, in both process and feelings."¹⁷³ Although the study focuses on the experiences of women long after the full decriminalization of abortion in Canada, many of the concerns from women regarding their treatment by medical professionals also

¹⁷¹ 25:20-30:04, interview with Irene Sisson, 26th October, 2017.

¹⁷² Kathryn J. LaRoche and Angel M. Foster, "Exploring Canadian Women's Multiple Abortion Experiences: Implications for Reducing Stigma and Improving Patient-Centered Care," *Women's Health Issues* vol. 28, no.4 (August 2018), 328.

¹⁷³ LaRoche and Foster, 330.

paralleled Professor Sisson's experience of her second abortion and her interactions with medical professionals. Following the birth of her child, Professor Sisson discussed an interaction with a nurse in a hospital emergency department when she was miscarrying. As she explained, she was asked to reveal the number of previous pregnancies:

IS: And the judgements don't really stop because when I had a miscarriage here, after I had my son, I was admitted into emergency. And they were taking [my medical history] and they said, 'how many times have you been pregnant?' And I was sitting there and thinking, 'Okay, I'm just going to be honest. Two ectopic pregnancies, one child, two abortions, so this will be number five.' And then the person said, 'Oh. Well you shouldn't be surprised because you have a history of miscarriages'. And I said, 'They weren't miscarriages. Two of them were abortions.' And I could see this person's face... 'what?'...And so it's really difficult to be honest with strangers, even medical personal. And yet, it's an important part of your history.¹⁷⁴

While in the emergency department suffering from an ectopic pregnancy, Professor Sisson recalled the judgement and insensitivity she received from disclosing her history of two prior abortions to the attending nurse. The facial expressions, tone, and language visible on the attending practitioners contributed to Professor Sisson's impression of this experience as they did with Dr. Harrowing's experience accessing her therapeutic abortion. Indeed, as exemplified in the recollections of both women, language played an important role in shaping either a negative or positive impression with medical professionals. Expanding on the importance of language in reducing stigma within the medical profession, specifically concerning reproductive health, LaRoche and Foster argue that, "Language plays a crucial role in producing, perpetuating, and advancing the social narratives and discourses that shape our reality. In reproductive health, a field that is already stigmatized, often misunderstood, and the subject of ongoing political and legislative attacks, the stakes seem especially high."¹⁷⁵

¹⁷⁴ 23:20-24:00, interview with Irene Sisson, 26th October, 2017.

¹⁷⁵ LaRoche and Foster, 330.

To redress some of the problematic or moralizing attitudes held by some medical practitioners regarding reproductive health and to expand the historiography of access to abortion services, the incorporation of women's narratives is crucial. Only by hearing these individual experiences will we better understand the complex history and struggle for reproductive autonomy. The experiences of both Dr. Harrowing and Professor Sisson shed light on the incongruities within history of the pro-choice movement in Canada and the United States. The most impactful reactions centered around pain, both the physical pain and the emotional pain associated when they were judged by those attending to their care.

Chapter Three: How *should* I Feel?: Methods for Incorporating Emotion Into The Histories of Women’s Reproductive Health

Throughout this thesis, I have incorporated how emotions have shaped my understanding of the history of abortion in Alberta stressing the importance of incorporating self-reflexivity and subjectivity as an analytic lens. My research is grounded in feminist literature on abortion politics in Canada, in oral history methods, and in the growing scholarship on the history of emotion. I apply Sara Ahmed’s description of ‘emotionality’ to understand how emotion historically enforced hierarchies of power between medical practitioners who were empowered to regulate access to abortion services and those women, in possession of considerably less power, who sought abortion procedures. Ahmed argues that the term ‘emotionality’ should not be viewed “as a characteristic of bodies... [rather emotionality should be studied] as a process whereby ‘being emotional’ comes to be seen as a characteristic of some bodies and not others. In order to do this, we need to consider how emotions operate to ‘make’ and ‘shape’ bodies as forms of action, which also involve orientations to others.”¹⁷⁶ Applying Ahmed’s description of ‘emotionality’ addresses how emotions were used historically by each narrator as a form of action. Further, through analyzing the ways in which bodies are oriented to one another unveils the social construction of power.

Emotions have historically created a foundation of authority to control women’s autonomy through the use of TACs. Each narrator also demonstrated, however, how emotion can be used to erode power. For example, both doctors interviewed discuss the ways in which they evaluated women petitioning for an abortion by adjudicating how each

¹⁷⁶ Sara Ahmed, “Introduction: Feel Your Way,” in *The Cultural Politics of Emotion* (New York: Routledge, 2012), 4.

woman 'ought' to feel. Understanding the emotional expectation expected of women facing an unplanned pregnancy was crucial for one narrator as she was able to articulate to the referring psychologist before he submitted an application to the Lethbridge TAC on her behalf. Central to my thesis is the question: how can the struggle women experienced in accessing abortions in Canada be understood through an analytic framework focusing on emotion?

Focusing on the cultural origins and the construction of emotion, scholar Jenny Harding argues that, "emotions can be put to work in critical categories in analysing social practices and relations, where they (emotions) are understood not as already formed but as historically situated inter-subjective processes produced through, and helping to produce, subjectivities, social structures, institutions, patterns of organization and power relations".¹⁷⁷ Reflecting on the practice of oral history and applying concepts central to the history of emotion enhanced my analysis of the memories shared by each narrator.

In addition to Ahmed's definition of 'emotionality' as forms of action that are oriented to one another, historian William Reddy provides an alternative use of emotions in his definition of 'emotives'. Emotives are described by Reddy as, "the process by which emotions are managed and shaped, not only by society and its expectations but also by individuals themselves as they seek to express the inexpressible."¹⁷⁸ Ahmed's term of 'emotionality' and Harding's understanding of emotion as 'historically-situated' complement Reddy's definition of 'emotives', enabling greater insight into how each narrator formed memories surrounding abortion. Moreover, with my analysis of the ways

¹⁷⁷ Jenny Harding, "Talk about Care: Emotions, Culture and Oral History," *Oral History* 38, no. 2 (Autumn 2010): 35.

¹⁷⁸ Barbara H. Rosenwein, "Worrying about Emotions in History," *The American Historical Review*, Vol. 107, No. 3 (June 2002), 837.

in which emotion has been used to argue for, or against women's bodily autonomy, I aim to create a more nuanced understanding of the complexities of women's lives and the lived experiences of medical practitioners concerning women's bodies.

'Queering the Act of Listening': Applying Dina Georgis's Theory of Affect

One of the unique qualities of using oral history as a mode of analytic inquiry is the researcher's realization that no matter how firm her plan the interview may be derailed. Oral historian Lynn Abrams argues that, "[through] conducting oral histories one is always aware of a project's open-ended nature in that few interviews stick to the script the researcher has set and new avenues are constantly being introduced by the respondent. But historians find it hard to break out from their disciplinary straightjacket."¹⁷⁹ To embrace the uncharted nature of the interview, I frequently consulted works from interdisciplinary scholars who more commonly and intentionally tread in the off-the-beaten path. One scholar that challenged me to embrace the uncharted territory of the interview process was Dina Georgis in *The Better Story: Queer Affects from the Middle East*.

In this book, Georgis focuses on the affective traces left within stories of conflict from the Middle East. Although drastically different from the historical context of accessing therapeutic abortions in Alberta, Georgis's argument drew my attention as an interviewer to the traces of affect within individual narratives. Georgis' conceptualization provided me with a deeper analytic tool to understand the memories shared by my interview subjects: Dr. Jacobson, Dr. Simons, Dr. Harrowing, and Professor Sisson. Using Georgis's analytic framework contextual to the political struggle in the Middle East, I was able to extract how all histories create a space to listen to individual narratives. It is the

¹⁷⁹ Abrams, 29.

responsibility of the researcher, however, to pay attention to the individual narratives. I garnered insight from Georgis's direction to pay attention to the sites of injury, described as the 'abject perversions of difference,' within a story to more comprehensively relate with each narrator. Georgis argues that, "stories give us access to the existential experience of trauma, loss, difficulty, and relationality. Stories, I propose, are emotional resources for political imagination and for political renewal because they allow us to understand struggles that lead to devastating conflicts...as human responses to histories of injury."¹⁸⁰ Once I applied Georgis's insight on the transformative nature of stories, I understood that a history of analyzing the barriers to accessing abortion begins with looking at the communities of affect that circulate between the individuals who participate in the relationships needed to secure an abortion. Analyzing the ways in which history is shaped by social relations allowed me to uncover a rich and complex narrative in women's individualized struggle for reproductive autonomy. Indeed, emotion is not static and responds to the historical and cultural. Individual experiences are shaped by emotions. Experiences, therefore, become memories and memories become histories.

Oral historians commonly refer to the practise of 'active listening' to describe how one ought to proceed throughout an interview. Listening actively involves paying attention to the words, gestures and silences within each participant's narrative. As an interviewer, I endeavored to apply this practice throughout each interview. In listening to the interviews afterwards, I frequently noticed my own reactions spotting missed opportunities to understand what each individual was saying or avoiding saying. Oral historian Kathryn Anderson describes in, "Learning to Listen: Interview Techniques and Analyses,"

¹⁸⁰ Georgis, 1.

throughout the course of an interview for a project on women's roles in northwest Washington farming communities, "[she became] painfully aware of lost opportunities for women to reflect on the activities and events they described and to explain their terms more fully in their own words."¹⁸¹ Similarly, through the process of listening to each of my interviews afterwards I too noticed the countless missed opportunities and blamed myself for distracted listening that seem to characterize each interview.

Embracing My Own Discomfort

Arguing for an alternative, and perhaps less judgmental, approach Georgis describes 'ethical listening' as, "[paradoxically: ethical listening] attends to being affected but is neither disengaged nor wanting to see or master what it sees and hears."¹⁸² More broadly, I applied Georgis's definition of 'ethical listening' to notice the moments within each interview where I disengaged or changed the dialogue to fit my own narrative of the history of TACs. Curiously, these inclinations became evident most acutely in my interview with Dr. Jacobson.

Prior to our interview, Dr. Jacobson was provided with a small amount of information regarding my religious history by the individual facilitating our contact. I was informed that Dr. Jacobson, who is a practicing Anglican, had been told that I was raised Mormon. Having learned of my religious upbringing prior to beginning our interview, I did not believe that this small fact would influence the outcome of our interview. Moreover, as I quickly discovered what I initially deemed irrelevant to the history of TACs was something of significant importance to Dr. Jacobson's recollections. Over the course of the

¹⁸¹ Kathryn Anderson and Dana C. Jack, "Learning to Listen: Interview Techniques and Analyses," in *The Oral History Reader*, eds. Robert Perks and Alistair Thomson (New York, NY: Routledge 1998), 159.

¹⁸² Georgis, 18.

interview, Dr. Jacobson mentioned on three separate occasions that many of the patients applying for abortions, specifically 50 percent, were Roman Catholic.¹⁸³ I initially dismissed his frequent mention of the religious affiliation of the applicants as I had become more interested in the medical recommendations that were often suggested for women subsequent to the therapeutic abortion. At the second mention of an applicant's religion, however, Dr. Jacobson repeated that the majority of the patients were Roman Catholic and later, referenced the Mormon Church's condemnation of abortion. Correspondingly, I became more attune to the direction that Dr. Jacobson's apparent redirection of our interaction.¹⁸⁴ Additionally, his mention of my own religious upbringing signaled to me that just as I entered the interview with a specific agenda as an interviewer, Dr. Jacobson also possessed a piqued interest in my decision to choose the topic of abortion, especially relative to my upbringing.

Abrams writes about the influence of the constitutive nature of the interviewer-interviewee relationship, arguing, "The historian cannot play such an active role in the production of a primary source and then conveniently ignore his or her own presence in the process at the analysis stage."¹⁸⁵ Indeed, neglecting some mention of the religion of the women seeking abortions in Lethbridge may have removed a key element of Dr. Jacobson's narrative; an element he appeared to want me to notice. Abrams further explains how objectivity is an impossibility in oral history, "Neutrality is not an option because we [as historians] are part of the story."¹⁸⁶ Including Dr. Jacobson's knowledge of my own

¹⁸³ 15:03, interview with Dr. Jacobson by Shannon Ingram, 23rd October 2015.

¹⁸⁴ 39:45. interview with Dr. Jacobson

¹⁸⁵ Abrams, 58.

¹⁸⁶ Abrams, 58.

religious past demonstrates that oral historians cannot be nonpartisan beings in the interview relationship.

Thus over the course of our interview, as Dr. Jacobson frequently circled back to the topic of religion, I redirected the conversation away. Even today, as I listen to the excerpts from the interview, I feel my body tense at the mere mention of the ‘Mormon’ Church. Unlike the other interview participants, Dr. Jacobson knew an intimate part of my personal history and a history that for me was contoured by memories of pain. Years after renouncing the Mormon Church, identifying as a feminist, and retrospectively conceiving of my sexual molestation as an act of gendered violence. Listening to the interview with Dr. Jacobson some years later, I am more aware of the failed opportunities where I allowed my own painful memories of religion to block the narrative that Dr. Jacobson attempted to share. This insight also provided me with a greater understanding of the discomfort associated with occupying a space of vulnerability; sites where I required the narrator to resurface historical trauma to allow me, a stranger, an opportunity to investigate further.

Just as I frequently and unintentionally blocked the moments where Dr. Jacobson attempted to articulate the influence of religion on TACs, I also experienced a degree of reticence in asking both Dr. Harrowing and Professor Sisson to remember the emotions connected with their therapeutic abortions. The structure of all four interviews were quite similar. Each participant had an opportunity to review the questions and make adjustments. The difference, however, in my reaction to the answers from Dr. Harrowing and Professor Sisson were heavily bounded by my controlling tendency to avoid eliciting any traumatic emotional memory.

Historian Valerie Yow has closely analyzed the rejection of objectivity within the historical discipline to explain how embracing subjectivity influences the interviewer-interviewee reciprocity. Yow writes that, "we cannot go about research without questioning ourselves, our biases, our purposes, our reactions to the narrator and the process, and the effects our research [may] have on the narrator."¹⁸⁷ Prior to the beginning of each interview, I had a somewhat limited understanding of the emotions that might emerge for me during my sessions with Dr. Harrowing and Professor Sisson. Although unaware of what I was acting on at the time, I unconsciously subscribed to the binary of abortion narratives. Only in my more recent attention to the affective traces embedded in each narrative have I come to understand my influential role in the interview process more fully.

Yow examines how the influence of "positive transference" must be acknowledged by the interviewer. Yow recalls memories where her own feelings towards the narrator significantly influenced the direction of the interview, "I [had] found myself hesitating to ask some things of narrators for whom I felt affection lest my questions cause them discomfort. Awareness of this positive transference might help the interviewer to confront the narrator with the difficult questions that would have perhaps been avoided otherwise."¹⁸⁸ Yow's insight indeed applied to my own reticence to ask some important follow-up questions in my interview with Dr. Harrowing and Professor Sisson. Moreover, this reluctance I exercised also when I prevented Dr. Jacobson the opportunity to expand on religion's influence on TACs.

¹⁸⁷ Valerie Yow, "'Do I like Them Too Much?': Effects of the Oral History on the Interviewer and Vice-Versa," *The Oral History Review*, Vol. 24, No. 1 (Summer 1997), 68.

¹⁸⁸ Yow, 76.

Georgis’s definition of ‘ethical listening,’ encompasses the need of the interviewer to pay attention to any moments of discomfort in order to allow the individual interview participant to further their own narrative without redirection or interference. Throughout *The Better Story*, Georgis poetically provides a different historiography of the Middle East. Georgis describes her theoretical approach as, “assembl[ing] a representative archive of racialized suffering...[while choosing] cultural texts that confront the emotional dilemmas of traumatic histories as enacted in everyday narratives.”¹⁸⁹ More broadly, Georgis’s analysis draws attention to ‘racialized suffering,’ that may be also applied to oral histories like my own that address topics such as accessing abortions where ‘emotional dilemmas’ are enacted in everyday narratives.

An Unconventional Archive: Tracing the Affective Narrative of Pain

Sara Ahmed’s “The Contingency of Pain,” delves into the socio-political understanding of pain, both individually and collectively. The question she poses is, “How are lived experiences of pain shaped by contact with others?”¹⁹⁰ Pain, she shows, is not merely a bodily sensation but a complex emotion that can manifest in solitude or, alternatively, unite bodies. Ahmed explores how, “the ‘labour’ of pain and the language of pain work in specific and determined ways to affect differences between bodies”.¹⁹¹ Applying Ahmed’s definition of pain as both a solitary and unifying experience is usefully applied to narratives shared by Dr. Harrowing and Professor Sisson as both broadly highlights the complexity of women’s struggle for reproductive autonomy.

¹⁸⁹ Georgis, 19.

¹⁹⁰ Ahmed, 20.

¹⁹¹ Ahmed, 23.

Paying attention to the affective traces evident within each of their narratives, I relied, at times, on my own memories to serve as a, “personal unconventional archive.”¹⁹² In her article titled, “Intimate internationalisms: 1970s ‘Third World’ queer feminist solidarity with Chile,”¹⁹³ Tamara Lea Spira utilizes an “unconventional archive” of scholars not frequently cited within Western academia’s discussion of second-wave feminism. Spira coins the term “intimate internationalisms” to describe the connections between the “US Third World queer and feminist movements and Latin American anti-imperialist revolutions of the 1970s”. These connections she understands through a framework of *movement of feeling*.¹⁹⁴ Her framework of *movement of feeling* can be applied to Ahmed’s question on how the lived experiences of pain is shared amongst bodies. As Spira argues, “*movements of feeling*...bind subjects implicitly in moments of political struggle; affect therefore emerges as a rarely acknowledged, yet powerful collective historical force”.¹⁹⁵ Spira explains how the 1970s Chilean revolution created economies of affect that moved borders to create space to listen to feelings of hope, rage, belief, and promise amongst individuals.¹⁹⁶ Spira’s concept of “intimate internationalisms” can be expanded more broadly to define intimate encounters where complex emotions such as pain, excitement, grief, fear, relief, and shame are understood in relation to others.

Obtaining a therapeutic abortion in Canada between the era of partial decriminalization and full decriminalization of abortion in Canada, as demonstrated in the four oral history interviews I conducted, was a convoluted process for all involved. Not

¹⁹² Tamara Lea Spira, “Intimate internationalism: 1970s ‘Third World’ queer feminist solidarity with Chile,” *Feminist Theory* vol. 15, no. 2 (2014), 119.

¹⁹³ Spira, 119.

¹⁹⁴ Spira, 121.

¹⁹⁵ Spira, 121.

¹⁹⁶ Spira, 126.

only was it necessary for the woman to navigate the bureaucratic obstacles enforced by the TACs but also through the negotiation process with many gatekeepers in the medical system of the time created an emotional terrain of judgement and shame. Additionally, as described by Dr. Simons, the polarity of views on abortion led some to resort to violence. This looming possibility of violence at any moment created a perception of fear that tyrannized Dr. Simons throughout her time as an abortion provider in Calgary. Applying emotion as an analytic lens to understand the four narratives of accessing or facilitating therapeutic abortions between 1969 and 1988 provided me with a more comprehensive historiography of access to abortion in Alberta. In so doing, just as emotions circulate between bodies, take form and “stick” and “unstick” to others, memories also take shape and change over time.

Epilogue: Where do we go from here?

Researching and writing this thesis has involved more reflection than I had ever anticipated when I initially settled on the topic of abortion. It has been a lengthy journey. However, since beginning this thesis there have been several important historical moments have occurred that particularly highlight the ongoing struggle for reproductive autonomy in Canada. As feminist activist Judith Mintz writes, “Despite abortion being legal...it still is a site of constrained expression”.¹⁹⁷ While my thesis discusses some historical aspects of limitations of accessing abortion services in Alberta, by focusing on the lived experiences as narrated by four individuals thematically my work is also steeped in contemporary North American abortion politics. Notably each event I briefly review for this epilogue, has magnified the underlying white supremacy, classism, and misogyny that prevailed and lingers relative to reproductive health throughout the twentieth-century Canada and the United States. For example, when I began this thesis in 2015, I never envisioned myself reflecting on the adverse consequences of the election of Donald Trump as the 45th President of the United States that are seriously threatening the legality of abortion in the United States.¹⁹⁸ Indeed, the threats caused by Trump’s administration cast a sombre tone over two out of the four interviews that I conducted as the threat of re-criminalization became a reality in the United States, particularly following the Trump’s vice presidential appointment of vehement anti-choice supporter, Mike Pence.

¹⁹⁷ Judith Mintz, “An Abortion Palimpsest: Writing the Hidden Stories of Our Bodies,” in *Without Apology: Writings on Abortion in Canada*, ed. by Shannon Stettner (Edmonton, AB: Athabasca Press, 2016), 78.

¹⁹⁸ “Donald Trump: America’s 45th President,” *CNN online*, February 5th, 2020, <https://www.cnn.com/2018/08/31/politics/gallery/donald-trump/index.html>.

Just as Albertans have witnessed a remarkable drop in provincial hospitals providing medical abortions following the decriminalization of abortion in Canada in 1988, the United States has experienced a significant decrease in both facilities that provide medical abortions and in practitioners willing to perform abortions following the 1973 *Roe v. Wade* Supreme court ruling.¹⁹⁹ Kathaleen Pittman, a clinic administrator at Hope Medical Group in Shreveport, Louisiana, recently interviewed by *BBC* news correspondent, Valeria Perasso, reflected on the change in access since the 1980s, “Back then there were 11 abortion providers across the state. Now there are three to serve 10,000 women.”²⁰⁰ Pittman describes how the stress from her job causes sleep disturbances as she worries as to how she and the medical workers at the clinic will continue to support the patients facing the new restrictions imposed by the Trump administration.²⁰¹ The undue stress placed on small clinics, and service providers like Pittman, in rural America and the travel associated with accessing abortion services is similarly to that experienced by cisgender women and transgender men who currently attempt to access abortion services in Alberta.

As many scholars can attest to, often it is the most inopportune moments and unconventional sources that sparks contemplation. Listening to the epilogue of Jodi Kanton and Megan Twoheys’ audiobook, *She Said* in which a room full of women reflect on the aftermath of coming forward with their “MEtoo” stories of sexual assault by Harvey Weinstein, I also pondered how the individuals with whom I interviewed also

¹⁹⁹ Valeria Perasso, “On the battle lines over US abortion,” *BBC News online*, May 18th, 2018, <https://www.bbc.com/news/world-us-canada-43966855>.

²⁰⁰ Ibid.

²⁰¹ Ibid.

retrospectively processed sharing their stories of accessing or facilitating abortions with me. The topic of abortion, as discussed throughout their respective interviews, are contoured by complex emotions. Memories reverberate and leave affective traces that are only further cemented when they are shared and witnessed by others. This research has encouraged me to believe that historic traumas resurface, creating communities of affect, because clearly in our contemporary moment, every bumper-sticker, sign, and brochure is aimed at shaming a woman for having an abortion. This act of shaming is calculated and deliberate. These acts undoubtedly have socio-political consequences in the lives of women, as it creates a standard where degrading women's bodies is normalized. To counter this deliberate attack against women's bodies and their reproductive autonomy, there is strength in the act of sharing one's story.

References

- “Abortion Services: Information for the Public.” *Alberta Health Services online*. Last modified 2018, <https://www.albertahealthservices.ca/info/Page14011.aspx>.
- Abrams, Lynn. *Oral History Theory*. New York: Routledge, 2010.
- “After an Abortion.” *Lethbridge Pregnancy Care Centre*. Accessed May 23, 2020, <https://lethbridgepregcentre.com/after-an-abortion/>.
- Ahmed, Sara. *The Cultural Politics of Emotion*. New York: Routledge Press, 2012.
- Anderson, Kathryn and Dana C. Jack. “Learning to Listen: Interview Techniques and Analyses.” In *The Oral History Reader*, edited by Robert Perks and Alistair Thomson, 157-171. New York, NY: Routledge 1998.
- Anonymous. “A birth control conference” *Women’s Journal* vol. 6, no. 11 (1921): 20.
- Badgley, Robert F. *Report of the Committee on the Operation of the Abortion Law*. Ottawa, ON: Minister of Supply and Services Canada, 1977.
- Bill C-150. *Criminal Law Amendment Act, 1968-69*. S.C. 1968-69, c. 38.
- Bunjun, Benita. “The (Un)making of Home, Entitlement, and Nation: An Intersectional Organizational Study of Power Relations in Vancouver Status of Women, 1971-2008.” PhD diss. University of British Columbia, 2011.
- CBC News. CBC Archive: *The Omnibus Bill doesn't go far enough*, 1970. Interview on May29th,1970. Accessed on 9th April, 2016, <http://www.cbc.ca/archives/entry/the-omnibus-bill-doesnt-go-far-enough>.
- Chapman, Frances E. and Tracy Penny Light. “Functionally Inaccessible: Historical Conflicts in Legal and Medical Access to Abortion.” In *Abortion: History, Politics, and Reproductive Justice after Morgentaler*, edited by Shannon Stettner, Kristen Burnett, and Travis Hay, 175-196. Vancouver: UBC Press, 2017.

- Chappell, Louise. *Gendering Government: Feminist Engagement with the State in Australia and Canada*. Vancouver, BC: UBC Press, 2002.
- Collins, Larry D. "The Politics of Abortion: Trends in Canadian Fertility Policy." *Atlantis* vol. 7, no. 2 (Spring 1982): 2-20.
- "Crisis Pregnancy Centres in Canada." *Canada Adopts! Canada's adoption meeting place*. Accessed May 23, 2020, <http://www.canadaadopts.com/adopting-in-canada/crisis-pregnancy-centres-canada/>.
- Dominion Bureau of Statistics. *Special Statement: Therapeutic Abortions in Canada: August 26th, 1969 to August 25th, 1970* Catalogue number CS82-002-1970-2-eng.pdf in Statistics Canada [database online]. Ottawa, ON.,1970. Accessed May 17th, 2020. Available from: http://publications.gc.ca/collection_2018/statcan/82-002/CS82-002-1970-2-eng.pdf.
- "Donald Trump: America's 45th President." *CNN online*. Last modified, February 5th, 2020, <https://www.cnn.com/2018/08/31/politics/gallery/donald-trump/index.html>.
- Doull, Marion, Christabelle Sethna, Evelyn Morisette, and Caitlin Scott. "When Research is Personal and Political: Researchers Reflect on the Study of Abortion." In *Abortion: History, Politics, and Reproductive Justice after Morgentaler*, edited by Shannon Stettner, Kristen Burnett, and Travis Hay, 152-173. Vancouver, BS: University of British Columbia Press, 2017.
- Dyck, Erika. "Eugenics: Choice, Coercion, and Context." In *Eugenics at the Edges of Empire: New Zealand, Australia, Canada and South Africa*, edited by Diane B. Paul, Hamish G. Spencer, and John Stenhouse, 41-62. New York, NY: Palgrave Macmillan US, 2017.
- Dyck, Erika. *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice*. Toronto, ON: University of Toronto Press, 2013.
- Finnigan, Joan. "Should Canada Change Its Abortion Law?" *Chatelaine*, October 1959. In Valerie J. Korinek, *Roughing it in the Suburb: Reading Chatelaine Magazine in the Fifties and Sixties*, 306. Toronto, ON: University of Toronto Press, 2000.

- Georgis, Dina. "Discarded Histories and Queer Affects in Anne Carson's *Autobiography of Red*." *Studies in Gender and Sexuality* vol. 15, no. 2 (June 2014):154-166.
- Gordon, Linda. "Introduction: Birth Control, the Moral Property of Women" In *The Moral Property of Women: A History of Birth Control Politics in America*, 1-4. Chicago, Illinois: University of Illinois Press, 2002.
- Gordon, Linda. "The Folklore of Birth Control." In *Reproduction and Society: Interdisciplinary Readings*, edited by Joffe, Carole and Jennifer Reich, 19-31. New York: Routledge Press, 2015.
- Grekul, Jana. "Sterilization in Alberta, 1928 to 1972: Gender Matters." *Canadian Review of Sociology* vol. 45, no. 3 (August 2008): 247-266.
- Harding, Jenny. "Talk about Care: Emotions, Culture and Oral History." *Oral History* vol. 38, no. 2 (Autumn 2010): 33-42.
- Harrison, C.P. "On the Futility of Legalizing Abortion." *Canadian Medical Association Journal* vol. 95 (1966): 360-366.
- Harrowing, Jean. Interview by Shannon Ingram. Audio recording. 2nd March 2017.
- "History of the Therapeutic Abortion Survey." *Statistics Canada*. Last modified 21st August, 2009, http://www23.statcan.gc.ca/imdbbmdi/document.3209_D1_T9_V7-eng.pdf.
- Holloban, Joan. "2,000 MDs Polled on Abortion by Association Studying Policy." *The Globe and Mail*. Wednesday, January 12th, 1983.
- Jacobson, George (pseudonym). Interview by Shannon Ingram. Audio recording. 23rd October 2015.
- Jenson, Jane. "Getting to Morgentaler: From One Representation to Another." In *The Politics of Abortion*, edited by Janine Brodie, Shelley A.M. Gavigan, and Jane Jenson, 15-56. Toronto: Oxford University Press, 1992.

- Junod, Suzanne White and Lara Marks. "Women's Trials: The Approval of the First Oral Contraceptive Pill in the United States and Great Britain." *Journal of the History of Applied Sciences*, vol. 57, no. 2 (April 2002): 117-160.
- Kaler, Amy. "Mothers' Duties: Eugenics, Sterilization, and the United Farm Women of Alberta." In *Baby Trouble in the Last Best West: Making New People in Alberta, 1905-1939*, 72-106. Toronto, ON: University of Toronto Press, 2017.
- Kellough, Gail. *Aborting Law: An Exploration of the Politics of Motherhood and Medicine*. Toronto, University of Toronto Press, 1996.
- Kennedy, David M. *Birth Control in America: the Career of Margaret Sanger*. New Haven, CT: Yale University Press, 1970.
- Klausen, Susanne M. "Eugenics and the Maintenance of White Supremacy in Modern South Africa." In *Eugenics at the Edges of Empire: New Zealand, Australia, Canada, and South Africa* edited by Diane B. Paul, Hamish G. Spencer, and John Stenhouse, 289-310. New York, NY: Palgrave Macmillan US, 2017.
- LaRoche, Kathryn J. and Angel M. Foster. "Exploring Canadian Women's Multiple Abortion Experiences: Implications for Reducing Stigma and Improving Patient-Centered Care." *Women's Health Issues* vol. 28, no.4 (August 2018): 327-332.
- Layman, Lenore. "Reticence in Oral History Interviews." *The Oral History Review* vol. 36, No. 2 (Summer-Fall, 2009): 207-230.
- Light, Tracy Penny. "Shifting Interests: The Medical Discourse on Abortion in English Canada, 1850-1969." PhD diss. University of Waterloo, 2003.
- Loder, Charisse M., Leah Minadeo, Laura Jimenez, Zakiya Luna, and Loretta Ross. "Bridging the Expertise of Advocates and Academics to Identify Reproductive Justice Learning Outcomes." *Teaching and Learning in Medicine* vol. 32, no. 1 (2020): 11-22.

- Louis-Courvoisier, Micheline. "Qu'est-ce qu'un malade sans son corps?" In Sonja Boon, *Telling the Flesh: Life Writing, Citizenship, and the Body in the Letters to Samuel Auguste Tissot*, 25. Montreal, QC: McGill-King's University Press, 2015.
- Malacrida, Claudia. "Bodily Practices as Vehicles for Dehumanization in an Institution for Mental Defectives," *Societies* vol. 2, No. 2 (December 2012): 286-301.
- Malacrida, Claudia. "Contested Memories: Efforts of the Powerful to Silence Former Inmates' Histories of Life in an Institution for 'Mental Defectives.'" In *The Canadian Oral History Reader*, edited by Kristina Llewellyn, Alexander Freund and Nolan Riley, 318-334. Montreal, QC: McGill-University Press, 2015.
- "Making Your Decision." *Kensington Clinic*. Accessed on 18th May, 2020, <https://kensingtonclinic.com/making-your-decision/>.
- McLaren, Angus and Arlene Tigar McLaren. *The Bedroom and the State: The Changing Practices and Politics of Contraception and Abortion in Canada, 1800-1980*. Toronto: McClelland and Stewart Limited, 1986.
- Mintz, Judith. "An Abortion Palimpsest: Writing the Hidden Stories of Our Bodies." In *Without Apology: Writings on Abortion in Canada*, edited by Shannon Stettner, 77-82. Edmonton, AB: Athabasca Press, 2016.
- Mitchinson, Wendy. *Body Failure: Medical Views of Women, 1900-1950*. Toronto: University of Toronto Press, 2013.
- "Obituary of Henry Morgentaler: Canadian Safe Abortion Crusader." *BMJ* online. 7th September, 2013, <https://www.bmj.com/bmj/sectionpdf/737987?path=/bmj/347/7923/Obituaries.full.pdf>.
- Perasso, Valeria. "On the battle lines over US abortion." *BBC News online*. Last modified on May 18th, 2018, <https://www.bbc.com/news/world-us-canada-43966855>.
- Prober, Jay C. "The Criminal Law Amendment Act 1968-1969 (Canada)." *The British Journal of Psychiatry*, Vol. 10, no. 2 (April 1970): 180-183.

Province of Alberta. *The Sexual Sterilization Act of Alberta*, 1928. Statutes of the Province of Alberta. Retrieved from: <https://www.canlii.org/en/ab/laws/astat/sa-1928-c-37/latest/sa-1928-c-37.html>.

R. vs. Morgentaler. 1956 SCR 30 (1988).

Roberts, Dorothy. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. Toronto, ON: Random House of Canada limited, 1999.

Rosenwein, Barbara H. "Worrying about Emotions in History." *The American Historical Review*, vol. 107, No. 3 (June 2002): 821-845.

Ross, Loretta J. "Conceptualizing Reproductive Justice Theory: A Manifesto for Activism." In *Radical Reproductive Justice: Foundations, Theory, Practice, and Critique*, edited by Loretta J. Ross, Lynn Roberts, and Erika Derkas, 170-232. New York, NY: Feminist Press, 2017.

Sands, Diane. "Using Oral History to Chart the Course of Illegal Abortions in Montana." In *Women's Oral History: The Frontier Reader*, edited by Susan H. Armitage, Patricia Hart, and Karen Weathermon, 213-226. Lincoln, Nebraska: University of Nebraska Press, 2002.

Saurette, Paul and Kelly Gordon. *The Changing Voice of the Anti-Abortion Movement: The Rise of 'Pro-Woman' Rhetoric in Canada and the United States*. Toronto, ON: University of Toronto Press, 2015.

Scarry, Elaine. *The Body in Pain: The Making and Unmaking of the World*. New York: Oxford University Press, 1985.

Simons, Meredith. Interview by Shannon Ingram. Audio recording. 27th February, 2016.

Sisson, Irene (pseudonym). Interview by Shannon Ingram. Audio recording. 26th October, 2017.

- Spira, Tamara Lea. "Intimate internationalism: 1970s 'Third World' queer feminist solidarity with Chile." *Feminist Theory* vol. 15, no. 2 (2014): 119-140.
- Stettner, Shannon. "He is Still Unwanted: Women's Assertion of Authority over Abortion in Letters to the Royal Commission on the Status of Women in Canada." In *Abortion: History, Politics, and Reproductive Justice after Morgentaler*, edited by Shannon Stettner, Kristin Burnett, and Travis Hay, 95-113. Vancouver: UBC Press, 2017.
- Stettner, Shannon. "'He is still unwanted': Women's Assertions of Authority over Abortion in Letters to the Royal Commission on the Status of Women in Canada." *Canadian Bulletin of Medical History* vol. 29, no. 1 (2012): 151-171.
- Stettner, Shannon. *Without Apology*. Edmonton, AB: Athabasca University Press, 2016.
- Stettner, Shannon. "Women and Abortion in English Canada: Public Debates and Political Participation, 1959-1970." PhD diss. York University, 2011.
- "The Royal Medico-Psychological Association Memorandum on Therapeutic Abortion." *British Journal of Psychiatry* vol. 112, (1966): 1070-1073.
- Thompson, Kirsten M.J. "A Brief History of Birth Control in the U.S." *Our Bodies, Ourselves Online* 14th December, 2013, <https://www.ourbodiesourselves.org/book-excerpts/health-article/a-brief-history-of-birth-control/>.
- Turner, John and Peter Loucks. "Omnibus Bill: A New Era in Canada." In *The World at Six*, Aug. 26th, 1969. Produced by CBC Digital Archives, <https://www.cbc.ca/archives/entry/omnibus-bill-a-new-era-in-canada>.
- Yow, Valerie. "'Do I like Them Too Much?': Effects of the Oral History on the Interviewer and Vice-Versa." *The Oral History Review*, vol. 24, No. 1 (Summer 1997): 55-79.

Appendix 1

13th January, 2016

Dear Participant:

You are being invited to participate in an interview as part of a Master's of Arts (History) at the University of Lethbridge. The purpose of this research is to capture the personal experiences of individuals who either accessed or attempted to access abortion services in Southern Alberta. Furthermore, the personal narratives are important as they insert the experiences of individuals during an era when silence on such matters such as abortion prevailed. The primary method that will be used to capture these stories is through oral history.

My project aims to understand the historical barriers to accessing abortion services in the decades when hospitals and doctors regulated access to personal matters of reproductive health through analyzing personal narratives. For my research, I will be gathering oral histories with those individuals who accessed or attempted to access abortion services and retired health practitioners (for example, nurses, general practitioners, psychiatrists, etc.) who experienced the impact of federal health policies that regulated access to abortion prior to 1988.

Interviews will provide an important source of personal reflection and professional insight about this time when abortion was regulated by hospital Therapeutic Abortion Committees (TACs) between 1969 and 1988.

My research will expand the history of women's reproductive health in Canada, specifically focusing on experiences within Southern Alberta.

The Interview:

I, _____(Interviewee) consent for the digital file and transcript of my interview conducted with researcher Shannon Ingram on, **Date of Interview**. The results of the interview will be stored digitally on Shannon Ingram's password protected computer and password protected external hard drive. I understand the purpose of this oral history interview and I realize the information that I share with the interviewer is to be used for the purposes of her research as described above.

A single interview will be held at the place of my choosing and will last approximately one hour. Shannon Ingram will digitally record the interview with a password protected recorder. There are no anticipated risks to participating in this project, nor is payment offered for participating. Shannon Ingram, the interviewer, will follow up after the

interview is concluded with excerpts of my interview that will be used in her thesis. Additionally, I may request a synopsis of my full interview.

I am aware that I am free to withdraw from the interview at any time up until the completion of Ms. Ingram's thesis or may choose not to respond to certain questions during the interview without penalty.

The research conducted by MA student Shannon Ingram is supervised by Dr. Carol Williams, Professor of History and Women and Gender Studies at the University of Lethbridge. If any questions or concerns about the research or conduct of Shannon Ingram as the researcher arise, I am welcome to directly contact Dr. Williams at 403-380-1818 or by email at carol.williams@uleth.ca.

Questions regarding my rights as a participant in this research may be addressed to the Office of Research Ethics, University of Lethbridge: (403) 329-2742 or email at research.services@uleth.ca. This thesis has been reviewed for ethical acceptability and approved by the University of Lethbridge Human Subject Research Committee.

Conditions of Participation:

I will receive excerpts of my interview that will be used in Ms. Ingram's thesis at her earliest convenience. I will also receive acknowledgement (anonymous or in name depending on the conditions agreed upon by me, the interviewee) as a research participant in Shannon Ingram's final thesis. It is important to note that my feedback to the student will be needed by a specific date to avoid missing significant deadlines in the student's thesis completion.

In terms of identification and reproduction of my interview, I agree to the following conditions:

My identity may be revealed in the thesis, and presentations that may result from this thesis, or any further work on this topic by Shannon Ingram. A copy of the audio file of the interview, correspondence, written transcript of the digital audio file, and Shannon Ingram's final thesis may be housed in an archive such as The Galt Museum & Archives in Lethbridge, AB. Another copy will be held by Shannon Ingram following my interview indefinitely.

Please note, however, should I prefer anonymity, Shannon Ingram will agree to use a pseudonym throughout the thesis, and other academic publications and presentations.

I understand that I will be able to see sections of the thesis in which I am quoted or referenced to highlight sections where my identity could be determined, as well as make suggestions on how to increase my anonymity up until completion of Ms. Ingram's thesis.

In terms of storage, transcription, and preservation of this interview, I agree to the following conditions:

_____ I agree that the digital recording of my interview will be transcribed and used by the researcher.

_____ I give Shannon Ingram permission to keep one copy of the interview for her personal records after the project is completed.

_____ I give Shannon Ingram permission to transfer my audio interview, transcript, and all other documents such as correspondence emails to the Galt Museum & Archives following the completion of her MA.

_____ All other copies of the interview not held by Shannon Ingram or myself (the interviewee) or housed at such archives as The Galt Museum & Archives will be destroyed following the completion of the project.

_____ Shannon Ingram will send me excerpts of her thesis where I will be quoted for approval before submitting her thesis.

_____ I would like my interview and transcript to be destroyed following the completion of Shannon Ingram's project.

I have read the above and understand this agreement. I freely and voluntarily agree to participate in this thesis.

(Printed Name of Participant)

(Signature)

(Date)

(Printed Name of Researcher)

(Signature)

(Date)

Researcher's Name: Shannon Ingram

Researcher's Project Title: Silenced Histories: Memories of Access to Abortion Services in Alberta, 1969 to 1988.

Research Conducted at: University of Lethbridge

Researcher's Phone Number: 403-894-6009

Researcher's email: silenced.histories@uleth.ca

A copy of this consent form has been given to you to keep for your records and reference.

Appendix 2

Questions for Retired Medical Practitioners involved with TACs

1. **When and where were you born?**
2. **When and where did you attend school to become a doctor (and/or nurse)?**
3. **How much training did you receive in medical school on medical procedures such as surgical abortions?**
4. **How did you first become involved with the Therapeutic Abortion Committee?**
5. **What can you tell me about the Committee?**
6. **How did Alberta's Therapeutic Abortion Committee compare to other provinces?**
7. **Did you ever feel that either you or your family's safety was threatened because of your involvement on the Therapeutic Abortion Committee?**
8. **What was your impression of how the Therapeutic Abortion Committee was organized?**
9. **Do you remember when abortion was decriminalized?**
10. **How did your role change as a medical professional following the decriminalization of abortion?**
11. **What is your opinion on the current access available to women for medical procedures such as surgical abortions?**

Appendix 3

Questions for Women who obtained a therapeutic abortion, 1969 to 1988

- 1. What can you tell me about when you first found out you were pregnant?**
- 2. When did you decide that you would have an abortion?**
- 3. Why did you decide that you would have an abortion?**
- 4. What can you remember about the process of having an abortion?**
- 5. How were you treated at the hospital?**
- 6. Without naming individuals, can you share any experiences from that time?**
- 7. Did you ever feel that your safety was compromised prior to the procedure?**
- 8. Did you ever feel that your safety was compromised after the procedure?**
- 9. Can you remember and/or describe your emotions from that period of time?**
- 10. What is your memory of the abortion today?**
- 11. How do you view access to abortion today?**
- 12. Is there anything that you would like to add?**