

Shifting Interests:  
The Medical Discourse on Abortion in English Canada, 1850-1969  
by  
Tracy Penny Light

A thesis  
presented to the University of Waterloo  
in fulfillment of the  
thesis requirement for the degree of  
Doctor of Philosophy  
in  
History

Waterloo, Ontario, Canada, 2003

© Tracy Penny Light, 2003



National Library  
of Canada

Acquisitions and  
Bibliographic Services

395 Wellington Street  
Ottawa ON K1A 0N4  
Canada

Bibliothèque nationale  
du Canada

Acquisitions et  
services bibliographiques

395, rue Wellington  
Ottawa ON K1A 0N4  
Canada

*Your file Votre référence*

*Our file Notre référence*

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

0-612-84920-1

Canada

### **Author's Declaration**

I hereby declare that I am the sole author of this thesis.

I authorize the University of Waterloo to lend this thesis to other institutions or individuals for the purpose of scholarly research.

*Macy Penny Light*

I further authorize the University of Waterloo to reproduce this thesis by photocopying or by other means, in total or in part, at the request of other institutions or individuals for the purpose of scholarly research.

*Macy Penny Light*

## **Borrower's Page**

The University of Waterloo requires the signatures of all persons using or photocopying this thesis. Please sign below, and give address and date.

## **Abstract**

This thesis examines the shifts in the medical discourse on abortion in English Canada between 1850 and 1969 as seen in the medical press. This approach allows us to see how (and when) the medical discourse on abortion shifted over time to reflect varying medical, social and political contexts. In the early period (1850-1919) doctors discussed abortion primarily as a means of regulating their profession. In the interwar period (1919-1939) doctors' discussions shifted to focus on how the practice negatively affected the high maternal mortality rate. In the later period (1940-1969) the profession became more interested in maternal welfare and their discussions of abortion reflected this interest. Throughout the period of study it is clear that because doctors operated within a scientific medical construct, as well as cultural constructs, it was difficult for them to address the problem of abortion outside what was considered to be proper or normal for the period. This means that as much as the medical profession shaped the discourse on abortion, it was also constrained by it.

## **Acknowledgements**

In the time I have spent completing the work on this dissertation I have been very fortunate to have had the support of many colleagues, friends and family members. From the moment I arrived at the University of Waterloo, nine months pregnant and determined to start (and complete) my Ph.D., I have had incredible support. Wendy Mitchinson encouraged me every step of the way. To have been mentored through this process by a distinguished and wise scholar and to be able, also, to call her my friend has been truly wonderful. I have also had the good luck of being part of an extremely collegial department at the University of Waterloo. Patrick Harrigan, Ken McLaughlin, John English, Karin MacHardy, and Geoff Hayes have all helped and supported me along the way. Irene Majer ensured that I fulfilled all my degree requirements, sent me encouraging emails, and provided lots of hugs. Jane Nicholas is a good friend and scholar, a great teaching partner, and fun at a party! More recently, the comments on this work provided by my external examiner, Angus McLaren of the University of Victoria and my internal-external examiner, Sandra Burt of the Political Science Department at the University of Waterloo, have been both valuable and thought-provoking. Thank you both for being part of this process.

Because the Ph.D. program is run jointly with Wilfrid Laurier University and Guelph University I have also had the pleasure of working with faculty from those campuses. Both Jamie Snell and Cynthia Comacchio have helped enormously in the revising of my thesis – your comments have been invaluable. This also meant that I worked with students from the other campuses. Both Scott Sheffield and Ian Miller made the drives to Guelph for classes intellectually stimulating and fun and I cherish our ongoing friendship.

I have not done a very good job of being a “normal” Ph.D. student, having both my

children (one 27 days after I started the program) during my program and working full-time for the last half of my degree. I do not regret my abnormality because it has made my experience as a graduate student “exceptional.” I owe many of my fond memories of this experience to colleagues at the University of Waterloo outside the Department of History. Donna Ellis of the TRACE office has helped me to become a better teacher and has been a great friend. My colleagues at the University of Waterloo’s Centre for Learning and Teaching Through Technology (LT3) have also supported me endlessly with encouraging words and days off to write. Tom Carey has been a patient mentor and always made me feel better when he assured me that I would not beat his record in terms of number of years to Ph.D. completion. I also thank Liwana Bringelson, Andrea Chappell, Kevin Harrigan, Vivian Schoner, Dawn Howard-Rose and Jill Porter. You are all exceptional colleagues and friends and you make me want to come to work every day.

A number of close friends also supported me through this process. Donna Lang, who I first met when she was the undergraduate administrator in the History Department, has been a cheerleader, a personal trainer, and an all-around amazing friend. I don’t know what I would have done without you! Mary Ellen Green has also played a crucial role in this process. I met Mary Ellen after my first year of the program when I was looking for child care for my daughter. I’m not sure that I would even have been able to keep up with my family and my program if it had not been for Mary Ellen and her family. She not only cared for my children but baked me pies, surprised me with a clean house and car, looked after pets, and, most important of all, treated my family as if we were her own. I hope she knows how important she is and how lucky I feel to know her and call her my friend. Chris and Gary Weber have also supported me (and our whole family) throughout this process.

Finally, my family has been an incredible support. My parents have always had faith in my ability to complete my Ph.D. and have helped to facilitate that completion by offering to care for my children – taking them over weeks in the summers and coming to our house to allow me to work later has been much appreciated. My sister, Lisa, is my best friend and has also helped with the girls (and with cleaning and organizing my house and my laundry!) despite having a few things going on in her life as well.

I've saved the best for last. What can I say about the love and support I've received from Thom, Emma and Meghan? You are the centre of my world and this thesis is for you.

## **Dedication**

For Thom, Emma and Meghan

and

In loving memory of

R. Allen and Audrey Kiff

## Table of Contents

Author's Declaration.....	ii
Borrower's Page.....	iii
Abstract.....	iv
Acknowledgements.....	v
Dedication.....	viii
Table of Contents.....	ix
Introduction.....	1
Chapter One	
Regulating Doctors: Abortion and the Professionalization of Medicine, 1850-1919.....	18
Chapter Two	
Abortion, Maternal Mortality and Doctors in the Interwar Period, 1919-1939.....	57
Chapter Three	
"They Die Smiling": Doctors, Maternal Welfare and Abortion, 1940-1969.....	99
Chapter Four	
"Are We Doing Too Many Therapeutic Abortions?" Doctors' Discussions, 1940-1969.....	136
Chapter Five	
"A General Consensus": The Role of Medical Discourse in Framing Revisions to the Legislation on Abortion.....	171
Conclusion.....	213
Bibliography.....	219

## *Introduction*

Mrs. L. Green<sup>♦</sup>  
XXXX  
Ottawa, Ont  
December 9<sup>th</sup> - 1968

The Hon. John Turner  
Minister of Justice,  
Ottawa, Ont.

Dear Mr. Turner:

With respect to your announced plans for changes to the Criminal Code concerning abortion, I wish to give you the following information.

My daughter, Eleanor, was raped on 5<sup>th</sup> September 1968 by a gang of boys. Criminal charges have been laid and a preliminary hearing has been held. At this hearing, the lawyer for one of the three accused applied for and was granted a period of not exceeding thirty days during which time his client is to [be] examined to determine his sanity.

My daughter has become pregnant as a result of this criminal act. The present laws do not permit an abortion - even a therapeutic one - to terminate this pregnancy despite the following facts:

Conception took place following moments of terror.

Since the beginning of October Eleanor has been sick, sometimes violently, nearly every day.

She has been and still is in a very depressed state most of the time.

The father of the unborn child is unknown.

Though three youths have been charged, it appears certain that more than three were involved.

A possible father may be judged to be insane.

To me, all the foregoing facts would seem to support most indisputably a case for a therapeutic abortion - yet any abortion is illegal in Canada. Furthermore, it appears to me that the planned legislation does not include pregnancy brought about as a result of rape. It is wrong that a girl or woman under such circumstances should have to go through the pregnancy.

I most strongly and earnestly recommend to your consideration of the inclusion in your legislation of the legalizing of therapeutic abortion of pregnancy resulting from rape.

Yours sincerely,  
Mrs. Linda Green<sup>1</sup>

---

<sup>♦</sup> All of the names of non-public officials have been changed to protect the privacy of the parties involved pursuant to the Freedom of Information and Protection of Privacy Act.

<sup>1</sup>Letter to the Honourable John Turner dated December 9<sup>th</sup>, 1968, National Archives of Canada, RG 13, Vol. 2972, File No. 185300-237-1 Pt. 7, Interim Box No. 124.

This letter, written by the mother of a pregnant rape victim, outlines the main arguments – that the pregnancy posed a threat to the mother’s life or health, the possibility that the child would be deformed in some way, and that the pregnancy occurred as a result of a sexual offense – presented by the medical profession in Canada for revising the law on abortion in the late 1960s. While the Criminal Code was revised in 1969 with wording that provided clarification of doctors’ position with regard to abortion, it did not really change the availability of abortion to women who wanted to terminate their unwanted pregnancies.

To note that the reform dealing with abortion did not legislate for women’s reproductive freedom is not new. As many academics have pointed out, the Liberal government’s omnibus bill did nothing more than address doctors’ difficulties with an ambiguous law.<sup>2</sup> It permitted physicians to perform an abortion in those circumstances where they perceived that the life or health of a woman would be endangered if the pregnancy was allowed to continue. The consent of a therapeutic abortion committee (TAC) was also required by the reform.<sup>3</sup> In essence, the

---

<sup>2</sup> For instance see Janine Brodie, Shelley A.M. Gavigan and Jane Jenson, *The Politics of Abortion*, Toronto: Oxford University Press, 1992; F.L. Morton, *Pro-Choice vs. Pro-Life: Abortion and the Courts in Canada*, Norman and London: University of Oklahoma Press, 1992; Robert Campbell and Leslie Pal, *The Real Worlds of Canadian Politics: Cases in Process and Policy*, Peterborough, Ontario: Broadview Press Ltd., 1989: 165-226; A. Anne McLellan, “Abortion Law in Canada,” in J. Douglas Butler and David F. Walbert (eds.), *Abortion, Medicine, and the Law, Fourth Edition*, New York: Facts on File, 1992: 333-367; Gail Kellough, *Aborting Law: An Exploration of the Politics of Motherhood and Medicine*, Toronto: University of Toronto Press, 1996.

<sup>3</sup> Jane Jenson, “Getting to Morgantaler: From One Representation to Another,” in Brodie, Gavigan and Jenson, *The Politics of Abortion*, p. 32. R.S.C. 1970, c. C-34, section 251 provided as follows: “(1) Every one who, with intent to procure the miscarriage of a female person, whether or not she is pregnant, uses any means for the purpose of carrying out his intention is guilty of an indictable offence and is liable to imprisonment for life. (2) Every female person who, being pregnant, with intent to procure her own miscarriage, uses any means or permits any means to be used for the purpose of carrying out her intention is guilty of an indictable offence and is liable to imprisonment for two years. (3) Subsections (1) and (2) do not apply to (a) a qualified medical practitioner, other than a member of a therapeutic abortion committee for any hospital who in good faith uses in an accredited hospital any means for the purpose of carrying out his intention to procure the miscarriage of a female person, or (b) a female person who, being pregnant, permits a qualified medical practitioner to use in an accredited or approved hospital any means described in paragraph (a) for the purpose of carrying out her intention to procure her own miscarriage, if, before the use of those means, the therapeutic abortion committee for that accredited hospital, by a majority of the members of the committee and at a meeting of the committee at which the case of such female person has been reviewed, (c) has by certificate in writing stated that in its opinion the continuation of the pregnancy of such female person would or would be likely to endanger her life or health, and (d) has caused a copy of such certificate to be given to the qualified medical practitioner.” Section 251(6) requires a therapeutic abortion committee for any hospital to be comprised of “not less than three members each of whom is a qualified medical practitioner” appointed by the board of the hospital for the purpose of determining these matters.

amendments to the Criminal Code put the decision to abort in doctors' rather than women's hands. For women like Eleanor who were raped and who became pregnant as a result, access to an abortion, even a therapeutic one, was not necessarily easier after 1969. To point out that the reform of the Criminal Code relied heavily upon the medicalization of the practice of abortion, and on the assertion by doctors that their scientific knowledge of medicine gave them the ability to determine when an abortion should or should not be performed, is also not new. What has not been examined, however, is how the medical discourse on abortion in Canada shifted over time, and how it was presented by the medical profession as they argued for changes to the 1969 legislation.

This thesis examines the medical discourse on abortion as found in the medical press from 1850 to 1969 in English Canada with an emphasis on the period between 1940 and 1969.<sup>4</sup> This may at first appear to be a very large time period to examine within the scope of a thesis. However, the scope of the thesis has been dictated by the discourse itself. This approach allows us to see how (and when) the medical discourse on abortion shifted over time to reflect changing medical, social and political contexts. Doctors have historically had the power/knowledge to

---

<sup>4</sup>I have read all of the major medical journals in Canada between 1900-1969. They are, *Alberta Medical Bulletin*, *British Columbia Medical Journal*, *Dalhousie Medical Journal*, *Laval medical*, *Manitoba Medical Review*, *McGill Medical Journal*, *Nova Scotia Medical Bulletin*, *Ontario Medical Review*, *Canadian Medical Association Journal (CMAJ)*, *Saskatchewan Medical Quarterly*, *Canadian Nurse*, *Canadian Public Health Journal*, *Canadian Psychiatric Association Journal*, *Canadian Journal of Surgery*. In reading these journals, I focussed on any articles which dealt with abortion, birth control/family planning, maternal mortality/welfare, medico-legal issues, and women's roles. A number of medical textbooks from the period were also reviewed. Although most of these originated in the United States and Britain they were used in Canadian medical schools. I also examined all of the proceedings and minutes of meetings of the Canadian Medical Association to better understand the professional position on the abortion issue. I attempted to access material from the Canadian Medical Protective Association (CMPA), the legal advisory organization for the CMA. However, access to any of their material was denied because it was protected information by the CMPA's mandate. Although I did examine journals from Quebec, there is very little evidence in the journals which would allow me to support conclusions about the situation in that province. Therefore, I have focussed my attention on English-Canada. To balance my findings in the medical journals and textbooks and to provide contextual information, I examined a number of collections dealing with abortion, specifically the public discussions relating to proposed changes in the law in the 1960s. These collections from the National Archives of Canada included material from the Justice Department (RG 13), the Department of Health and Welfare (RG 29), the collection of material from the Association for the Modernization of the Canadian Abortion Law (AMCAL) (MG 28), and Planned Parenthood (MG 28). Finally, I examined some of the discussions in a number of newspapers from all over Canada including *The Globe and Mail* as well as religious papers like the *United Church Observer* and the *Catholic Commonweal*. For a "women's" perspective I examined *Chatelaine* magazine and for the legal perspective I examined a number of law journals for the period.

speak about the practice of abortion because of their medical knowledge when others were constrained from doing so because they did not possess the same scientific authority of doctors. This has meant that the medical discourse is difficult to circumvent, even for those (doctors and others) who wish to do so. Because doctors operated within a scientific medical construct, as well as cultural constructs, it was difficult for them to address the problem of abortion outside what was considered to be proper or normal for the period. This means that as much as doctors shaped the discourse on abortion, they were also constrained by it.

A number of important changes in the lives of Canadians occurred between 1850 and 1969 which shaped the discourse. In what I refer to as the early period (1850-1918), regular medical doctors worked to regulate their profession. Abortion was one issue that they used to denote their superiority over other irregular practitioners in this period. It was also a time when middle-class Canadians were focused on the morality of the nation and when women were viewed as being at the heart of such discussions because of their “natural” role as mothers. This emphasis on motherhood would remain, throughout this entire period of study as central to women’s experiences, even though the two world wars would bring suffrage to women and opportunities to demonstrate the ability to work in non-traditional occupations. Despite the fact that both birth control and abortion would remain illegal throughout this period the birth rate declined steadily until the baby boom of the post-World War Two era. The so-called “sexual revolution” of the 1960s did not necessarily change most women’s experiences of reproduction since both abortion and birth control remained illegal until late in that decade. However, there was evidence that, at least in terms of birth control, the ability of women to (publicly) control their fertility was becoming more acceptable. In large measure, this change was helped along by the movement for population control internationally which made it much more difficult to continue to restrict women’s access to birth control in Canada. Despite these many changes, most women did not experience much of a revolution in their lives during this period. Throughout this examination it has been evident that the biological essentialism of the late nineteenth century continued to play a role in women’s lives and the medical profession was

central in shaping the ideals for women which suggested that they were “made to be mothers”. Abortion was one issue that they discussed throughout the period that helped to reinforce these gender prescriptions.

In *When Abortion Was A Crime: Women, Medicine, and Law in the United States, 1867-1973*, Leslie Reagan notes the importance of examining the medical (and legal) discourse on abortion because these discourses “introduced new meanings of abortion and shaped people’s views (and fears) of abortion and sexuality.” However, Reagan is wary of the potential for exclusive examinations of medical discourse to distort the history by convincing some that physicians did not perform abortions during their illegality. She argues that “analysis of discourse alone would miss the ongoing medical practice of abortion in contradiction of official medical mores.”<sup>5</sup> While this thesis does not disagree with Reagan’s point about the fact that the discourse does not necessarily represent reality – in other words, it recognizes that some doctors did indeed operate outside of the official discourse by performing illegal operations – it does suggest that examination of the medical discourse is necessary.

By examining the medical discourse over time we can better see where other groups have been able or not to enter and shape the discourse.<sup>6</sup> This approach, therefore, allows us to better understand how the medical profession viewed women who sought abortions during the period of its illegality and to address the concern by feminist scholars who have lamented the lack of voice by those women in determining their own reproductive health. It should be noted, however, that doctors are not a monolithic group. While the medical discourse can tell us much about how doctors viewed abortion (and women) and how they sought to deal with the issue

---

<sup>5</sup> Leslie J. Reagan, *When Abortion Was a Crime: Women, Medicine, and Law in the United States, 1867-1973*, Berkeley: University of California Press, 1997, p. 7. In particular, Reagan disagrees with the conclusions by Kristin Luker that the discourse represented reality – that since the medical discourse condemned the practice of abortion, doctors were not performing them. See Luker, *Abortion and the Politics of Motherhood*, Los Angeles: University of California Press, 1984, chapter 3. I would agree with Reagan on this point.

<sup>6</sup> *Ibid.*, p. 7. Reagan points out that Foucault’s theory about the production of sexuality through discourses ignores the ability for other individuals and social groups to enter and shape the discourse. In gender history, Joan Wallach Scott has done the best job of emphasizing this point, especially in *Only Paradoxes to Offer: French Feminists and the Rights of Man*, Cambridge: Harvard University Press, 1996. See also her *Gender and the Politics of History*, New York: Columbia University Press, 1988.

during the period of its illegality, this was primarily the “official” position on abortion constructed by elite practitioners – most often medical faculty, specialists, or prominent members of the Canadian Medical Association. There is much evidence to suggest, however, that not all doctors subscribed to the approaches outlined in the medical discourse. We know, for instance, that some doctors found ways to justify the performance of therapeutic abortions during the period of its illegality in order to help their patients, despite the official stance presented by the profession. Other doctors, most notably Catholic physicians, had to approach the issue of abortion (this was most evident in discussions of therapeutic abortion) in a different way than many of their colleagues because their religious beliefs prevented them from accepting that it was ever necessary to terminate the life of the fetus in order to save the life of the mother. Indeed, these evasions of the official discourse by some doctors actually caused shifts in the discourse as the Canadian medical profession attempted to address inconsistencies between the discourse and actual practice. Finally, while Reagan and others have argued that the medical discourse on abortion rarely included the voices of women, an examination of the medical discourse over time actually serves to demonstrate examples of women’s perspectives beyond the “shocking examples of depraved womanhood”<sup>7</sup> and illuminates doctors’ concerns for their patients. In short, it is necessary to examine the central role of the medical profession in shaping abortion practices in order to more fully understand the medical discourse and its power in shaping other discourses.

Historians have long since recognized the key role that doctors played through the medical discourse on abortion. This thesis builds on many of the studies of abortion and contraception which have recognized the influential role of doctors in the evolving practices and politics of abortion and contraception. The best known of such studies in Canada is Angus and Arlene Tigar McLaren’s book, *The Bedroom and the State: The Changing Practices and Politics of Contraception and Abortion in Canada, 1880-1997*. The McLarens trace the history of contraception and abortion in Canada in order to explore the reproductive practices of Canadians

---

<sup>7</sup> Reagan, *When Abortion Was a Crime*, p. 8.

within the history of reproductive policies. While this work clearly acknowledges the role of doctors in such practices and policies, it does not focus on the medical profession per se. Other works, too, have noted the central role played by the medical profession. Constance Backhouse has examined the role of the medical profession in abortion cases at the turn of the century. In “Physicians, Abortions, and the Law in Early Twentieth-Century Ontario” she discusses both the medical and legal professions in order to situate how the two groups wrestled to influence ways in which to address the demand for illegal abortions. Backhouse, however, is particularly interested in the legal aspect of abortion and her work has held that primary focus.<sup>8</sup> In the United States, the focus has been primarily on the history of abortion laws, and on the social movements which influenced changes to abortion laws and practices, although historians recognize the important role played by the medical profession in forming abortion laws.<sup>9</sup> In Britain, however, two scholars have examined the role of medical discourse in legal reform. Sally Sheldon examines the 1967 abortion Act in Britain to argue that a shift occurred in the model of law from one which was based on criminal prohibition of abortion to one which focused on abortion as a medical matter. She argues that by reframing the British abortion law in

---

<sup>8</sup> Scholars have mainly investigated the connection between doctors and abortion and have provided factual evidence about abortion procedures and practices gleaned primarily from court records or medical journals for the late nineteenth and early twentieth centuries. Abortion has also been suggested as an issue used by doctors in the late nineteenth and early twentieth centuries to regulate and legitimate their profession. In Canada, see Angus and Arlene Tigar McLaren, *The Bedroom and the State: The Changing Practices and Politics of Contraception and Abortion in Canada, 1880-1967*, Toronto: Oxford University Press, 1997; Angus McLaren, “Birth Control and Abortion in Canada, 1870-1920.” *Canadian Historical Review*, 59 (1978): 319-340; “Illegal Operations: Women, Doctors and Abortion, 1886-1939,” *Journal of Social History*, 26, 4 (1993): 797-816; Constance Backhouse, “Involuntary Motherhood: Abortion, Birth Control and the Law in Nineteenth Century Canada,” *Windsor Yearbook of Access to Justice*, (1983): 61-130; “Physicians, Abortions, and the Law in Early Twentieth-Century Ontario,” *Canadian Bulletin of Medical History*, 10 (1993): 229-249; “Prosecution of Abortions under Canadian Law, 1900-1950,” in Jim Phillips et. al. (eds.) *Essays in the History of Canadian Law, Volume 5*, Toronto: University of Toronto Press, 1994: 252-292; Shelley Gavigan, “The Criminal Sanction as it Relates to Human Reproduction: The Genesis of Statutory Prohibition of Abortion,” *Journal of Legal History*, 5 (1984): 20-43; Susanne Klausen, “Doctors and Dying Declarations: The Role of the State in Abortion Regulation in British Columbia,” *Canadian Bulletin of Medical History*, 13, 1 (1996): 53-82. For a discussion of more recent history, see Brodie, Gavigan and Jenson, *The Politics of Abortion*; A. Anne McLellan, “Abortion Law in Canada,” Campbell and Pal, “Courts, Politics and Morality.”

<sup>9</sup> For instance see Kristin Luker, *Abortion and the Politics of Motherhood*; James Mohr, *Abortion in America: The Origins and Evolution of National Policy, 1800-1900*, New York: Oxford University Press, 1978; Janet Farrell Brodie, *Contraception and Abortion in 19<sup>th</sup> Century America*, Ithaca: Cornell University Press, 1994; Leslie J. Reagan, *When Abortion Was a Crime*. See also Linda Gordon, *Woman's Body, Woman's Right: Birth Control in America*: New York: Penguin Books, 1990.

this way, abortion became a medical matter rather than a political one, leaving important abortion (and reproductive) decisions in the hands of doctors, rather than the political arena.<sup>10</sup>

Similarly, Michael Thomson has suggested that abortion was constructed as a medical and social issue which has allowed the medical profession to promote its own parochial concerns.<sup>11</sup>

The work by both Thomson and Sheldon has been useful and suggests that there is a need to examine how the medical discourse on abortion and, by relation, women's reproductive roles, changed over time, enabling it to be so influential in this process. How doctors obtained such power and the significance of that position in the reform of the Canadian Criminal Code are considered to reveal how the medical position on the practice has been inextricably linked to their status and the construction of women's reproductive roles throughout the history of abortion in Canada. By examining the changes which occurred in the medical discourse between 1850 and 1969, the strength and power of the medical discourse is revealed. Doctors' authority to speak about, and even define, the practice of abortion stems from the disciplinary power of medicine. This legitimates the discourse because medicine is viewed within the discourse (incorrectly) as a science – the pursuit of the “truth” – when in fact medicine is more about “trial and error.”<sup>12</sup>

If we consider that doctors worked throughout the twentieth century to secure the medical profession's hold over health matters, it is not surprising that the main lobbyists for change in the late 1960's were not women or feminists but doctors (and lawyers given that abortion was a crime according to the Criminal Code). They did so to minimize criminal liability for doctors

---

<sup>10</sup> Sally Sheldon, *Beyond Control: Medical Power and Abortion Law*, London: Pluto Press, 1997.

<sup>11</sup> Michael Thomson, “Woman, Medicine and Abortion in the Nineteenth Century,” *Feminist Legal Studies*, 3, 2 (1995): 159-183. See also Thomson, *Reproducing Narrative: Gender, Reproduction and Law*, Aldershot: Ashgate Publishing, 1999.

<sup>12</sup> I am drawing on Michael Thomson's work on doctors' disciplinary power which he refers to as doctors' authority to discuss abortion practices and to define gender roles. This also gives them the power to decide what constitutes wellness or illness, as well as actions that can be deemed “unphysiological.” Behaviour considered inappropriate or inconsistent with the “proper” gender roles as constructed in a given period can be construed, therefore, as unnatural or unhealthy. Further, he suggests that the construction of such social and gender differences by the medical profession is constant and that we must acknowledge “the perennial nature of the desire to define the role of women.” See “Woman, Medicine and Abortion in the Nineteenth Century,” p. 182.

who performed abortions.<sup>13</sup> The new provisions really just served to entrench in legislation the power of doctors to construct and regulate the discourse as they long had, allowing them to continue to extend their influence and privileged position in determining women's reproductive rights. Indeed, as the academic literature on abortion in Canada points out, abortion is traditionally imagined as an almost exclusively medical matter.<sup>14</sup> Even now, contemporary arguments both for and against the procedure are inextricably linked to medical definitions. It is not surprising, then, that examinations of the history of abortion practices and procedures in Canada traditionally emphasize this medicalization and the legal prohibitions of the practice. These seem to point to the unequal social relationships between men and women and how doctors play a key role in perpetuating such inequalities.

Janine Brodie, Shelley Gavigan and Jane Jenson make the argument, for instance, that "the history of legal abortions in Canada teaches us that politics maintains relations of domination over women in part by defining the very meaning of those relations as well as by institutionalizing practices which restrain women."<sup>15</sup> Their argument is essentially centred on how women have been unable, because of their lack of a political voice, to shape the political discourse on abortion in their favour. In other words, women have been unable to influence the legislation on abortion in a way that would enable them to control their own reproductive capabilities. In fact, we still do not have legislation in Canada which gives women the right to access abortion on demand, or in other words, that allows them to make their own decision about when to terminate a pregnancy.

Feminist historians have also generally lamented the fact that women in the past, and still, lack the power to cause such legislative change. They point out that since abortion has been defined by the medical profession, which also allowed them to define proper gender roles and to shape and maintain their status as professionals, the disciplinary power of doctors has been

---

<sup>13</sup> Campbell and Pal, "Courts, Politics and Morality," p. 166.

<sup>14</sup> Michael Thomson (among others) has also made this assertion. See *Reproducing Narrative* especially chapter 1.

<sup>15</sup> Brodie, Gavigan and Jenson, *The Politics of Abortion*, p. 18-19. However, they note that this changed in 1988 when the Supreme Court of Canada "at least partially accepted strains of the pro-choice movement's 'rights' rhetoric asserting women's right to bodily integrity and reproductive control." p. 59.

nearly impossible to circumvent.<sup>16</sup> Indeed, the medicalization of the practice is a centrally important aspect of abortion history in Canada. Studies of the inequality between doctors and their patients have also emphasized, in one way or the other, that doctors' possession of disciplinary power allows them to shape medical practices. As Kathryn Pauly Morgan warns, it is "wise to remember that doctor-patient interactions are highly political. The institutionalized power of the physician to diagnose, to discipline, to carry out surveillance, to expect confession and compliance to 'doctor's orders' are particularly central to the exercise of authoritative knowledge built into hierarchical medicalized doctor-patient relationships." Further, she notes the problem for patients in general that "resistance and refusal can be quickly labelled 'lack of compliance' and can have frightening consequences, particularly for women and anyone vulnerably situated in oppressive circumstances."<sup>17</sup> And frightening consequences have indeed been part of women's experience of abortion.

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. Wendy Mitchinson notes that women could negotiate with their physician about what they wanted done and, if necessary, fashion a story about what was wrong with them in an attempt to achieve the results they wanted. While this kind of dialogue seldom equalized the power relationship between patient and doctor (a relationship which existed, I would argue, among all patients and doctors, not just women patients), it does suggest that a degree of choice and agency on the part of individual women helped to offset the power of any

---

<sup>16</sup> Constance Backhouse has suggested that doctors constructed abortion in order to promote their own professional status. See "Involuntary Motherhood." Gail Kellough and Michael Thomson have made similar claims. See Kellough, *Aborting Law* and Thomson, *Reproducing Narrative*. Wendy Mitchinson describes doctors' prescriptions of proper roles for women in her book, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*, Toronto: University of Toronto Press, 1991. See also Penny, "'Getting Rid of My Trouble': A Social History of Abortion in Ontario, 1880-1969," unpublished MA Thesis, Laurentian University, 1995.

<sup>17</sup> Kathryn Pauly Morgan, "Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalization," in Susan Sherwin (ed.), *The Politics of Women's Health: Exploring Agency and Autonomy*, Philadelphia: Temple University Press, 1998, p. 92.

individual physician.<sup>18</sup> There is no question that women's voices were subordinated to those of doctors because their collective voices were not yet able to be heard loudly enough to be recognized as important; medical doctors' voices were rooted in a discourse based on the "truth" of medical science. In this sense, women's voices were "...silenced, [and they were] speaking among themselves in a language that only they [could] understand."<sup>19</sup> And although it is clear that women's collective voice was not strong enough in 1969 to influence the legislation, at least publicly, a closer examination of the medical discourse on abortion reveals that their voices had been heard by doctors because of physicians' connection with the women who sought out the procedure, or who came to them after a botched attempt at ridding themselves of an unwanted pregnancy. The agency exercised by individual women and their resultant visits to their medical practitioners did indeed help to shape the medical discourse on abortion which in turn shaped legislation on the practice. In this sense, women did have a voice which resonated in the medical discourse.

Michel Foucault has drawn attention to the value of such a discourse analysis for historical studies because of the ability of these examinations to reveal how discourses are constructed, how they are constrained, and how they influence actions in different historical periods. The rules of discourse, as outlined by Foucault, set up systems of exclusion which denote who can speak about a given topic (like abortion practices) and what can be spoken.<sup>20</sup> Further, Foucault has pointed to the formation of binaries within discourses which create power hierarchies where some speakers are superior to others (for example, doctors have the authority to listen to their patients' symptoms). Connected to this division is the will to truth where those with "power" can impose on a knowing subject a position or viewpoint.<sup>21</sup> Power and knowledge

---

<sup>18</sup> Wendy Mitchinson, "Agency, Diversity, and Constraints: Women and Their Physicians, Canada, 1850-1950," in Susan Sherwin (ed.), *The Politics of Women's Health: Exploring Agency and Autonomy*, Philadelphia: Temple University Press, 1998, p. 127. While Mitchinson has not denied that a power relationship also exists between male patients and their doctors, she would argue that a lack of power has been felt more by women.

<sup>19</sup> Brodie, Gavigan and Jenson, *The Politics of Abortion*, p. 19.

<sup>20</sup> See Michel Foucault, "The Discourse on Language," in *The Archaeology of Knowledge*, trans. A.M. Sheridan Smith, New York: Pantheon Books, 1972: 215-38.

<sup>21</sup> For Foucault, "power is everywhere, not because it embraces everything, but because it comes from everywhere." It is not possessed by a dominant agent, nor located in that agent's relations to those dominated, but is instead

exist in direct relation to each other because who is empowered to speak at a given time, within a specific discursive formation, has the knowledge necessary to speak and be taken seriously. Hence, doctors had (and continue to have) the ability to speak about abortion in a given historical period and their discourse of the practice is legitimated based on their scientific knowledge of the body - "disciplinary power."<sup>22</sup> Historically, doctors have had the power/knowledge to speak about the practice when others were constrained from doing so. Although abortion was essentially an illegal procedure up to the liberalization of the law in 1969, those that had the power to speak about it framed and kept the discussion alive.<sup>23</sup>

Doctors' authority, which stemmed from the disciplinary power of medicine, was central to the shape the discourse took on in the different periods. A strong desire shared by doctors, other professionals, and a broadly-defined "middle class", to ensure that women embodied their role as mothers, influenced the discourse. Doctors' disciplinary power also influenced the measures that they advocated to "fix" problems associated with abortion, specifically, with illegal abortions. These measures seem to have established their control over women's bodies as they gave doctors the power to determine when and if a woman could terminate a pregnancy.

---

distributed throughout complex social networks. "Power is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategical situation in a particular society." Joseph Rouse, "Power/Knowledge", in Gary Gutting (ed.), *The Cambridge Companion to Foucault*, Cambridge: Cambridge University Press, 1994, p. 93-96.

<sup>22</sup> Michael Thomson refers to doctors' authority to discuss abortion practices and to define gender roles as well as to decide not only what constitutes wellness or illness, but also actions that can be deemed "unphysiological." Behaviour considered inappropriate or inconsistent with the "proper" gender roles as constructed in a given period could be construed, therefore, as unnatural or unhealthy. Further, Thomson suggests that the construction of such social and gender differences by the medical profession is constant and that we must acknowledge "the perennial nature of the desire to define the role of women." See "Woman, Medicine and Abortion in the Nineteenth Century," p. 182.

<sup>23</sup> Foucault's discourse analysis has proven to be useful for examining other historiographical topics and new literature is beginning to emerge which recognizes both the centrality of the medical discourse in determining the availability of abortion practices, as well as the profession's role in shaping abortion legislation. For instance, Gail Kellough has studied how different discourses "appropriate and transform the linguistic code that directs reproductive activity." Specifically, she examines medicine and the law to understand the way that all hegemonic social and legal codes - despite opposition and contradiction - interlock on the basis of gendered moral assumptions about individual liberty and collective responsibility. See her book, *Aborting Law*, p.6. Michael Thomson has examined the medical discourse on reproduction in Britain and the United States to locate the sites or technologies at or through which gender is constructed, and to locate medical power. See *Reproducing Narrative*. These studies, however, have examined the medical discourse primarily for the period before the First World War and the period surrounding the liberalization of access to abortion which occurred with the enactment of new abortion legislation in 1969 (1967 in Britain). While they have contributed immensely to the historiography in this area by demonstrating the usefulness of discourse analysis, they have largely ignored the discourse of the interwar period.

But within the power hierarchy created by the dominant medical discourse, it is clear that other speakers on the issue were heard. Their voices resonated in case reports presented by doctors as a means of discussing the abortion “problem.” These were the voices of women, who, despite the medical and legal prescriptions which did not allow abortion, sought control over their own bodies. These women exercised agency by seeking their own solutions to unwanted pregnancies. Sometimes the solutions were medical, in terms of their use of abortionists who provided instrumental procedures, and sometimes they were in the form of folk remedies, passed on to them by other women. The point is that some women made choices without the help of their doctors, yet we know about them largely because it was doctors who reported their experiences. Their voices in the medical press illuminate doctors’ interest in their patients’ welfare at the same time that doctors felt the need to maintain their professional status through their recommendations to the Canadian Parliament for changes in the law. Doctors, therefore, used their scientific knowledge/power not only to shape the discourse in terms that allowed them to be the regulators of reproduction and which legitimated the scientific knowledge of the medical profession, but also in ways that allowed them to address their concern for their patients’ health. The eventual call by doctors for state legislation to reinforce their power over reproduction reveals a clear relation between medicine’s disciplinary power and gender relations which served to embed women’s bodies in an enormous weight of scientific and cultural meaning.

Many feminist scholars have questioned the social construction of the body by biological science. Ruth Bleier, for instance, notes the importance of recognizing that “science, like all culture, reflects....historical bias.”<sup>24</sup> Given the reflection of cultural attitudes in the understanding of the human body, in particular the female body, in different time periods, it is important to understand that the medical profession’s construction of women’s bodies and how abortion affected women’s place in society cannot be separated. Since doctors most closely associated women’s health as being inextricably connected to their bodies, “the woman’s body

---

<sup>24</sup> Ruth Bleier, *Science and Gender: A Critique of Biology and Its Theories on Women*, New York: Pergamon Press, 1984, p. 2.

became equated with a reproductive body.”<sup>25</sup> Doctors’ discussions of women’s health were always placed within the context of the proper role for women of the day. Historically, that role has been “mother” and those discussions have been legitimized by scientific “proof” of those roles.<sup>26</sup> Any historical study of abortion, then, needs to bear in mind that societal attitudes toward women in any period affected the medical profession’s view of the practice of abortion.

The medical discourse on abortion in different historical periods is significant for the history of abortion.<sup>27</sup> Yet most historians interested in the history of abortion (and birth control) have not focused on the discourse. The studies that do exist most typically probe the reasons for state legislation criminalizing abortion, examine the interaction between medical and legal authorities who were jostling over the proper response to the demand for illegal abortions, and trace the history of the practice of abortion, while at the same time revealing the nature of the relationship of women who sought out abortions with their male partners, their friends, their doctors and ultimately the judiciary. They also have only examined the late nineteenth and early twentieth centuries.<sup>28</sup> An examination of the discourse over a longer period of time helps to

---

<sup>25</sup> Wendy Mitchinson, *Giving Birth in Canada, 1900-1950*, Toronto: University of Toronto Press, 2002.

<sup>26</sup> For an excellent discussion of how science reinforces cultural constructs of gender see Emily Martin, “The Egg and the Sperm: How Science has Constructed a Romance Based on Stereotypical Male-Female Roles,” *Signs*, 16, 3 (1991): 485-501. See also Ruth Hubbard, *The Politics of Women’s Biology*, New Jersey: Rutgers University Press, 1990; Marian Lowe and Ruth Hubbard (eds.), *Woman’s Nature: Rationalizations of Inequality*, New York: Pergamon Press, 1983; Thomas Laqueur, *Making Sex: Body and Gender from the Greeks to Freud*, Cambridge: Harvard University Press, 1990; Ludmilla Jordanova, *Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries*, Madison: University of Wisconsin Press, 1989; Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity*, New York: Routledge, 1990; Mary Jacobus, Evelyn Fox Keller and Sally Shuttleworth (eds.), *Body/Politics: Women and the Discoveries of Science*, New York: Routledge, 1990.

<sup>27</sup> Discourse analysis of the medical position on abortion as well as for other historiographical topics is beginning to gain recognition. Post-structuralists have encouraged “reading against the grain” to expose how texts are cultural constructions of the past, rather than the “reality” of the past. Perhaps the best example of this is Natalie Zemon Davis, *Fiction in the Archives: Pardon Tales and Their Tellers in Sixteenth Century France*, Stanford: Stanford University Press, 1987. Davis was one of the first historians to acknowledge that there is a relationship between the “real” and the “historical” to the fictional.” Some historians have followed Davis’ lead. For instance, see Franca Iacovetta and Wendy Mitchinson (eds.), *On the Case: Explorations in Social History*, Toronto: University of Toronto Press, 1998; Joan W. Scott, “The Evidence of Experience,” in Henry Abelove, Michele Aina Barale, and David M. Halperin (eds.), *The Gay and Lesbian Studies Reader*, New York: Routledge, 1993; Joan Scott, *Only Paradoxes to Offer*; Harriet Nowell-Smith, “Nineteenth-Century Narrative Case Histories: An Inquiry into Stylistics and History,” *Canadian Bulletin of Medical History*, 12 (1995): 47-67. Michel Foucault’s discourse analysis is the most well-known and controversial approach for historians. See *The History of Sexuality - Volume 1: An Introduction*, trans. Robert Hurley, New York: Vintage Books, 1978.

<sup>28</sup> See McLaren and McLaren, *The Bedroom and the State*; McLaren, “Birth Control and Abortion in Canada”; “Illegal Operations”; Backhouse, “Involuntary Motherhood,”; “Physicians, Abortions, and the Law”; “Prosecution

reveal the shifts in how doctors spoke about, and indeed, conceptualized abortion in different periods and in different contexts. These shifts reflect the changing attitudes toward, not only the practice of abortion, but also the contexts of the day. Although the discourse shifted in different periods, three themes emerge and remain a part of the medical discourse on abortion throughout the period of study. Doctors' status as a profession, the morality of abortion, and the proper role of women are themes which can be found in the discourse in all periods. Depending on the social context in which doctors were speaking about abortion, these themes were more or less prominent in their discussions.

The first two chapters in the thesis provide contextual background as well as illuminate the shifts in the medical discourse on abortion in what I refer to as the early period (1850-1918) and the interwar period (1919-1939). Chapter one examines doctors' use of the issue of abortion as a means of regulating their own profession as well as to construct the role of motherhood for women. By using the issue of abortion, regular doctors were able to reinforce their status as professionals in the "truth" of medical science. This truth also enshrined women's role as mothers in scientific and cultural meaning which still proves to be difficult to escape. Chapter two examines the medical discourse on abortion in the interwar period. It is clear that a shift in the discourse occurred between 1919 and 1939 as doctors attempted to address the issue of a static, high maternal mortality rate. In trying to combat the problem and the questions it raised about their ability as professionals to prevent maternal death, doctors used abortion to explain how they were not responsible for many of the deaths that appeared in the mortality statistics. These were deaths of women who came to them because of botched attempts at abortion. Since such women arrived at hospitals when it was too late to save them doctors argued that their deaths should not reflect on the profession's ability to prevent maternal deaths. This period is also significant for the measures which doctors implemented to combat the problem, like prenatal exams, and better classification on death certificates. Maternal mortality studies were

---

of Abortions under Canadian Law"; Gavigan, "The Criminal Sanction as it Relates to Human Reproduction"; Klausen, "Doctors and Dying Declarations"; Penny, "Getting Rid of My Trouble."

also significant because of their ability to point out “fault” in maternal deaths. While both the early and interwar periods have been examined in the Canadian historiography on abortion their inclusion in this thesis is necessary to demonstrate the shifts which occurred in the medical discourse on abortion over time and to root the discourse in its own history.<sup>29</sup> To fully understand how and why the discourse shifted over time we need to understand its past. This also helps us to see the aspects of the discourse which change or remain the same in later periods. Furthermore, no other previous examinations of abortion history in Canada have focused on the medical discourse explicitly for these time periods necessitating the examination here.

By the early 1940s, the maternal mortality rate had dropped substantially in Canada. Doctors, therefore, shifted their focus away from mortality to maternal welfare. It is in this context of maternal welfare that abortion was discussed in the 1940s, 1950s and 1960s. Chapter three examines doctors’ ongoing discussions of measures to combat maternal mortality, as well as how their discussions of maternal welfare can be seen within discussions of contraception. Chapter four explores how their limitation of contraindications to healthy pregnancy influenced their recommendations for termination of pregnancies or therapeutic abortion. New approaches to the issue of therapeutic abortion, such as the use of psychology in determining mothers’ mental welfare, were used in this period. I also examine the shift from doctors’ reliance on the 1938 *Bourne* decision to determine the legality of performing a therapeutic abortion to their questioning of the law in Canada. This led to their recommendations to the House of Commons Standing Committee on Health and Welfare which are discussed in chapter five. The Standing Committee reports show the immense power of the medical profession in shaping the legislation in 1969 and questions the traditional historical belief that doctors’ main motivation for recommending changes was to protect their professional status. By examining the briefs presented to Health and Welfare in light of the debates held over the course of the century by the

---

<sup>29</sup> While the early and interwar periods have been examined, the medical discourse per se has not been central to earlier studies.

medical profession, it is clear that doctors' recommendations, specifically those of the Canadian Medical Association, clearly reflect, not only doctors' concern for their own professional well-being, but also their concerns for what they believed to be the best interests of their patients. The Standing Committee reports also demonstrate that witnesses, who took a feminist, pro-choice approach to encouraging revision, also placed their views within the context of medicine. They testified that, although women had the right to request an abortion, doctors were still needed to confirm the medical value of such a procedure.

The value of examining the medical discourse over time is that shifts are revealed in how doctors discussed the practice of abortion, shifts that are not evident from studying a particular period in isolation. It allows us to see how medical science has become so entrenched, which may be why it has been difficult for other competing discourses to circumvent it. And although we cannot be certain that discourses actually reflect practices, what is clear is that doctors' concern over the abortion issue was not solely based on their desire to protect their disciplinary power. It was clearly also related to a concern for their patients and their welfare – for women's welfare.

## Chapter One

### *Regulating Doctors: Abortion and the Professionalization of Medicine, 1850-1918*

“One of the grandest aims of the doctor,” a 1908 editorial in *The Canada Lancet* noted, “should be to raise the social and moral status of his patients as well as improving their physical condition.”<sup>1</sup> This article, written primarily to discourage regular physicians<sup>2</sup> from performing illegal abortions, provides a window into how doctors viewed themselves and their profession at the turn of the century. Doctors, this editorial suggested, should promote the morality of their patients. Their role, therefore, was not only to cure illness but also to ensure moral health. The notion that doctors played a role in upholding their patients’ morality was connected to regular doctors’ status. By the turn of the century, regular physicians had established themselves as a

---

<sup>1</sup>Editorial, “Does It Pay? No!” *The Canada Lancet*, 42 (1908-09), p. 648.

<sup>2</sup>Regular doctors were those who had received medical training in a university medical school and who followed traditional therapeutic practices. Regular or allopathic doctors in the early nineteenth century were typically trained in British medical schools or through an apprenticeship system (by the last third of the century, though, doctors were no longer trained using the apprenticeship model) and based their beliefs on the concept of balance within the body. In the early decades of the nineteenth century, regulars viewed sickness as an imbalance of the humours (blood, phlegm, yellow bile, black bile) which they believed could be restored through such heroic practices as bleeding, blistering and purging. Blistering was said to alleviate both agitation and fever and was used to counter irritants causing disequilibrium. Purging was used in the same manner, most often in the form of large doses of chloride of mercury. Because of the interventionist nature of regular medical practice, it has been referred to as “heroic” medicine. Irregulars were any health practitioners who did not share this background and training and who proposed alternative methods of treatment. They typically had little or no training (in the traditional sense of medical school or apprenticeship) and, while their overarching view of disease was not necessarily that different from that of the regulars, they were typically more “natural” in their approach, concocting remedies from a variety of herbs and patent medicines derived from “family” recipes. Irregulars also did not believe in heroic measures. In fact, some groups even diluted drugs to treat illness believing that the result would be a patient’s body restoring itself to health. See R.D. Gidney and W.P.J. Millar, “The Origins of Organized Medicine in Ontario, 1850-1869” in Charles G. Roland (ed.), *Health Disease and Medicine: Essays in Canadian History*, Toronto: The Hannah Institute for the History of Medicine, 1984: 64-95; Charles E. Rosenberg, “The Therapeutic Revolution: Medicine, Meaning, and Social Change in Nineteenth Century America”, in Morris J. Vogel and Charles E. Rosenberg (eds.), *The Therapeutic Revolution: Essays in the Social History of American Medicine*, Philadelphia: University of Pennsylvania Press, 1979, p. 6. For a discussion of the different medical sects in Canada in this period see James Connor, “Minority Medicine in Ontario, 1795-1903: A Study of Medical Pluralism and Its Decline”, unpublished PhD thesis, University of Waterloo, 1989.

profession which essentially controlled the health care market. This needed to be guarded, though, and refusing to perform illegal operations for their patients was an important step in ensuring that the profession would retain its elevated position. As the editorial noted, “every time that a medical practitioner does an improper act for a fee, he has gone a long way towards lowering himself in his own estimation; and this is the most dreadful misfortune that can befall any practitioner.” Physicians were further urged to be wary of those who sought out abortions because of the effect that their association with such patients could have on the regular practitioner’s status as a profession. “The class of young men and women who seek to have these operations performed to get themselves out of trouble,” the author noted, “will bring discredit to any doctor who yields to their requests...It is truly a case of choosing in which class a doctor purposes living out his professional life amongst. Shall it be the abortionist class, ever downwards, or among the self-respecting class, ever upwards?”<sup>3</sup>

The regular medical profession’s concern about its status (and the protection of that status) was (and continues to be) at the heart of their discussions of abortion. Since it appears that its status is centrally important to them and plays a key role in shaping the medical discourse on abortion much of the academic literature which discusses the liberalization of the abortion laws in Canada in 1969 has also held this focus.<sup>4</sup> Indeed, it has been argued that the power and status of the medical profession allowed it to shape and essentially frame the legislation in its own interests – that their views on abortion were so entrenched in both the social and political contexts of 1969 that it was impossible for other voices (namely those of women) to be heard.<sup>5</sup>

---

<sup>3</sup> Editorial, “Does It Pay? No!,” p. 648-649. The “young men” the writer was referring to was likely the male partner of the woman in trouble.

<sup>4</sup> Most academics refer to the abortion laws being liberalized because the changes in the legislation were part of a larger omnibus bill tabled by then Justice Minister, Pierre Trudeau, to remove moral laws from the Criminal Code such as those on birth control, abortion, and homosexuality. A more detailed discussion of this can be found in chapter five.

<sup>5</sup> This would largely have been due to the fact that only a small percentage of women were doctors throughout the

But is this the whole story? Did all doctors agree that their professional status needed to be protected and that abortion practices posed a serious threat to the maintenance of their position? In order to assess whether this was the case, we need to first examine how regular doctors established their status and power in the practice of medicine.

It may at first seem strange in the 21<sup>st</sup> century to be examining how doctors established their profession. After all, we usually think of the medical profession as a group of specialists whose expertise is derived from their knowledge of medical science which in turn shapes their position on different issues, including abortion. Modern studies of the medical profession have helped to cement this notion for us. For instance, in his 1970 examination of the medical profession, sociologist Eliot Friedson connected doctors' scientific knowledge with their status. Friedson described the profession as preeminent. "Such preeminence" he noted, "is not merely that of prestige but also that of expert authority. This is to say, the medical profession's knowledge about illness and its treatment is considered to be authoritative and definitive."<sup>6</sup> He continued his analysis by comparing the profession of modern medicine to state religions of the past, where those religions had the power ("an officially approved monopoly") to prescribe behaviour. In the case of the medical profession, argued Friedson, that monopoly represents

---

period of study. Even by the post-war period the numbers were still quite small. See Alison Prentice et.al, *Canadian Women: A History*, Toronto: Harcourt Brace, 1988, p. 327. The voices of women patients were also rarely made public. For discussions of the lack of women's voice in the abortion debate in 1960s Canada see Janine Brodie, Shelley A.M. Gavigan and Jane Jenson, *The Politics of Abortion: Representations of Women in Canada*, Toronto: Oxford University Press, 1992; Gail Kellough, *Aborting Law: An Exploration of the Politics of Motherhood and Medicine*, Toronto: University of Toronto Press, 1996. In Canada, Brenda Margaret Appleby has made the same argument about the medical profession's role in revisions to the legislation on birth control. See *Responsible Parenthood: Decriminalizing Contraception in Canada*, Toronto: University of Toronto Press, 1999. Similar arguments have also been made about the medical profession and abortion in the United States. For instance, see Kristin Luker, *Abortion and the Politics of Motherhood*, Los Angeles: University of California Press, 1984; James Mohr, *Abortion in America: The Origins and Evolution of National Policy, 1800-1900*, New York: Oxford University Press, 1978. In Britain see Michael Thomson, *Reproducing Narrative: Gender, Reproduction and Law*, Aldershot: Ashgate Publishing, 1999; J. Keown, *Abortion, Doctors and the Law*, Cambridge: Cambridge University Press, 1988.

<sup>6</sup> Eliot Friedson, *Profession of Medicine: A Study in the Sociology of Applied Knowledge*, New York: Harper and Row, 1970, p. 5.

their “right to define health and illness and to treat illness.”<sup>7</sup> Most would probably agree that the power of medicine in the early 21<sup>st</sup> century is not that much different than it was in 1970.<sup>8</sup> If anything, the power of medical science may be increasing as the body of scientific knowledge that doctors contribute to and, in turn use in their practices, grows.

Friedson’s analysis encapsulates the idea that doctors’ power comes from their scientific expertise - expertise that we as patients have come to rely on. We look to our physicians to “fix” us if we do not feel quite right, to guard us against illnesses that might harm us, and to find cures and/or identify preventative measures for us to follow to avoid becoming sick. The help doctors provide, we assume (and, perhaps, even take for granted) is based on their scientific medical knowledge of the body. We also assume that our doctors’ knowledge is current and up-to-date, and that it is in step with the latest studies on preventing, treating and managing disease. In short, the patient/physician relationship is one based on trust - trust by us, the patients, that our physicians will act in our best interests and provide us with the best medical (which implies scientific) solution(s) to our ailments.

Maglia Larson’s study of the rise of professionalism suggests that doctors’ knowledge of medicine, which is considered a science, is a source of power for the profession. Larson sees professionalization as a process where producers (medical doctors) of special services seek to constitute *and control* a market for their expertise. But there is more to Larson’s description of power. She argues that it is knowledge that facilitates the attainment of power.

---

<sup>7</sup> *Ibid.*

<sup>8</sup> It should be noted here, however, that there are probably those who would be willing to argue that the status of medicine has declined since 1970 given that it is controlled more today by government, that there are more legalized competitors like chiropractors, homeopaths, and midwives, and that their patients are unwilling to take their opinion as truth. My view, which has influenced this interpretation of the history of abortion in Canada, however, suggests that doctors still maintain a great deal of power because medicine is viewed by the majority of patients as being scientific making doctors’ prescriptions, “reliable.” Recent polls support this view. For instance, see Ipsos-Reid, “So Whom Do We Trust? Reader’s Digest Trust Survey Finds that Pharmacists, Doctors and Airline Pilots Top the List as Canada’s Most Trusted Professions,” January 22, 2003.

Professionalization allows the translation of special knowledge and skills (typically a scarce resource) into social and economic rewards. Professionalization, therefore, can be viewed as an attempt to control market power through the construction of a formal knowledge base and the formation of knowledge communities.<sup>9</sup>

In both Friedson's and Larson's examinations of the medical profession, power plays an important role. Michael Thomson, however, has viewed this power in a slightly different way. Using Foucault's productive hypothesis that says that "bodies are constructed, through discourses and practices, to fit properly within certain social structures," Thomson suggests that "techniques of power operate on the body transforming, dividing, and investing it with capacities and training it to perform certain functions."<sup>10</sup> This power changes in different periods depending on "...what kind of body the current society needs."<sup>11</sup> Foucault's concept of the regulation of bodies is largely connected to his theory of bio-power which notes the shifts in how power has operated on bodies in different time periods.<sup>12</sup> Thomson uses this theoretical approach to situate the medical campaign against abortion in the late nineteenth century not only within the regular physicians' promotion of professional concerns, but also within their desire to maintain existing gender relations. Women, he notes, have traditionally been assigned different roles than men, and, therefore, the anti-abortion campaign must be seen also in terms of the regulation of bodies in general, in this case, the female body. The regulation of the medical

---

<sup>9</sup> Maglia Larson, *The Rise of Professionalism: A Sociological Analysis*, Berkeley: University of California Press, 1977. See also A. Witz, *Professions and Patriarchy*, London: Routledge and Kegan Paul, 1992; Eliot Friedson, *Professional Dominance: The Social Structure of Medical Care*, New York: Atherton Press, 1970. Other interpretations of professionalization have understood the professions in terms of altruism or service – in the case of the medical profession, that doctors served a social function by helping others to maintain or regain their health. For instance, see J.L. Berlant, *Profession and Monopoly: A Study of Medicine in the United States and Great Britain*, Berkeley: University of California Press, 1975.

<sup>10</sup> Michael Thomson, "Woman, Medicine and Abortion in the Nineteenth Century". *Feminist Legal Studies*, 3, 2 (1995), p. 161. See also Michel Foucault, *The History of Sexuality, Volume One*, New York: Penguin Books, 1979, p. 25.

<sup>11</sup> Michel Foucault, "Body/Power" in Colin Gordon (ed.), *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*, New York: Pantheon Books, 1980, p. 58.

profession in the nineteenth century and its connection with abortion, according to Thomson, must therefore be viewed in terms of the larger shifts in how governments operate (bio-power) and in terms of how the body became regulated in this period. Within this framework the knowledge that the medical profession possessed (and constructed) about the body, specifically the female reproductive system, became a “disciplinary power.”<sup>13</sup> Also useful and equally applicable is S.E.D. Shortt’s definition of professionalization. He notes, “medical professionalization may be said simply to denote a process by which a heterogeneous collection of individuals is gradually recognized, both by themselves and other members of society, as constituting a relatively homogeneous and distinct occupational group.”<sup>14</sup> Therefore, the disciplinary power of medicine can be defined for our purposes as the knowledge of medical science subscribed to and applied by a heterogeneous group of individuals to establish a profession. Disciplinary power and professionalization as defined here are inextricably linked.

This concept of disciplinary power is instructive because the power and status of the medical profession, as this thesis shows, is always at the heart of doctors’ discussions about abortion. Also, as stated at the outset, it is important to understand the shifts that occur in the medical discourse over time (1850-1969). In order to do so, it is first necessary to understand how the medical profession’s views on abortion were shaped or constructed early on. For instance, in what context did doctors discuss the practice of abortion in the early period and what factors influenced that discussion? The medical discourse on abortion in this period needs to be examined in order to help us fully understand the influence, and indeed, power of medicine over our lives and more specifically, over changes to the legislation on abortion in 1969.

---

<sup>12</sup> See Michel Foucault, *The History of Sexuality*.

<sup>13</sup> *Ibid.*, p. 163.

<sup>14</sup> S.E.D. Shortt, “Physicians, Science, and Status: Issues in the Professionalization of Anglo-American Medicine in the Nineteenth Century”, *Medical History*, 27 (1983), p. 52.

In all these analyses of the medical profession, the importance of scientific knowledge and doctors' ability to use that knowledge (for the purposes of prescribing behaviour, for market control, as a disciplinary power) to facilitate the regulation of their profession is evident. As patients, we take that regulation for granted. We assume that doctors do indeed possess knowledge beyond our own when we seek medical treatment. However, the assumptions most of us make today when we seek help from medical practitioners and our trust in our doctors are not representative of the patient/physician relationship as it existed in the mid to late nineteenth and early twentieth century Canada (or elsewhere). Doctors did not experience an assumed authority over the body - they had not yet fully attained power as a profession - especially when it came to abortion practices. When this is considered, the 1908 editorial quoted at the beginning of this chapter does not seem so strange. At the beginning of what I will refer to as the early period (1850), regular doctors worked actively to compel their patients to follow their prescriptions, and discussed their practices in medical journals as they worked toward a common goal - full recognition of their status as professionals.

This chapter begins the analysis of how regular doctors worked to establish their disciplinary power within the profession in the early period (1850-1918) and how their discussions of abortion were connected to the establishment of their power. Three main themes emerge in their discussions of the practice. The first is regular doctors' representations of their role and the status of their profession when they discussed abortion. Influencing their views was the emergence of "science" in medicine and the fact that most regular doctors in this period were members of the growing "middle class". The distinct outlook of this group unquestionably affected both their discussions of their role as professionals and abortion. The second theme is the concept of abortion as an immoral practice and the role that medical ethics played in terms of

that immorality. It was a theme which was infused in the discussions of abortion not only by the regular medical profession but also by many members of the middle class as they discussed the “social evil” of abortion. Indeed, doctors would use their new scientific evidence of viability at the moment of conception to affirm the immorality of the procedure. The third and last theme centered on women’s proper role in society. Doctors’ views of the role of women influenced not only their discussions, but also how they spoke of women who sought to rid themselves of an unwanted pregnancy. The discourse and its focus on these three themes contributed to the strengthening of the disciplinary power of the regular medical profession in this period. That power, and indeed, the views established by doctors in mid to late nineteenth and early twentieth-century English Canada would become entrenched in later periods, allowing the profession to dominate abortion discussions.

### ***Regulating Doctors’ Status: Science and Abortion***

In the first half of the nineteenth century regular doctors, most typically characterized as those who were trained at the allopathic medical schools of the day or through apprenticeship, struggled with irregular doctors, those practitioners who had alternate views of medicine like homeopaths, eclectics and midwives, in competing for patients. Particularly for the regulars, competition was undesirable because it prevented them from achieving the social status they believed their profession deserved. “In their view, their calling was of ancient lineage, grounded in a liberal education, expertise, and dedication to the betterment of humankind. This high vocation entitled them to claim the social rewards per respectability and an income that assured ‘an honourable independence.’”<sup>15</sup> Hence, regular physicians sought to restrict entry to the practice of medicine.

A number of laws were enacted beginning in the late eighteenth century designed to

regulate the profession but these were largely unsuccessful and a great deal of medical pluralism still existed even by the mid-nineteenth century.<sup>16</sup> The lack of success of early licensing laws probably stems partly from the fact that most trained physicians were located in more urban areas like York (Toronto) which caused difficulty in itself because a disproportionate number of doctors per population existed.<sup>17</sup> This meant that licensed physicians were often competing with each other for patients. Given the competition among fellow regular practitioners, rivalry with unlicensed or irregular practitioners with little or no formal training was surely undesirable.<sup>18</sup> In more rural areas, there were not enough regular physicians. This left rural residents to fend for themselves, or else enlist the help of an irregular practitioner.<sup>19</sup> Another likely reason for the

---

<sup>15</sup> Gidney and Millar, "The Origins of Organized Medicine," p. 67.

<sup>16</sup> In 1788 'An Ordinance to prevent persons practicing Physic and Surgery within the Province of Quebec, and Midwifery in towns of Quebec and Montreal without a license' was enacted in an attempt to impede the number of irregular physicians or so-called quacks who were practicing medicine there, with a similar enactment in Upper Canada in 1795. Subsequent laws to the 1795 Act in Upper Canada moved to establish medical examining boards which clarified who could be licensed, as well as defined in whose interest (regular or irregular physicians) the boards were acting. In addition to examining those physicians who had studied medicine by means of the required apprenticeship, a common form of training for doctors, legislation in 1818 authorized the Medical Board of Upper Canada to grant a license without an examination to any physician authorized to practice medicine by any university in the Dominion, or by virtue of commissions in the military or naval services. Similar licensing laws also existed in New Brunswick (1816), and Nova Scotia (1828). Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*, Toronto: University of Toronto Press, 1991, p. 17; Bernard Blishen, *Doctors in Canada: The Changing World of Medical Practice*, Toronto: University of Toronto Press, 1991, p. 9. Early laws also attempted to confine the practice of medicine to those physicians educated in British schools rather than possible republican sympathizers who received their training in the United States. In his history of the Canadian Medical Association, H.E. MacDermot discusses the large influx of United Empire Loyalists to Upper Canada between 1775-1800 which would necessitate such regulating laws. *One Hundred Years of Medicine in Canada, 1867-1967*, Toronto: McClelland and Stewart, 1967, p. 20-21. For other discussions of licensing in this period see Rainer Baehre, "The Medical Profession in Upper Canada Reconsidered: Politics, Medical Reform, and Law in a Colonial Society," *Canadian Bulletin of Medical History*, 12 (1995): 101-124; Gidney and Millar, "The Origins of Organized Medicine," 64-95; Peter J. Mitham, "For 'the Honor and Dignity of the Profession': Organized Medicine in Colonial New Brunswick, 1793-1860," *Canadian Bulletin of Medical History*, 13 (1996): 83-108; Hilda Neatby, "The Medical Profession in the North-West Territories," in S.E.D. Shortt (ed.), *Medicine in Canadian Society: Historical Perspectives*, Montreal: McGill-Queen's University Press, 1981: 165-188; Barbara R. Tunis, "Medical Licensing in Lower Canada: The Dispute Over Canada's First Medical Degree," in Shortt (ed.), *Medicine in Canadian Society*: 137-164.

<sup>17</sup> Baehre, "The Medical Profession in Upper Canada Reconsidered," p. 103. He notes, "In 1836 Toronto boasted 15 doctors in a population of 6,000, or 1:400" which caused pressure on physicians to relocate to rural practices.

<sup>18</sup> Gidney and Millar note, for instance, that in the case of homeopaths, they were often both well-trained and well-educated and had converted to homeopathy from allopathy which made them an even greater threat to the regulars. "The Origins of Organized Medicine," p. 68.

<sup>19</sup> Mitchinson suggests that regulating physicians only made sense if there were enough practitioners to service the needs of British North Americans, but that early in the nineteenth century there were not. In his *Statistical Account*

lack of success of the early legislation was that the remedies offered by the irregulars were often less frightening than the heroic approaches of the regulars. But the main difficulty encountered by the regulars as they sought to regulate the profession was the lack of organization of the regulars early in the century, which prevented them from creating an effective lobby for stricter licensing laws.<sup>20</sup> As R.D. Gidney and W.P.J. Millar note, the main reason initially for the push by regulars to control the profession of medicine derived from a few prominent regulars who claimed to speak for the rest of the profession. By 1869 regular doctors in Ontario had managed to force the creation of the College of Physicians and Surgeons of Ontario, the body which governed professional licensing as well as the curriculum for the various medical schools.<sup>21</sup> Despite such milestones in the regulation of the profession, regular doctors continued to feel the pressures of competition with the irregulars into the final decades of the nineteenth century. It became clear to regular practitioners that more was required than simply legislation dictating who could be licensed. What was needed was a shift in public opinion about the value of regular medical advice. Many historians have argued that the emerging discourse of biological science facilitated that shift.<sup>22</sup>

Today, science is a central concept in physicians' knowledge and training - what some

---

of *Upper Canada* in 1822, Robert Gourlay after noting the lack of practitioners in, for instance, the London and Niagara districts, criticized, "How absurd to think of preventing remotely scattered people from choosing whom they liked to draw their teeth, bleed or blister them - or that a woman should not have the assistance of a handy sagacious neighbour without fear of a fine." See Gourlay as quoted in Mitchinson, *The Nature of Their Bodies*, p. 17-18.

<sup>20</sup> Gidney and Millar, "The Origins of Organized Medicine," p. 66.

<sup>21</sup> For a more detailed description of this, see Gidney and Millar, "The Origins of Organized Medicine."

<sup>22</sup> For example, see Colin D. Howell, "Elite Doctors and the Development of Scientific Medicine: The Halifax Medical Establishment and 19<sup>th</sup> Century Medical Professionalism," in Roland (ed.), *Health, Disease and Medicine: Essays in Canadian History*, The Hannah Institute for the History of Medicine, 1984:105-122; Shortt, "Physicians, Science, and Status"; Vogel and Rosenberg (eds.), *The Therapeutic Revolution*; John Harley Warner, *The Therapeutic Perspective: Medical Practice, Knowledge, and Identity in America, 1820-1885*, Cambridge: Harvard University Press, 1986. In contrast, Paul Starr argues that the professionalization of medicine "can be more adequately explained as a mirror of the development of capitalism." *The Social Transformation of American Medicine*, New York: Basic Books, Inc., 1982, p. 16.

might call a “core competency.”<sup>23</sup> But this was not necessarily the case even in late-nineteenth century Canada. While it is true that there were some significant scientific developments earlier in the century which had practical implications for medicine it appears that doctors were more successful in incorporating the rhetoric of science into the discourse of regular medicine which helped regulars to promote their own status and eliminate competition with the irregulars. To fully understand how this regulation was possible, Wendy Mitchinson suggests that it is first necessary to understand the Victorian belief in progress and how science bolstered that belief.<sup>24</sup>

The scientific developments of the century, among the most important of which was Darwin’s theory of natural selection which he first introduced in *The Origin of the Species by Means of Natural Selection* (1859) led to the rethinking of Canadian society because it “...challenged fundamental assumptions in Victorian culture” most notably, the role of God in the design of nature. The doubt that Darwin’s theory caused about the truth of religion led many Victorian Canadians to turn toward the certainty of science because of its supposed infallibility.<sup>25</sup> For the literate Victorian public, Darwin’s theory, as well as new findings in geology which demonstrated that the earth had not always been what they observed around them, “...intensified [their]...interest in natural history beyond the confines of scientific circles.”<sup>26</sup> These Canadians, then, sought a means to understand their place in the world and they believed that science had the answers. From phrenology to geology, the discourse of science was more and more valued by

---

<sup>23</sup> The term “core competency” is often used to describe skills in the corporate world and has been defined as “fundamental knowledge, ability, or expertise in a specific subject area or skill set...The *core* part of the term indicates that the individual has a strong basis from which to gain the additional *competence* to do a specific job or that a company has a strong basis from which to develop additional products.” In the case of regular medicine it is their ability to use medical science as a means to treat their patients and to use their knowledge to gain additional skills or knowledge about medicine in order to treat their patients. See [http://whatis.techtarget.com/definition/0%2C%2Csid9\\_gci214621%2C00.html](http://whatis.techtarget.com/definition/0%2C%2Csid9_gci214621%2C00.html)

<sup>24</sup> Mitchinson, *The Nature of Their Bodies*, p. 41-42.

<sup>25</sup> Darwin’s theory, in essence, posited that evolution occurs through the process of natural selection where new species arise because random variations in the environment make survival for some individuals possible rather than others. Suzanne Zeller, *Land of Promise, Promised Land: The Culture of Victorian Science in Canada*, Canadian Historical Association, Historical Booklet No. 56, 1996, p. 15.

Canadians. Indeed, it appears that the nineteenth century cultural context which believed in scientific innovation coincided with the professional aspirations of regular medicine.<sup>27</sup> As S.E.D. Shortt notes, science helped the regular practitioner persuade his middle-class patients to heed his advice despite “any demonstrable improvement in therapeutic efficacy.”<sup>28</sup> The increased influence of regular doctors within the community is evidence that doctors were indeed successful in persuading patients to listen to their prescriptions.<sup>29</sup> In essence, regular physicians ensured that science became part of middle-class discourse by promoting its advantages to their patients. This promotion coupled with a middle-class interest in natural science “was essential to the initial phase of professionalization.”<sup>30</sup>

Although it appears that by the mid-nineteenth century both regulars and irregulars shared similar skill levels when it came to surgery and obstetrics and that they even used similar widely accepted therapies when available like smallpox vaccine,<sup>31</sup> regular physicians’ promotion of scientific medicine allowed them to begin to transform the profession of medicine. Of course, the use of scientific language by the regulars did not mean that they no longer encountered challenges to their attempts to establish themselves as a profession. It seems that a large part of the problem with regular medicine was that the methods used by those doctors did not necessarily work so regular doctors had to work to convince their patients to come to them for medical advice.<sup>32</sup>

---

<sup>26</sup> Carl Berger, *Science, God and Nature in Victorian Canada*, Toronto: University of Toronto Press, 1983, p. xiii.

<sup>27</sup> Shortt, “Physicians, Science, and Status,” p. 67.

<sup>28</sup> *Ibid.*, p. 62.

<sup>29</sup> *Ibid.*

<sup>30</sup> *Ibid.*, p. 63. Charles Rosenberg makes similar arguments, although he focuses more on the issue of science as rhetoric in this period in his “The Therapeutic Revolution.”

<sup>31</sup> Gidney and Millar, “The Origins of Organized Medicine”, p. 68.

<sup>32</sup> Indeed, there was a history of patients choosing practitioners, not for their “expertise” but because of personal preferences. Geoffrey Bilson has noted this tendency in his study of the 1830s cholera epidemic in Canada. He notes that “many people chose irregular practitioners because they preferred them and because there was no social or scientific reason for choosing regulars.” This tendency would continue well into the later nineteenth century even when scientific advances, at least rhetorically, put regulars in a position to better treat their patients. See “Canadian

Helpful in convincing patients of regulars' aptitude to treat their ailments more effectively were the new technologies available like the microscope, widely used by the 1830s, and anesthetics like ether and then chloroform used to relieve pain during surgical procedures.<sup>33</sup> The emergence of germ theory and doctors' knowledge of antiseptics through the work of Lister in the 1860s increasingly influenced regular doctors' approaches to the practice of medicine by the end of the nineteenth century allowing them to provide better care for their patients which helped to circumvent the public's uncertainty of their approaches.<sup>34</sup> One of the key aspects of the emerging discourse of science was that it allowed "proof" of illness. Germ theory especially changed regular medical practice and forced a rethinking of their approach to treatment encouraging a less "heroic" approach because it provided regular practitioners with scientific proof for the treatments they administered.<sup>35</sup> Although not all doctors agreed with scientific approaches, by the 1880s few regular practitioners challenged this advance.<sup>36</sup>

How did the use of scientific rhetoric in regular medicine affect doctors' discussions of abortion and birth control? Science was particularly important because doctors had determined that life began at conception with the discovery of the human ovum in 1832.<sup>37</sup> Given this scientific "fact," doctors could decide when, if ever, it was appropriate to terminate a pregnancy. Dr. George Napheys' 1869 advice book for women, *The Physical Life of Woman - Advice to the Maiden, Wife and Mother*, for instance, had noted that, "from the moment of conception a new

---

Doctors and the Cholera," in Shortt (ed.), *Medicine in Canadian Society*, p. 122.

<sup>33</sup> Ether was introduced in 1846 quickly followed by chloroform which became the anesthetic of choice until the 1870s when ether made a comeback. Mitchinson, *The Nature of Their Bodies*, p. 41.

<sup>34</sup> Howell, "Elite Doctors and the Development of Scientific Medicine", p. 108-110; Mitchinson, *The Nature of Their Bodies*, p. 41.

<sup>35</sup> While regular doctors' promotion of their use of scientific techniques was more theoretical than practical, the intent was to provide the public with confidence in their services, although Colin Howell has questioned whether the promotion of scientific approaches together with condemnation of irregular approaches were really convincing to the general public at mid-century given that regular physicians still relied heavily on heroic practices. See "Elite Doctors and the Development of Scientific Medicine," p. 109

<sup>36</sup> Mitchinson, *The Nature of Their Bodies* p. 41-42.

<sup>37</sup> Richard A. Leonardo, *History of Gynecology*, New York: Froben Press, 1944, p. 255 as quoted in Alison Prentice,

life commences, a new individual exists...”<sup>38</sup> The idea that life begins at conception was demonstrably new in this period given that the earliest common law writers had held that abortion was an ecclesiastical offence rather than a crime punishable by law. The practice itself was criminalized in 1803 with Britain’s Lord Ellenborough’s Act.<sup>39</sup> However, once regular medicine incorporated science into its own discourse, so too did its position on abortion change. Abortion was no longer viewed as an ecclesiastical offence but as murder.<sup>40</sup>

### ***Regular Medicine, Morality and Abortion***

As Dr. R.V. Pierce noted in his 1888 medical text, *The Peoples Common Sense Medical Adviser in Plain English or Medicine Simplified*, “it should be remembered that *life begins with*

---

et al., *Canadian Women: A History*, Toronto: Harcourt Brace Jovanovich, 1988, p. 92.

<sup>38</sup> George Napheys, *The Physical Life of Woman - Advice to the Maiden, Wife and Mother*, Toronto: The Hunter-Rose Company Limited, 1869, p.98.

<sup>39</sup> Lord Ellenborough’s Act was the first legislation in Britain to make abortion a criminal act. It stated that abortion at any stage of a woman’s pregnancy was a statutory felony with a penalty of death for those who procured an abortion after quickening and a lesser sentence for those performed prior to quickening. Constance Backhouse, “Involuntary Motherhood: Abortion, Birth Control and the Law in Nineteenth Century Canada,” *Windsor Yearbook of Access to Justice*, (1983), p. 64. Since the practice was criminalized before proof of the human ovum existed the change in the legal status of abortion was more likely related to changing religious doctrine. However, it appears that the medical profession used this change to support their view that abortion was morally wrong initially and scientifically wrong in later decades. Backhouse notes that early common law held that abortion was not a crime if performed prior to quickening, where quickening was, according to Backhouse and others, different than viability. The quickening distinction can be traced back to ancient beliefs about when life began, and there was certainly debate regarding when that occurred. Aristotle, for example, suggested that life began at 40 days after conception for males and 90 days for females. Hippocrates suggested that it was 42 days both for males and females. A number of different writers proposed a number of different dates. The Christian Church, most notably St. Augustine, made the distinction between “embryo inanimatus” and “embryo animatus” to denote the fetus before it was infused with a soul and after and imposed a fine if an abortion was performed before life with a soul (inanimatus) whereas abortions performed after the fetus was infused with a soul (animatus) was punishable by death. See “Involuntary Motherhood,” p. 65-66. See also Glanville Williams, *The Sanctity of Life and the Criminal Law*, New York: Alfred A. Knopf, 1957, p. 148-150; Shelley Gavigan, “On ‘Bringing on the Menses’: The Criminal Liability of Women and the Therapeutic Exception in Canadian Abortion Law,” *Canadian Journal of Women and the Law*, 1 (1986), p. 299.

<sup>40</sup> A number of publications in this period promoted the view that abortion was murder. For instance, one article entitled “Foeticide” in *The Canada Lancet* in 1877 lamented the fact that women did not seem to want to believe that termination of an unwanted pregnancy was abortion. “What practitioner, who has not found his advice ‘not to kill’ spurned...” vol. 10 (November), p. 93. Another article in *The Canada Lancet* in 1889 referred to abortion as “this growing murder of the innocents...” “Abortionists,” 21 (March, 1889), p 217. See also Rev. James Simpson’s article in *Saturday Night*, 14 (March 1, 1901), p. 4; Alice Stockham, *Tokology: A Book of Every Woman*, Chicago: Stockham Publishing, 1902, p. 246; Penny “‘Getting Rid of My Trouble’: A Social History of Abortion in Ontario, 1880-1929,” unpublished MA Thesis, Laurentian University, 1995, chapter 2; Angus McLaren and Arlene Tigar McLaren, *The Bedroom and the State: The Changing Practices of Contraception and Abortion in Canada, 1880-1997*, Toronto: Oxford University Press, 1997, p. 33-36; Kellough, *Aborting Law*, p. 55.

conception, and, at whatever period of pregnancy abortion is committed, *life is destroyed*.”<sup>41</sup>

Other doctors noted that abortion was the “murder of the innocents”<sup>42</sup> and that abortion practitioners were “traffickers in human life [who] live and flourish on the blood they spill.”<sup>43</sup>

Since, as has been noted, science provided regular physicians with a new way of viewing the practice of abortion and abortion, in turn, provided the regulars with a forceful means to differentiate themselves from the irregulars they claimed that only irregulars performed abortions. The ability to differentiate themselves in such a way was crucial to both the maintenance of their economic<sup>44</sup> and social status.

The use of abortion as a means to regulate the profession has been discussed by many historians. Constance Backhouse, for instance, argues that anti-abortion legislation passed in Canada during the nineteenth century was not enacted in response to public opinion on the issue of fertility control, but was rather the result of regular physicians’ desire to assert monopoly control over their profession. She suggests that this desire materialized because regulars were able to use the illegality of abortion as a way to differentiate themselves from irregulars. Not only could regulars promote themselves as being more capable practitioners because of their knowledge of science, but also as more moral than irregulars who practiced abortion. Similarly, in her work on the history of abortion in the United States, Kristen Luker suggests that doctors in their attempts to regulate their profession were “probably the single most important influence in

---

<sup>41</sup> R.V. Pierce, *The Peoples Common Sense Medical Adviser in Plain English or Medicine Simplified*, Buffalo, N.Y.: World’s Dispensary Printing Office and Bindery, 1888, p. 750.

<sup>42</sup> Editorial, “Abortionists”, *The Canada Lancet*, 21 (1889), p. 217.

<sup>43</sup> Editorial, “Criminal Abortion”, *The Canada Lancet*, 4 (1871), p. 185.

<sup>44</sup> Mitham, “For ‘the Honor and Dignity of the Profession’”; Mitchinson, *The Nature of Their Bodies*, p. 139; McCulloch, “‘Dr. Tumblety, the Indian Herb Doctor’: Politics, Professionalism, and Abortion in Mid-Nineteenth-Century Montreal,” *Canadian Bulletin of Medical History*, 10 (1993): 49-66; Baehre, *The Medical Profession in Upper Canada Reconsidered: Politics, Medical Reform, and Law in Colonial Society*,” *Canadian Bulletin of Medical History*, 12 (1995): 101-124; Gidney and Millar, “The Origins of Organized Medicine.”

bringing about anti-abortion laws.”<sup>45</sup> Indeed, it would appear that regular physicians actively constructed abortion as a medical issue in a period when the practice had long been viewed as being within the woman’s sphere.

Michael Thomson suggests that, in fact, abortion was constructed by the regulars both as a way to regulate their profession as well as to maintain existing gender relations. He argues that legislation enacted in Britain in the nineteenth century was in response to regulars’ calls for legislative sanctions against irregular practitioners. Therefore, abortion practices facilitated regulars’ monopoly of the practice of medicine by making illegal the practice of abortion when the perception was that it was irregulars who were performing the procedure.<sup>46</sup> At the same time, doctors’ belief in the concept of “True Womanhood” which opposed women’s role beyond the confines of the home, “her *natural sphere*,” framed their medical discussions to support this view. Abortion fits well into this framework as we will see below. Although Thomson’s work examines Britain and the United States, his findings also hold true for Canada, especially given that Canadian abortion legislation followed the lead of Britain right into the twentieth century and the discussions of abortion definitely provide evidence of doctors’ views of women.<sup>47</sup> While Thomson points out the connection between professional status and gender regulation in terms of doctors’ discussions about abortion, he does not see science or morality as central to the construction of abortion as the practice of irregulars. In Canada, the connections between

---

<sup>45</sup> Kristen Luker, *Abortion and the Politics of Motherhood*, Berkeley: University of California Press, 1984, p 16. See also John Keown, *Abortion, Doctors and the Law*, Cambridge: Cambridge University Press, 1988; John Mohr, *Abortion in America: The Origins and Evolution of National Policy*, New York: Oxford University Press, 1978; Gail Kellough, *Aborting Law*; Angus McLaren, “Illegal Operations: Women, Doctors and Abortion, 1886-1939,” *Journal of Social History*, 26, 4 (1993): 797-816; McLaren and McLaren, *The Bedroom and the State*.

<sup>46</sup> Thomson, “Woman, Medicine and Law”, p. 159-160; Kellough, *Aborting Law*, p. 54; Constance Backhouse, “Involuntary Motherhood”, p. 73; McLaren and McLaren, *The Bedroom and the State*, p. 37; Penny, ““Getting Rid of My Trouble””, p. 52. See also Kristin Luker, *Abortion and the Politics of Motherhood*, p. 16; James Mohr, *Abortion in America*, p. 43; John Keown, *Abortion, Doctors and the Law*, p. 159.

<sup>47</sup> Thomson, “Woman, Medicine and Law”. See also Joseph Kett, “American and Canadian Medical Institutions 1800-1870” in Shortt (ed.), *Medicine in Canadian Society*; Kellough, *Aborting Law*; McLaren and McLaren, *The Bedroom and the State*.

professionalization and science and gender regulation and morality, are all present in its abortion history. Particularly in the case of the medical discourse, these themes are central in the early period to doctors' discussions and remain so right up until the Criminal Code was revised with respect to abortion in 1969, shifting to suit the social and political context of the period.

Prior to 1803, there were no statutes prohibiting abortion in Britain, Canada, or the United States. After the passing of Lord Ellenborough's Act (1803) in Britain, similar acts were passed in Canada beginning in 1810.<sup>48</sup> What is interesting about the initial abortion acts is that they all focused on abortion as a crime after quickening, the first time the mother feels the baby in the womb (usually around 4 months gestation) with lesser penalties if performed earlier. The quickening distinction was an important one, especially given that abortions performed prior to that event had not been considered a crime in the past. New legislation, however, sought to eliminate long-held beliefs that abortion prior to quickening was an acceptable practice which was neither a crime, nor a sin.<sup>49</sup> Indeed, doctors were still working to counter this commonly held belief late in the nineteenth century. As Dr. Pierce noted in his 1888 medical manual, "an opinion is very prevalent that if abortion is produced before the movements of the foetus are felt, there is no crime committed."<sup>50</sup> Clearly, women in desperate circumstances continued to hold on to traditional beliefs about pregnancy, rather than buy-in to the new claims of medical science and the morality claims of the regulars.<sup>51</sup>

---

<sup>48</sup> The first act in Canada dealing with abortion was passed in New Brunswick in 1810, and was almost a duplicate of the English Act (1803). In addition, the New Brunswick Act provided punishment for anyone who supplied medicines, drugs, or instruments to women to be used with the intent to procure their miscarriage. Prince Edward Island passed a similar statute in 1836, but none of the other Canadian jurisdictions passed statutes in this period.

<sup>49</sup> Linda Gordon, *Woman's Body, Woman's Right: Birth Control in America*: New York: Penguin Books, 1990, p. 52.

<sup>50</sup> R.V. Pierce, *The Peoples Common Sense Medical Adviser in Plain English; or, Medicine Simplified*, Buffalo: World's Dispensary Printing Office and Bindery, 1888, p. 750.

<sup>51</sup> My own study of criminal indictment case files from late nineteenth and early twentieth century Ontario indicates that women continued to hold onto traditional beliefs about pregnancy and used those beliefs in their own defense when charged with their own abortions. See Penny, "Getting Rid of My Trouble."

Upper Canada was the first area of the country to abolish the quickening distinction to make it a crime to procure an abortion at any stage of pregnancy. The 1841 “Offences Against the Person Act” charged that it was a crime to perform an abortion at any point in a woman’s pregnancy, and was in fact the first abortion law to be enacted in the province. There have been many arguments about why legislators changed the law in Upper Canada. Backhouse suggests that one explanation might be “...that it illustrated a concern over abortions done in the early stages of pregnancy.”<sup>52</sup> As has been noted, the regular medical and scientific community had begun to emphasize that life begins at conception. In essence, doctors began to see quickening more as a stage of foetal development, rather than as the point when the fetus became a person, or, in terms of theological definitions, when it gained a soul.<sup>53</sup> One of the first texts on medical jurisprudence notes this assumption:

Quickening...instead of marking the period at which the future individual becomes imbued with humanity or vitality, or elevated to distinct personal identity is but the sign of a certain advance in the development and aggrandizement of the growing body to a certain pitch, and of its now possessing a *greater* degree of force; and hence it has been contended that there is no ground for the great distinction in criminal punishment, whether or not the child has quickened.<sup>54</sup>

This assumption which led to the distinction of quickening ceasing to have any real meaning is significant because it indicates a greater reliance on the scientific idea that life begins at conception, making when quickening occurred irrelevant. It is also quite possible, though, that

---

<sup>52</sup> Backhouse, “Involuntary Motherhood,” p 69.

<sup>53</sup> The early Christian Church stressed the sanctity of life from its very beginning, and has held this view to the present. See Shelley Gavigan, “The Criminal Sanction as it Relates to Human Reproduction: The Genesis of the Statutory Prohibition of Abortion,” *Journal of Legal History*, 5 (1984), p. 20; Williams, *The Sanctity of Life and the Criminal Law*; Wendell W. Watters, “Breeding and Salvation: Christianity and Human Reproduction,” and “The Human Production Line: Anti-Abortion Laws in the Nineteenth Century”, in his *Compulsory Parenthood: The Truth About Abortion*, Toronto: McClelland and Stewart, 1976.

<sup>54</sup> Joseph Chitty, *A Practical Treatise on Medical Jurisprudence: Part I*, London: Roworth and Sons, 1834), p. 402 as quoted in Shelley Gavigan, *The Criminal Sanction as it Relates to Human Reproduction: The Genesis of Statutory Prohibition of Abortion*,” *Journal of Legal History*, 5 (1984), p. 34.

legislators were simply attempting to eliminate the obvious evidentiary difficulties inherent in establishing when a woman had quickened.<sup>55</sup> Indeed, the removal of the problem associated with gathering evidence with respect to the crime of abortion seems to be the impetus in Upper Canada's move to change the legislation. Nevertheless, there seems to have been an increasing connection between the legislation regulating abortion and medical science which foreshadowed a connection in contemporary legislation.

In 1849, New Brunswick specifically made it a crime for a woman to procure her own abortion. This shifted the legislation from an exclusive emphasis on abortionists, as it had been in the original act of 1810. Nova Scotia and England followed suit shortly after in 1851 and 1861 respectively. This move shows that legislators began to view women as being directly involved in the abortion process, and were thought, therefore, to be equally responsible. New Brunswick (the province to enact the most legislation dealing with abortion in this period) expanded its legislation in 1864 to prohibit anyone from supplying anything, (for example, a drug or instrument to be used by a woman) for the purpose of procuring an abortion, whether they were directly involved as the abortionist or not. The statute further stated that offenders could be prosecuted whether the woman was pregnant or not.<sup>56</sup>

The first federal consolidation of criminal law in 1869 borrowed substantially from the

---

<sup>55</sup> After 1803 the use of a Jury of Matrons was used in order to determine whether quickening had occurred in a woman before an abortion had been performed. The Jury was usually "...composed of twelve married women then present in court...[who] examined the woman to see if she was 'quick with child.' Medical aid could be sought to ensure a true verdict, but it appears that women were reluctant to sit..." The problem, of course, was whether or not the Jury had the ability to determine positively whether or not quickening had occurred, and whether or not they were willing to "make such life-determining decisions on the basis of what must have been such a subjective finding." Obviously, this practice could only be instituted with defendants who had survived the abortion attempt. Medical professionals could be called in for a final decision, although as Shelley Gavigan notes, by the 1830s the medical profession was offended by the involvement of Juries of Matrons at all. Not only that, it is clear that Juries of Matrons were reluctant to participate in the process, especially since medical knowledge had not yet determined an accurate means of testing for pregnancy in this period. In all likelihood the main reason for the quickening distinction being done away with was that it was difficult to prove medically whether or not the woman had indeed felt the fetus move inside her. Gavigan, "The Criminal Sanction as it Relates to Human Reproduction," p. 35 and Backhouse, "Involuntary Motherhood," p. 67.

New Brunswick Act of 1864 making only changes to the penalties for specific offences. The legislation was extended to Manitoba in 1871, British Columbia in 1874, and finally Prince Edward Island in 1877. The Criminal Code, enacted in 1892, included a revision of the penalty for women who procured their own abortions, reducing it from a maximum of life imprisonment to a maximum of seven years. This was probably done to surmount the reluctance of prosecutors to try women suspected of having an abortion. Throughout the period, however, the focus of prosecution was mainly on the abortionist, rather than women.<sup>57</sup>

At the beginning of the century, a woman's involvement in procuring her own, or having an abortionist procure her abortion was not acknowledged. The immorality was that of the abortionist, not the woman. However, the evolution of abortion law over the course of the nineteenth century eventually led to abortion being defined as a crime punishable by law for anyone (including the mother whether she was actually pregnant or not) who attempted to procure, or assisted in procuring or supplied the means of abortion. Clearly the legislation began to challenge women's ability to determine their own reproduction as they had in the past. Gail Kellough suggests that early abortion legislation in Canada was the beginning of a move toward male domination by both the medical and legal professions over women because the legislation removed the (legal) power of women to control their own fertility. She notes, "while the beginning of the modern period has been hailed as a major advance for man in his quest to control the vagaries of nature [through scientific pursuits], the same period brought women's reproductive capacity under the scrutiny of professionals. It began an intermittent process that gradually transformed the accumulation of medical knowledge from a reproductive task into a

---

<sup>56</sup> Backhouse, "Involuntary Motherhood," p. 64-73.

<sup>57</sup> *Ibid.*

process involving male ‘scientists.’”<sup>58</sup>

Whether doctors constructed abortion as an issue with which to regulate their profession, or whether they simply used a contentious issue to support their professional aspirations, there is no doubt that doctors writing about abortion in the medical journals and textbooks of this period were keen to contrast themselves with the sort of practitioner who would perform abortion. Despite their success at incorporating the rhetoric of science into their medical discourse, regular physicians remained unsure of their professional status and continued to be eager to cement their status as health care providers. Abortion allowed them to condemn irregular practitioners by claiming that they were not only “unscientific” but also immoral, and they described such abortion practitioners as “degraded specimens of humanity”<sup>59</sup> and “criminals”<sup>60</sup> and “the severest punishment”<sup>61</sup> was called for those who performed abortion.

Angus and Arlene Tigar McLaren point to Canadian regular doctors’ desire to control their profession and how the illegality of the practice of abortion supported the idea that it was both medically and morally wrong. In terms of regular physicians’ goal of achieving a monopoly over medicine, regulars distinguished themselves from those practitioners, professional or non-professional, who performed abortions. Abortionists considered to be professionals included anyone from irregular practitioners such as homeopaths and midwives to those who simply chose to perform illegal operations. Non-professional abortionists often included family or friends of pregnant women - a mother or sister who practiced medicine in the home and “...who used her herb garden to great effect,”<sup>62</sup> or a male partner or spouse. Women

---

<sup>58</sup> Kellough, *Aborting Law*, p. 50-51. James Mohr has suggested that the development of anti-abortion legislation arose largely out of medical associations’ actions to ensure monopoly control over medical practices. See, *Aborting America: The Origins and Evolution of National Policy*, New York: Oxford University Press, 1978.

<sup>59</sup> Editorial, “Criminal Abortion”, *The Canada Lancet*, 4, 4 (December, 1871), p. 186.

<sup>60</sup> Editorial, “Abortionists”, *The Canada Lancet*, 21 (1889), p. 217.

<sup>61</sup> Editorial, “Criminal Abortion”, p. 186.

<sup>62</sup> Charles Godfrey, *Medicine for Ontario: A History*, Belleville: Mika Publishing Co., 1979, p. 83. My MA

who actually performed an abortion on themselves were also considered to be non-professionals. Doctors spoke out against these abortion practitioners, promoting the idea that the procedure itself was immoral and not one practiced by the more moral regulars. The basis for these morality claims against abortion practices came partly from the new assertion by the medical profession that the fetus had the status of personhood - a fact which could be proven scientifically.<sup>63</sup> Doctors' new reliance on this scientific fact was important in their denunciation of the procedure, criminal or otherwise. "Scientifically, regulars had realized for some time that conception inaugurated a more or less continuous process of development which would produce a new human being if uninterrupted...From this scientific reasoning stemmed the regulars' moral opposition to abortion at any stage in gestation."<sup>64</sup> This view, as we have seen above, seems to have been embraced by legal authorities as they increasingly placed more restrictions on the practice. Perhaps this is not surprising given that many doctors and legislators would have shared similar class and cultural values.

Doctors' desire to regulate the morality of both their profession and their patients reflected their class status. They believed that, due to their status in society, they had the ability to dictate moral values to their patients. As with the rhetoric of science, such claims were more representative of the theory rather than the practice since we know that many regulars, despite their claims to status, were really unsure of themselves. Their profession was overcrowded, which created financial pressures for doctors and threatened their middle-class position in society.<sup>65</sup> Nonetheless, their ability to instruct their patients about how to conduct themselves in

---

research based on criminal indictment charges for abortion in Ontario between 1880-1929 is where this distinction between professional and non-professional abortionists comes from. See Penny, "Getting Rid of My Trouble," chapter 3.

<sup>63</sup> Mitchinson, *The Nature of Their Bodies*, p. 141.

<sup>64</sup> Mohr, *Abortion in America*, p. 35-36 as quoted in Jonathan Imber, *Abortion and the Private Practice of Medicine*, New Haven: Yale University Press, 1986, p. 3.

<sup>65</sup> The American Medical Association had estimated that a doctor needed 2000 patients to earn an adequate living

society was part of the discourse they used to promote their own status. For instance, Dr. Alfred A. Andrews of Windsor, Ontario made the analogy between physicians and ministers in terms of the role that doctors played in helping their patients uphold their moral status. He noted the difference between Protestant and Catholic patients.

I had for many years noted and wondered at the fact, that of the married women who sought my co-operation, nearly all were Protestants. Being myself a Protestant of the broadest Orange stripe, and not ready to acknowledge any marked moral inferiority in my co-religionists, I was for a long season puzzled, but I think the solution is this. The Pulpit is debarred, but the Roman Catholic Priesthood, have in their confessional an opportunity of instructing and warning their flock. Protestant women do not go there, but we, and we only, have the private and confidential ear of the whole sex, and it is, I conceive our duty, to lose no opportunity of diffusing the information we possess in this regard. Let us purify the moral atmosphere.<sup>66</sup>

There is a tone in Dr. Andrews' statement of moral superiority of doctors over their patients and the need for doctors to guide them in their daily lives. In the case of abortion, doctors believed that it was their duty to ensure that their patients did not stray, and in so doing, were able to separate themselves from irregular practitioners who were willing or perceived to be willing to perform the procedure. Dr. Andrews' statement also points to another distinction between different groups of doctors, however. In pointing out that he perceived there to be a difference between his Catholic and Protestant patients he implied that, for the most part, Protestant women were seeking to terminate their pregnancies rather than Catholic women. Catholic doctors presumably did not need to counsel their patients against the evils of abortion because they received such advice from their Priests whereas Protestant women needed their doctors to guide them. While there is evidence to suggest that some Catholic women, sought to terminate

---

yet in Canada in 1891, the ratio of doctors to the population was 1:1079. Penny, "Getting Rid of My Trouble" p. 54. See also Mitchinson, *The Nature of Their Bodies*, p. 29.

<sup>66</sup> Alfred A. Andrews, "On Abortion," *The Canada Lancet*, 7, 9 (May, 1875), p. 291. A similar statement was made by Dr. J.C. in Andrew Nebinger, "Criminal Abortion; Its Extent and Prevention", in Charles Rosenberg and Carroll

unwanted pregnancies in this period, this statement suggests that there was a difference between doctors of different religious backgrounds.<sup>67</sup> Regardless of whether or not regular doctors were Protestant or Catholic, they shared the desire to promote the status of their profession.

While it seems clear that their main goal was to separate themselves from irregular practitioners, there is ample evidence to suggest they knew that sometimes regular practitioners also performed the procedure.<sup>68</sup> In fact, some of the rhetoric surrounding abortion published in the period also condemned regular physicians for such practices. These doctors were accused of succumbing to the temptation to earn extra money in large cities where thriving medical practices might not materialize immediately upon graduation from medical school. Competition was an issue faced by doctors throughout the nineteenth century and as Canada moved from being primarily rural to increasingly urban, doctors continued to feel the pinch because there were not enough patients to go around. In an effort to reinforce the claim that extra money earned by performing abortions would hurt a young doctor's career rather than help it, an editorial in a 1908-09 issue of *The Canada Lancet* cautioned that practising abortion did not pay. "...No fee, however large, nor for any influence, however great it may appear, yield to do a criminal abortion."<sup>69</sup> Similarly, an anonymous article in the *Dominion Medical Monthly*, in 1909 stressed the point that money or lack of it caused some doctors to turn to the criminal practice of

---

Smith-Rosenberg (eds.), *Abortion in Nineteenth Century America*, New York: Arno Press, 1974, p. 9.

<sup>67</sup> Joseph G. Ryan has noted, for instance, the difference in practice of Catholic physicians when it came to the practices of craniotomy and embryotomy in obstetrics from their Protestant colleagues. Craniotomy is the perforation and destruction of the fetal skull with cutting instruments and embryotomy is the removal of the fetus in pieces. See Joseph G. Ryan, "The Chapel and the Operating Room: The Struggle of Roman Catholic Clergy, Physicians, and Believers with the Dilemmas of Obstetric Surgery, 1800-1900," *Bulletin of the History of Medicine*, 76 (2002): 461-494. See also Wendy Mitchinson, *Giving Birth in Canada, 1900-1950*, Toronto: University of Toronto Press, 2002, p. 236.

<sup>68</sup> For instance, in a study of all abortion-related indictments found in Criminal Case files in Ontario between 1880-1929 (108 charges in total), at least seven of the professional practitioners charged with abortion were regular physicians, accounting for 28% of the total number of charges. 30 of the 108 indictments for abortion in Ontario between 1880-1929 were against so-called professional abortionists like naturopaths and midwives (those considered to be "irregular"). Penny, "Getting Rid of My Trouble," p. 54.

<sup>69</sup> Editorial, "Does It Pay? No!" *The Canada Lancet*, 42 (1908-09), p. 649.

abortion:

All doctors in a great city have probably been approached some time or other in this respect. Where most sternly and curtly refuse, one yields. Why? He needs the money. General practice in a great city is uncertain, unstable, precarious. In the country a steady income is assured. The great city is crowded. Its allurements are many. Work is comparatively easy. Life looks rosy. Thither doctors flock. There are too many of us. There is not enough sickness to go round. The result is a fall now and again by the wayside...our university is turning out too many doctors. There are not sick people enough for them to practice upon. This makes of an honest man, a criminal.<sup>70</sup>

The criminal practice of abortion was also believed to be related to the lax admission standards of medical schools. Young (regular) doctors, it was suggested, should “attack the wholesale admission into medicine and put up a determined fight for higher qualifications, longer periods of study, and curtailment of the inrush. So will criminal abortion cease.”<sup>71</sup> While these authors suggest that some regular physicians could fall into the trap of performing abortions for money, the issue of the connection between women patients and doctors' fees is also apparent. Surely doctors were able to make the connection between family size and longstanding medical fees. If women ceased to have large families there would be increasingly fewer patients for doctors to treat, not to mention the fact that doctors would have to compete with the irregulars for patients if their profession was not regulated. This was certainly an issue given the declining birth rate in this period.<sup>72</sup>

Regulation of their profession and the economic threat to their future medical fees, and the falling birth rate led doctors in the medical press to condemn the well-known practice of abortion, openly criticizing any doctor, irregular or not, who performed the procedure.<sup>73</sup> So although regulars could not “hide” the fact that some of their colleagues performed abortions and

---

<sup>70</sup> Anonymous, “When a Doctor is Accused of Criminal Abortion”, *Dominion Medical Monthly*, 32 (1909), p. 121.

<sup>71</sup> *Ibid.*, p. 122.

<sup>72</sup> *Ibid.*

tried to explain the reasoning behind such a decision as being related to competition, there was an underlying notion that these were the exceptions and that overall, the regular medical profession did not perform abortions. As one author noted in *The Canada Lancet* in 1889, “it is to the credit of the profession that so few have fallen victims to so alluring a temptation, especially the younger members, to whom these applications are more frequently made when patients and fees are often extremely rare.”<sup>74</sup> But there was another issue present in the discussions by regular physicians of abortion procedures, and that was the need for therapeutic abortion.

Despite their public assertion that abortion was not only a crime, but also, immoral, there can be no question that some doctors acknowledged that, in some circumstances, abortion was necessary to save the life of the mother when threatened by childbirth. Indeed, circumvention of the scientific fact about when life begins was not that difficult in the early period because, despite the assertion about the personhood of the fetus, many doctors in this period still viewed the life of the mother as taking precedence over the unborn child. As W.C. Bowers noted in *The Canada Lancet* in 1899, “in any disease of a woman which is aggravated to so great a degree, because of pregnancy, as to endanger her life, and which cannot be remedied so that she may live after labour, induced abortion should be considered in her interest.”<sup>75</sup> And although they were able to prove that life was a continuous process from conception, science had not advanced enough in other areas, like the treatment and prevention of infections, or the elimination of a variety of medical contraindications to pregnancy, as to avert doctors from the need to perform abortions to save the life of the mother. For instance, Dr. D.A. Stewart noted in the *Annual*

---

<sup>73</sup> See Penny, ““Getting Rid of My Trouble””, especially chapter three.

<sup>74</sup> Editorial, “Abortionists”, *The Canada Lancet*, 21 (1889), p. 217.

<sup>75</sup> W.C. Bowers, “Justifiable Artificial Abortion and Induced Premature Labour,” *The Canada Lancet*, 32 (1899), p. 113. See also Report, “The Induction of Abortion as a Therapeutic Measure,” *The Canada Lancet*, 13 (July, 1881),

*Report of the Canadian Association for the Prevention of Tuberculosis* in 1917 that, “when pregnancy has begun in one whose disease is advanced or active, definite increase in symptoms should not be waited for. Pregnancy should be terminated without delay.”<sup>76</sup> Other conditions which posed a threat to the expectant mother included previous insanity of pregnancy, pyelonephritis, pernicious vomiting, and heart disease.<sup>77</sup> However, not all doctors viewed the life of the mother as taking precedence over that of the child. Catholic physicians, for instance, believed that an attempt to save the child should be made no matter what the cost.<sup>78</sup> This belief was part of the religious doctrine to which they subscribed which dictated that it was immoral to take any life intentionally which meant that to terminate the life of a child to save that of the mother was unacceptable.

While not all individual doctors agreed, the profession did discuss the conditions under which an abortion could be legitimately performed. One of the leading experts on abortion in the western world in this period, Dr. Frederick J. Taussig of the United States, went so far as to suggest that pregnancies be terminated if they fell into one of three categories: pathologic conditions due directly to pregnancy like incarceration of the pregnant uterus, acute hydraminos or hyperemesis<sup>79</sup>; maternal diseases aggravated by the pregnancy primarily those of the heart and

---

p. 342-343; A.L. Smith, *Montreal Medical Journal*, 30, 5 (May, 1901); *The Canada Lancet*, 34, 12 (August, 1901), p. 663.

<sup>76</sup> D.A. Stewart, “Tuberculosis and Maternity,” *Annual Report of the Canadian Association for the Prevention of Tuberculosis*, 1917, p. 49.

<sup>77</sup> *Ibid.* W.C. Bowers noted that “the reasons for premature emptying of the uterus are many: the procedure is considered in these diseases and conditions, viz: nephritis, advanced tuberculosis, aneurism, valvular lesions of the heart, chorea gravidarum, peripheral neuritis of pregnancy, goitre, diabetes mellitus, eclampsia, cancer of the uterus, melancholia, hystero-epilepsy and insanity, irreducible displacement of the uterus, unavoidable hemorrhage of placenta previa, accidental hemorrhage, and hyperemesis gravidarium. The last is probably the most common reason for interrupting pregnancy.” “Justifiable Artificial Abortion and Induced Premature Labor,” *The Canada Lancet*, 32 (1899), p. 113. See also, Editorial, “The Induction of Abortion as a Therapeutic Measure,” *The Canada Lancet*, 13 (July, 1881), p. 343.

<sup>78</sup> Although this approach certainly applied to abortion it also applied to other obstetrical issues like craniotomy. See Mitchinson, *Giving Birth in Canada*, p. 236.

<sup>79</sup> Hydraminos is “an excess of liquor amnii, which leads to overdilatation of the uterus and the possibility of malpresentation.” Hyperemesis is “excessive vomiting.” Clayton L. Thomas (ed.), *Taber’s Cyclopedic Medical*

kidney; tuberculosis; and extreme contractions of the birth canal, otherwise defined as a marked narrowing of the birth canal.<sup>80</sup> For conditions that fell into any of these categories, therapeutic abortion was recommended to save the life of the mother, although Taussig noted that such a procedure was most strongly indicated in emergency situations.<sup>81</sup>

A number of issues influenced doctors' definition of therapeutic abortion in this early period, all of which were related to their desire to regulate their profession. They were careful to ensure that only those indications that had scientific backing were used as a means of determining when a therapeutic abortion could be performed - abortions performed outside this rubric were determined to be immoral and their practitioners working outside the legitimate science of medicine. Regular doctors worked to maintain a tight hold over their colleagues and urged them to avoid both the women who requested the procedure and the practice overall so as not to reflect negatively on their profession.

Regulars stressed in their discussions that they neither approved of nor provided abortions themselves (except in the dire circumstances noted above) in contrast to the irregulars.

---

*Dictionary, 16<sup>th</sup> Edition*, Philadelphia: F.A. Davis Company, 1985, p. 848, 861.

<sup>80</sup> Frederick J. Taussig, *The Prevention and Treatment of Abortion*, St. Louis: C.V. Mosby Company, 1910, p. 162-165. Incarceration of the uterus was "most often due to retroflexion or retroversion of the gravid uterus." "Acute hydramnios," noted Taussig, "may at times give rise to such marked distention of the uterus and abdomen as to endanger the patient's life. Beside the severe pain we may have cardiac insufficiency (cyanosis, dyspnoea). Here the interruption of pregnancy is absolutely necessary, as the condition grows progressively worse, and the chance of obtaining a living child is practically nil." He noted that, "hyperemesis is one of the most frequent and important indications for therapeutic abortions." (p. 163) Maternal diseases which led to the need to perform therapeutic abortions, like those associated with the heart and kidney and tuberculosis, noted Taussig, were generally exacerbated by the pregnancy, or the pregnancy caused complications of the disease which caused the need for termination, rather than the disease itself. (p. 164) Finally, with respect to marked narrowing of the birth canal, Taussig noted that "only when the true conjugate is less than 6 cms. does induction of abortion come up for consideration: In other words, only the cases where Caesarian section is absolutely necessary for the delivery of a living child. Here the mother is entitled to decide whether or not she will submit to the performance of such an operation. As a rule, if she is in fair general condition she should be persuaded to await the end of pregnancy and have a Caesarian section performed, since statistics show that where the operative indications have been set some time ahead, this operation is attended with a very small mortality." p. 165. For a more detailed description of Taussig and his career, see Jonathan Imber, *Abortion and the Private Practice of Medicine*, New Haven: Yale University Press, 1986.

<sup>81</sup> While there is definitely evidence to suggest that the treatment provided by some doctors was distorted by their dislike for abortion, many doctors, when faced with a specific case, had difficulty condemning their patients. See

As Kristin Luker notes, “what the physicians did, in effect, was to simultaneously claim both an *absolute* right to life for the embryo (by claiming that abortion is always murder) and a *conditional* one (by claiming that doctors have a right to declare some abortions ‘necessary’).”<sup>82</sup> Clearly the discourse represented the ideal rather than the reality - a theme that would continue in doctors’ discussions of the practice. In other words, their position on abortion helped regulars to separate themselves from the irregulars and facilitated their claim to superiority. At the same time, such claims by the regulars strove to call into question any alternate knowledge on the part of either irregular practitioners or women to control reproduction - a common practice given that abortion had only been a crime since the beginning of the nineteenth century. By labeling the practice immoral, regulars were able to strengthen their position, both practically and socially.

The rhetoric surrounding the morality of the practice was also used by other members of the professional class. For instance, at the sentencing of Bridget Blasdell, an abortionist from Hamilton, Ontario, Judge Armour noted that the offence committed by Blasdell,

is an offence which, in my mind, is the worst offense that can be committed – the procuring of an abortion upon the person of another. It is an offense against society; it is an offense against God. If there were no persons such as you who procure abortions, such offenses would die out; but the effect of your carrying out this nefarious trade is that persons are more willing to get into that condition that necessitates or impels them to seek your services than they otherwise would be...Abortion is a crime that is on the increase in the country, and it is a crime which ought to be put a stop to in the interests of society.<sup>83</sup>

Not only, then, was the practice of abortion affecting individual women and the regular profession of medicine, but society as a whole.

### **Abortion and Women’s Proper Role**

---

Wendy Mitchinson, *The Nature of Their Bodies*, p. 141-142.

<sup>82</sup> Luker, *Abortion and the Politics of Motherhood*, p. 32.

<sup>83</sup> *The Hamilton Spectator*, March 18, 1881, p. 4.

The comments by the regular medical profession about the immorality of the practice were entwined with observations about women's "proper" role as mothers, part of middle-class prescriptions of true womanhood.<sup>84</sup> The period spanning the mid to late nineteenth and early twentieth centuries in Canada witnessed a number of changes related to demographics (a declining birth rate, increased immigration) and industrialization (a shift in population from rural to urban areas, new jobs in cities). Many members of the middle-class like theologians, politicians, educators and physicians discussed these changes as they sought to understand the changing contexts of the world in which they lived. One of their biggest concerns arising from these discussions was the declining birth rate. Questions about the reasons for the decline eventually led to the denunciation of the practice of fertility limitation or birth control largely because of a fear of "race suicide."<sup>85</sup> The predominant concern was that women were shirking their responsibility as mothers by artificially limiting their fertility, although a high infant mortality rate certainly also played a role in the declining birth rate.<sup>86</sup> In the case of working-

---

<sup>84</sup> Many historians have examined the prescriptions for women in this period. For instance, see Karen Dubinsky, *Improper Advances: Rape and Heterosexual Conflict in Ontario, 1880-1929*, Chicago: University of Chicago Press, 1993; Carolyn Strange, *Toronto's Girl Problem: The Perils and Pleasures of the City, 1880-1930*, Toronto: University of Toronto Press, 1995. For discussions about women and the medical profession in this period see Wendy Mitchinson, *The Nature of Their Bodies*; Christine Ball, "Female Sexual Ideologies in Mid to Late Nineteenth-Century Canada," *Canadian Journal of Women and the Law*, 1, 2 (1986): 324-338. There are a number of studies which examine the role of medical science in the construction of gender differences. For instance see Thomas Laqueur, *Making Sex: Body and Gender from the Greeks to Freud*, Cambridge: Harvard University Press, 1990; Catherine Gallagher and Thomas Laqueur (eds.), *The Making of the Modern Body: Sexuality and Society in the Nineteenth Century*, Los Angeles: University of California Press, 1987; Ruth Bleier, *Science and Gender: A Critique of Biology and Its Theories on Women*, New York: Pergamon Press, 1984; Marian Lowe and Ruth Hubbard (eds.), *Woman's Nature: Rationalizations of Inequality*, New York: Pergamon Press, 1983; Emily Martin, "The Egg and the Sperm: How Science has Constructed a Romance Based on Stereotypical Male-Female Roles," *Signs*, 16, 3 (1991): 485-501.

<sup>85</sup> As Angus and Arlene Tigar McLaren note, much of the discussion about 'race suicide' was popularized in North America by U.S. President Theodore Roosevelt who stated, "The woman who flinches from childbirth stands on par with the soldier who drops his rifle and runs in battle." *The Bedroom and the State*, p. 15. See also *Toronto Globe*, December 17, 1901; *Toronto Evening Telegram*, March 26, 1908, p. 9; *Manitoba Free Press*, August 30, 1909, p. 3; Sylvanus Stall, *What a Young Man Ought to Know*, Toronto: 1897, p. 198; "Childless Marriages", *Canadian Churchman*, November 29, 1900, p. 724.

<sup>86</sup> Wendy Mitchinson has noted that the views of society in this period emphasized the role of women as mothers. She writes, "women's role was to be mother and doctors condemned any form of birth control as physically debilitating." "Causes of Disease in Women: The Case of Late 19<sup>th</sup> Century English Canada," in Charles G. Roland (ed.), *Health, Disease and Medicine: Essays in Canadian History*, The Hannah Institute for the History of

class women, it was feared that their employment prior to marriage would somehow leave them uninterested in bearing children (because they would be too used to their independence) and in middle-class women the concern was that they were limiting their families out of a “desire for greater luxury and self-indulgence.” In reality, the declining birth rate in Canada was similar to that of other Western nations.<sup>87</sup> This does not alter the fact, though, that somehow couples were seeking the means to control their family sizes.<sup>88</sup> Given the connection of abortion to birth control practices in this period, there was also a great deal of discussion about abortion practices.<sup>89</sup>

A strong belief in women’s virtue existed and was a stabilizing constant, especially in a world in which religion was increasingly being challenged. This was as true in the late nineteenth century as it was during the Great War. Despite the granting of suffrage and new opportunities in the public sphere, women did not live lives that were all that different from those of their mothers.<sup>90</sup> Women in their maternal role provided security and hope for the future generations they would raise.<sup>91</sup> Essentially, women were made to be mothers. Biological and medical arguments were used to establish gender roles where women’s status became a product of nature - she was woman because of her biological differences from man, the most important of which was her ability to bear children. “Nature defined gender roles: ‘implanting in each sex

---

Medicine, 1984, p. 382.

<sup>87</sup> McLaren and McLaren describe the “fertility transition” as “the replacement of a society with high birth and death rates by a society with low birth and death rates. Death rates [in Canada] tended to fall sooner, producing the population surge of the nineteenth century. The decline of the birth rate brought the demographic system back into equilibrium. But whereas the lowering of mortality was regarded as a natural result of progress, many regarded the lowering of fertility as ‘unnatural.’” *The Bedroom and the State*, p. 17.

<sup>88</sup> *Ibid.*

<sup>89</sup> Given that advances in contraception had not yet been made in this period women were often faced with the need to terminate pregnancies after they had occurred, rather than with preventing them. For this reason, many women held the traditional view that they were only regulating themselves, rather than having an abortion as they sought out ways to terminate unwanted pregnancies. See Penny, “‘Getting Rid of My Trouble,’” p. 44.

<sup>90</sup> Veronica Strong-Boag, *The New Day Recalled: Lives of Girls and Women in English Canada, 1919-1939*, Toronto: Copp Clark Pitman, 1993, p. 2. As Strong-Boag notes, women are not a monolithic group yet women did experience life “in ways that remained similar enough to be collectively characterized.” p. 4.

the peculiarities which are responsible for things as they are, and for the most part, must continue to be.”<sup>92</sup> The nineteenth-century woman, then, was expected to embody a number of virtues including a spirit of obedience and submission, pliability of temper, and humility of mind and these virtues were declared to have a biological basis. In essence, the disciplinary power of medicine stemming from a belief in science empowered doctors to define undesirable behaviour (in essence, behaviour which did not fit with the virtues noted above) as *unphysiological*.<sup>93</sup> As Michael Thomson notes, “woman had become a prisoner of her reproductive organs and their physiological processes.” To challenge this role, which was becoming increasingly defined by, and supported by the “truth” of medical, biological science, by procuring an abortion was problematic.<sup>94</sup>

Regular doctors realized that women were not necessarily adhering to the prescriptions of the day (as was evidenced by the declining birth rate)<sup>95</sup> and, at a time when they were struggling to control the practice of medicine, this was particularly disturbing because it questioned their medical authority to specify behaviour. Perhaps the greatest source of distress for doctors in the late nineteenth and early twentieth centuries was that women from the better classes of society seemed to be challenging their role. While they were believed to be those best suited to be mothers and to take on a “moralizing” role, physicians suspected that they were having abortions. For instance an 1871 editorial in *The Canada Lancet* had referred to abortion as “the crime of the period:”

---

<sup>91</sup> Mitchinson, *The Nature of Their Bodies*, p. 38.

<sup>92</sup> Thomson, “Woman, Medicine and Abortion”, p. 162-163.

<sup>93</sup> For a more in depth discussion of the connection between the medical profession and women’s roles in this period, see Wendy Mitchinson, “Causes of Disease in Women: The Case of Late 19<sup>th</sup> Century English Canada” in Roland (ed.), *Health, Disease and Medicine*: 381-395.

<sup>94</sup> Thomson, “Woman, Medicine and Abortion”, p. 162-163.

<sup>95</sup> Canada’s fertility rate in 1871 was 189 per 1000 and steadily declined, reaching a rate of 120 per 1000 by 1921, and falling to 94 per 1000 by 1930. Jacques Henripin, *Trends and Factors of Fertility in Canada*, Ottawa: Statistics Canada – Census Division, 1972, p. 21.

In the wealthier circles it is 'not fashionable' to have a large family...The various modes of preventing conception, and of destroying the offspring of their womb, are subjects of common conversation, and no more is thought of it than if it were a duty imposed upon them which they felt bound to perform. In reference to this crime there is a moral obliquity pervading all ranks of society that is truly appalling.<sup>96</sup>

This quote suggests that the scientific fact that life begins at conception was not being heeded by middle-class women who wanted to limit their family sizes.<sup>97</sup> Other doctors writing in the medical journals of this period noted that married women were trying to "shirk the responsibilities of maternity..." and that abortions perverted "...the highest function of woman's nature, and...turn blessings into cursings."<sup>98</sup>

Some doctors, particularly disturbed by women who were seeking out abortions, and who defied the prescriptive "ideal" that promoted motherhood as "natural," suggested that they were "designing women" who "often consult the physician for amenorrhea, when they know they are pregnant, hoping that something will be done to bring on their courses and interrupt gestation."<sup>99</sup> Doctors were warned not to let themselves be fooled by such "trickery." Dr. D.W. Cathell, author of *The Physician Himself and Things that Concern His Reputation and Success*, classified women who sought out abortions in an even more negative stereotypical way. He suggested they were "unmarried negresses, ladies of easy virtue, and other low females (and sometimes even the wealthy, young and beautiful)..."<sup>100</sup> It is clear from these excerpts that doctors were distressed

---

<sup>96</sup> "Criminal Abortion", *The Canada Lancet*, 4, 1 (December, 1871), p. 185.

<sup>97</sup> A number of articles discussed the limitation of fertility. For instance see Horatio R. Storer, "The Abetment of Criminal Abortion by Medical Men," *Canada Medical Journal*, 3 (1863): 225-234; Andrews, "On Abortion"; Editorial, "Foeticide,"; Editorial, "Does It Pay? No!,"; Editorial, "Abortionists."

<sup>98</sup> Alfred A. Andrews, "On Abortion," p. 291; Editorial, "Criminal Abortion," *The Canada Lancet*, 4, 4 (December, 1871), p. 186.

<sup>99</sup> R.W. Garrett, *Textbook of Medical and Surgical Gynecology*, Kingston, 1897, p. 109. See also J.M. Baldy (ed.), *An American Text-book of Gynaecology, Medical and Surgical, For Practitioners and Students*, Philadelphia: W.B. Saunders Company, 1896, p. 102.

<sup>100</sup> The reference to "negrresses" probably represents this text's origin in the United States where issues of race were much more prominent. It also uses race as a code for morality or in this case, immorality. This is a code that would have been clear to many. D.W. Cathell, *The Physician Himself and Things that Concern His Reputation and*

by the idea that women were seeking out abortions and tended to characterize them in a way that fit with the stereotypes of the day. They also discussed the practice in a way that allowed them to fit women's actions of procuring abortions within the larger social discourse which placed women in the role of mothers and upholders of the morality of the nation. In essence, women were supposed to embrace their role as mothers - to do otherwise suggested a "physiological"<sup>101</sup> or at least a sociological problem.

Doctors also needed to place such actions within the existing discourse on abortion and medical practice in general and it is clear that those who sought to escape the prescribed gender roles faced considerable opposition from medical experts who had defined such roles based on "scientific" truths.<sup>102</sup> And although doctors were particularly concerned about their middle-class patients limiting their fertility, at the heart of their discussions was the belief that the practice of limiting births, by abortion or any another method was simply immoral. Clearly, doctors' desire to assert their influence over the profession played heavily into their discussions about proper roles. One way to achieve both professional status and to regulate women's roles was to denounce the practice of abortion.<sup>103</sup>

Convincing the public that abortion was wrong was easier said than done in this period given that, despite the legal restriction on contraceptive information and abortifacients, there was a wide range of products for sale that purported to do the trick. Advertisements for these products, as well as for abortionists, could be found in abundance in the newspapers of the day.

---

*Success*, Philadelphia: The F.A. Davis Company Publishers, 1898, p. 79.

<sup>101</sup> Michael Thomson has discussed this gender stereotyping as it specifically relates to abortion practices in "Woman, Medicine and Abortion in the Nineteenth Century." There has also been work in the area of mental illness and women which makes similar arguments. For instance, see Carol Smith-Rosenberg, "The Hysterical Woman: Sex Role Conflict in Nineteenth Century America," *Social Research*, 39 (Winter, 1972); Wendy Mitchinson, *The Nature of Their Bodies*, chapter ten. Women looking for an alternative to marriage and childbirth sometimes became nuns. For a discussion of this phenomenon see Marta Danylewycz, *Taking the Veil: An Alternative to Marriage, Motherhood and Spinsterhood in Quebec, 1840-1920*, Toronto: McClelland and Stewart, 1987.

<sup>102</sup> Thomson, "Woman, Medicine and Abortion", p. 164-168.

Evidence found in medical journals and textbooks, as well as from the testimony of women accused of procuring their own abortions at criminal court trials, indicate that there were indeed a variety of methods available for “regulation” in this period.<sup>104</sup> These ranged from coitus interruptus to prevent a pregnancy,<sup>105</sup> to patent medicines and herbal remedies to regulate oneself and, when those failed (as they often did), abortion. These methods were promoted in a variety of sources including mass-produced medical and self-help literature as well as advertised for sale in the newspapers and periodicals of the period.<sup>106</sup> To get around the law the information was often couched in language that explicitly stated the advertised products were to be avoided by pregnant women. For instance, the advertisement for Friar’s French Female Regulator noted that, “ladies who have reason to suspect pregnancy are cautioned against using these tablets...They will speedily restore the menstrual secretions when all other remedies fail...”<sup>107</sup> This, of course affirmed the dangers of taking such a remedy if one were pregnant, but also was an assertion that it was a means of terminating an unwanted pregnancy. The concern about the use of abortifacients by women to terminate unwanted pregnancies was clearly part of regular physicians’ attempt to regulate both their profession and women’s roles. Indeed, doctors had been discussing this issue for some time. For instance, an 1871 editorial in *The Canada Lancet*

---

<sup>103</sup> *Ibid.*, p. 162-163.

<sup>104</sup> For instance, in a study of the 108 criminal court indictments for abortion in Ontario between 1890-1929, 27 (26%) had used at least drugs or patent medicines to procure abortion, 35 (33%) had used at least instruments and 42 (39%) had used multiple devices either more than one drug or a combination of drugs and instrumentation to procure their abortion. See Penny, “Getting Rid of My Trouble,” p. 80.

<sup>105</sup> McLaren and McLaren refer to coitus interruptus as the primary means of contraception employed by Canadian couples well into the twentieth century. *The Bedroom and the State*, p. 22.

<sup>106</sup> For instance, see Napheys, *The Physical Life of Woman*; Pierce, *The People’s Common Sense Medical Advisor*; F. Harrison Doane, *The Young Married Lady’s Private Medical Guide*, Boston: Publisher unknown, 1854; Emma F. Angell Drake, *What a Young Wife Ought to Know*, Toronto: W. Briggs, 1908. Periodicals included newspapers like the *Toronto Daily Mail and Empire*, in medical journals like the *Dominion Medical Monthly*, or even in catalogues like that of the T. Eaton Company. McLaren and McLaren, *The Bedroom and the State*, p. 21; Penny, “Getting Rid of My Trouble.”

<sup>107</sup> The question of whether such statements amounted to an announcement that the product was an abortifacient was addressed by Appeal Court Justices who decided that such statements were the best way to enforce its efficacy. In other words, if it was dangerous to take such a remedy if one were pregnant, it could logically have been assumed

had noted disapprovingly that

the press teems with advertisements for female pills for the relief of all female irregularities and obstructions accompanied by the *well known caution* for the pregnant woman to avoid them...the facility for obtaining drugs for procuring abortion is one of the most prolific causes of the increase of this crime. There is not a single difficulty in the way; Clark's Female Pills, Hooper's Female Pills, and hundreds of other nostrums are for sale in all our drug stores, and in many groceries also. The sale of these drugs is immense; it is estimated that in the United States upwards of a million dollar's worth are sold annually, and the matter-of-business way with which even respectable druggists sell violent and noxious drugs to women far advanced in pregnancy is one of the most alarming features of this trade.<sup>108</sup>

While women could find this information in the public sphere, there is also evidence to suggest that women also had their own social networks in which they shared "home remedies" as well as information about where to go to get out of trouble.<sup>109</sup> Translation of such advertisements and/or information from family members and friends continued to be the predominant way of learning about methods of contraception and/or termination of pregnancy in this period.

The medical profession overall was opposed to contraception, particularly contraceptive devices, for a number of reasons. First, they feared being associated with "the libertine, the prostitute, and the midwife..." Given regular physicians' ongoing struggle to assert control over health care practices, association with those who did not fit with their prescriptions of proper, moral behaviour threatened their profession. Women who needed contraceptive devices certainly did not fit within the "proper" sphere being carved out for women by regular physicians. Second, they overtly promoted that they were more moral and, indeed, trustworthy than irregulars whom they portrayed as being criminals and outside the realm of respectable

---

that such a medicine would cause the termination of an unwanted pregnancy. See *R. V. Karn* (1903) 5 O.L.R. 704 (C.A.); *R. v. Karn* C.C.C. 479; *R. v. Karn* 6 C.C.C. 543.

<sup>108</sup> Editorial, "Criminal Abortion." For a detailed description of the patent medicines available in this period see Peter Gossage, "Absorbing Junior: The Use of Patent Medicines as Abortifacients in Nineteenth Century Montreal", *The Register*, 3, 1 (March, 1982): 1-13.

<sup>109</sup> Penny, "Getting Rid of My Trouble."

medicine. Given the illegality of endorsing contraception in this period, regular physicians could not be seen to be prescribing birth control for their patients, despite the fact that physicians had at least some knowledge that they could have passed on.<sup>110</sup> “Rather than using the available knowledge to assist women, physicians argued for a greater degree of regulation over quacks and popular practitioners.”<sup>111</sup> Indeed, regular doctors’ assertion about their expertise on health issues left them little room to maneuver philosophically and professionally on the issues of either birth control or abortion. The limitation of births evidenced by the declining birth rate was disturbing because it reflected their inability to exercise control over their female patients - both in terms of regulating their fertility and in regulating their morality.

The other important point to note about the connection between abortion and morality in the early period is the medicalization of the practice. Prior to the nineteenth century, reproductive regulation had been within the sphere of women because there were really no legal restrictions on abortion.<sup>112</sup> In this sense, women exercised agency over their own bodies.<sup>113</sup> For instance, if performed prior to quickening, abortion was not viewed as being immoral. Given that the mother herself was really the only person who could determine if a pregnancy existed, she had the power to choose a course of action, however limited such options were. However, regular doctors succeeded by the end of the nineteenth century in medicalizing the practice by pathologizing abortion. Not only was there something morally wrong with abortionists

---

<sup>110</sup> McLaren and McLaren, *The Bedroom and the State*, p. 21.

<sup>111</sup> Kellough, *Aborting Law*, p. 56. See also McLaren and McLaren, *The Bedroom and the State*, p. 293.

<sup>112</sup> Gavigan, “The Criminal Sanction as it Relates to Human Reproduction,” p. 20.

<sup>113</sup> This is not meant to imply that women understood their own reproduction or how to regulate themselves in the case of an unwanted pregnancy although there is evidence to suggest that women, at least by the time of quickening, were aware of remedies that they could use to attempt to “get rid of their trouble.” However, as Bryan Turner has noted, throughout history women’s bodies have been viewed as threatening to the moral and social stability of society. “In particular, female sexuality has been the target of religious and magical practices which have been mobilized to restrain women and to provide a surveillance of female reproductive capacity.” *Medical Power and Social Knowledge, Second Edition*, London: Sage Publications, 1995, p. 87. This shows the complexity of the issue of women’s agency.

(professional and non-professional) who performed the procedure and with women who sought to terminate their pregnancies, but there was also something unscientific about those doctors who performed the procedure. Thus abortion was transformed from a woman-centered practice to one in which doctors needed to be involved.<sup>114</sup> Doctors believed that part of their role was to protect their patients' well-being, not only physically but also morally. This was one way that it was easy to use abortion to differentiate themselves from irregulars - by claiming that they could provide moral education of their patients. A concern for regulars was the ongoing assertion by many women who procured their abortions that they were only "regulating" themselves. This, of course, demonstrated that women continued to disregard medical opinion about when life began.

In the early period, a number of themes emerged in the medical discourse on abortion. At the heart of the discussions was regular physicians' desire to regulate the medical profession and increase their status in society. Their means of addressing competition from irregulars came largely from their reliance on medical science, which allowed them (regulars) to promote their superiority over other health practitioners (irregulars, midwives, quacks) because of the scientific training the regulars received at medical school. Encompassed within their scientific definitions was the new evidence about when life began. Abortion was placed in a moral debate where regular practitioners were moral because they (supposedly) did not approve of or perform abortions and where irregular practitioners were immoral because of their connection with such practices.

This approach to abortion, of course, also had implications for the prescription of women's proper roles. As abortion began to be viewed as a medical issue, women lost control

---

<sup>114</sup> Wendy Mitchinson suggests that in the case of obstetricians and gynecologists specifically, their attempts by doctors to be more involved in abortion practices was an attempt to deal with the low status of the specialty. "The Sometimes Uncertain World of Canadian Obstetrics, 1900-1950," *Canadian Bulletin of Medical History*, 17 (2000) p. 193. 194.

that they had earlier had over their own reproduction. Abortion, then, was one issue that spoke to the different areas that doctors wanted to control including the practice of medicine itself, the maintenance of their social status, the morality of both their profession and their patients, and the proper role of women. This control, embedded in their discussions of abortion in the early period, allowed doctors to determine who had the power to speak about abortion, how it continued to be defined in terms of proper roles, and inevitably, how those speakers and their definitions of the practice would influence the type of legislation that was later enacted. As we will see in chapter two, doctors shifted their approach to abortion in the interwar period in order to address the high maternal mortality rate, and to ensure that they continued to maintain the disciplinary power that they achieved for themselves in the early period.

*Chapter Two*  
*Abortion, Maternal Mortality and Doctors*  
*in the Interwar Period, 1919-1939*

At a 1922 meeting of the Toronto Academy of Medicine, Dr. W.B. Hendry noted that:

When we take into consideration the advances that have been made in preventative medicine and in the education of the public in all matters pertaining to the health of the community at large, with the result that the man of today is supposed to have ten years or more of life than the man of a century ago, we are inclined to feel pride in the profession which has been able to add to man's allotted time of three scores and ten, and to take, each of us to himself, some credit for this change. But when we exam[ine] the vital statistics of the community and find that the number of deaths directly or indirectly attributable to childbirth is second only to that of tuberculosis during the reproductive years, we are compelled to pause and take stock of ourselves in order to determine wherein the fault lies, and why these things should be.<sup>1</sup>

Dr. Hendry's concern about the static, high maternal mortality rate, and who was at fault, was shared by other doctors of the interwar period. The discovery of antiseptics by Joseph Lister in 1867 had assisted in eliminating many of the causes of maternal death, and yet the rate continued to remain high, accounting for ten to fifteen percent of all deaths among women in the child-bearing years in the 1930s.<sup>2</sup> The medical profession responded by discussing this issue in the medical journals of the day. Maternal mortality was particularly disturbing to doctors because it questioned their scientific, medical ability to prevent deaths - an ability that they had worked

---

<sup>1</sup> Dr. W.B. Hendry, "Maternal Mortality," *Canadian Medical Association Journal* (hereafter cited as *CMAJ*), 13, 4 (April, 1923), p. 252. Hendry practiced out of the Burnside Lying-In Clinic of the Toronto General Hospital and was later head of the Canadian Medical Association's Maternal Welfare Committee. See Cynthia Comacchio, *Nations Are Built of Babies: Saving Ontario's Mothers and Children, 1900-1940*, Montreal and Kingston: McGill-Queen's University Press, 1993, p. 69.

hard to promote in the preceding decades.

In the early period regular doctors regulated their profession by advertising their use of medical science. Given that they promoted the idea that science made them better doctors than irregular physicians (even though this was perhaps more true rhetorically than in actual practice), the high maternal mortality rate of the interwar period caused much concern because it showed a definite discrepancy between the discourse of medical science and doctors' actual ability to use their scientific knowledge to prevent maternal deaths. International studies in the 1920s suggested that Canada had one of the highest maternal mortality rates in the Western World. In fact, a 1923 study by Dr. Helen MacMurchy, Director of the Child Welfare division of the federal Department of Health, showed that when compared to seventeen Western countries Canada ranked fourteenth.<sup>3</sup> These statistics led the profession to look for the chief influences in maternal deaths. It is perhaps not surprising that some pointed to women as the cause of the high rate due to their continuing attempts to control their fertility (thereby challenging their maternal role) by having abortions. Indeed, doctors argued that one of the major factors in the unchanging (and at times during the interwar period, increasing) maternal mortality rate was that they were receiving women for treatment after an abortion procedure was performed. These patients were already in a septic state and it was too late for doctors to save them.<sup>4</sup> In other

---

<sup>2</sup> Angus McLaren and Arlene Tigar McLaren, "Discoveries and Dissimulations: The Impact of Abortion Deaths on Maternal Mortality in British Columbia", *BC Studies*, 64-67 (1984-85), p. 3.

<sup>3</sup> Dr. Helen MacMurchy's investigation on the topic of maternal mortality was presented to the Dominion Council of Health in June, 1923. A summary of her report was published in *Social Welfare*, 6 (1923): 28-30. See also Katherine Arnup, *Education for Motherhood: Advice for Mothers in Twentieth Century Canada*, Toronto: University of Toronto Press, 1994.

<sup>4</sup> Sepsis is defined as a "pathologic state, usually febrile, resulting from the presence of microorganisms or their poisonous products in the bloodstream. May be manifested as...bacteremia (widespread dissemination by way of the bloodstream)." Puerperal sepsis is "any infection of the genital tract occurring during the puerperium [the period of 42 days following childbirth and expulsion of the placenta and membranes] or as a complication of abortion. This disease is presumed to be present when the temperature is 38 C (100.4 F) on any two consecutive days, exclusive of the first 24 hours postpartum, if no other causes of fever are apparent. The causitive organisms, which are usually *Streptococci* or *Clostridia* are introduced from the outside in the majority of cases." Clayton L. Thomas (ed.), *Taber's Cyclopedic Medical Dictionary 16<sup>th</sup> Edition*, Philadelphia: F.A. Davis Company, 1989, p. 1661, 1521.

words, it was neither an inadequacy in medical science nor inability on the part of physicians that was responsible for the high death rates. As the issue of abortion had served doctors' needs in terms of regulating their profession in the early period, it similarly provided doctors with an explanation for the high maternal mortality rate. The link that doctors perceived between abortion and the maternal death rate is interesting because, despite the obvious risks posed by having an illegal procedure, its actual mortality rate was low which means that many more women were seeking to terminate their pregnancies and having some success than the actual statistics show. In the first half of the twentieth century, for instance, it has been estimated that only one-tenth of one percent of all abortions, both spontaneous and induced, resulted in death. Angus and Arlene Tigar McLaren have noted an interesting case in British Columbia, however. According to the province's vital statistics in the 1930s and 1940s, abortion deaths rose in absolute numbers (not just relative to maternal deaths), which means that more women than before were seeking to terminate their pregnancies, despite the illegality of the practice. Even though there is evidence to show that the maternal death rate due to abortion was increasing in this period, we still cannot take the numbers from vital statistics as an indicator of the actual numbers of women who actually sought abortion because, as the McLarens' point out, many abortion deaths went unreported. They suggest that this was due to the ambivalence of the medical profession and that British Columbia statistics on abortion (and, I would argue, for the rest of Canada) were flawed for the same reasons as they were in United States. Helena Huntington Smith noted such flaws in a 1934 issue of the *New Republic*.

It is natural to wonder why, with scores of statistical tables being published year after year, the true state of affairs has not been revealed before. But it is not hard to understand when you know how the statistics are obtained. For example, Anna J. Brown comes into a hospital with a high temperature, and a story of falling down the cellar stairs in the third month of pregnancy.

The hospital authorities may or may not believe the cellar-stairs explanation, but their function is to treat her for a dangerous septic condition, not to do police work. If she dies, the death is correctly certified as due to puerperal septicaemia, and that's that, so far as the hospital is concerned. This grain of fact is deposited in the county health records. Eventually it is turned over to the federal Census Bureau. And Anna J. Brown, now relegated to the limbo of statistics, becomes one of six thousand infinitely shadowy women who die in this country each year of puerperal septicaemia – a disease known to centuries of women as childbed fever.<sup>5</sup>

Further, the rate of pregnancies which ended by spontaneous or induced abortion in this period rose from between 10 to 15 percent though as noted above, the actual death rate due to abortions was actually relatively low in this period. This means that more women were seeking out the procedure in this period making the absolute numbers of abortion deaths frighteningly high.<sup>6</sup> The high maternal death rate from abortion in this period when maternal deaths from other causes were decreasing, points to the fact that women were forced to work within an illegal system where they could not benefit from the scientific advances found in hospital care.<sup>7</sup>

Doctors seem to have been well aware that the numbers of women seeking out abortion were not being indicated in the maternal mortality figures. That their perceptions of the connection between the maternal death rates and the role that abortion played in those rates differed from what actually was reflected in death rates is not really surprising. As we have seen, doctors discussed abortion in a context that made sense to them at the time. In the early period, they discussed the practice in terms of their professional status, the emergence of medical science, morality and women's role. In that context, they used the practice of abortion to discredit irregular practitioners, claiming that it was irregulars who performed abortions, a

---

<sup>5</sup> Helena Huntington Smith, "Wasting Women's Lives: The Frightful Toll of Abortion," *New Republic*, 28 March, 1934, p. 179 as quoted in Angus McLaren and Arlene Tigar McLaren, *The Bedroom and the State: The Changing Practices of Contraception and Abortion in Canada, 1880-1980*, Toronto: McClelland and Stewart, 1986, p. 46.

<sup>6</sup> McLaren and McLaren, *The Bedroom and the State*, p. 50-51. See also Tracy Penny, "'Getting Rid of My Trouble': A Social History of Abortion in Ontario, 1880-1929," unpublished MA Thesis, Laurentian University, 1995.

procedure that was immoral and that degraded women's proper role as mothers. Yet the context of their discussions about abortion shifted in the interwar period as doctors were faced with the serious problem of a high maternal mortality rate (particularly serious at a time when Canadians were greatly focused on "building a strong and healthy nation"). This forced doctors to examine more closely the maternal mortality rate and the connection of maternal deaths to illegal abortion. Indeed, there seems to be little question that doctors recognized abortion deaths when they saw them but that they were often reluctant to classify them as such. This may have been to protect themselves or to protect the women who were their patients. However, this reluctance began to change through the interwar period as it became obvious that the profession had to deal with the high maternal mortality rate.

This chapter examines doctors' discussions about abortion and its connection to maternal mortality between 1919 and 1939. The discourse from this era reveals a shift in how the profession dealt with the practice of abortion from the earlier period. Despite their success at regulating the profession in the early period, doctors continued to be concerned with their status and the high maternal mortality rate necessitated that they look for the cause to protect the profession. Significantly, they did not use morality as an argument against the practice. Instead, the discourse shifted to focus specifically on the issue of maternal mortality and the connection of abortion to the high death rate. In many ways, the discourse on abortion in this period is contained within doctors' discussions of the death rate, rather than about abortion itself. What remains from the late nineteenth and early twentieth-centuries is their position on women's proper role as mothers. The desire to dictate proper gender roles within the medical discourse led to prescriptions for women that became firmly entrenched in the discourse on abortion in the interwar years as the medical profession continued to stress that women's role was as mother.

---

<sup>7</sup> McLaren and McLaren, *The Bedroom and the State*, p. 50.

There was clearly a contradiction in the prescriptions promoted by doctors and what women themselves desired and the evidence of this contradiction was seen in the increasing maternal mortality rate. Doctors sought to address the problem by calling for the specialization of doctors in the area of obstetrics, for the education of women both in terms of the dangers of abortion and the importance of proper prenatal care (or preventative obstetrics), and for better classification of maternal deaths. The disciplinary power they established in the early period continued to allow them to shift the discourse on abortion to suit their professional needs, in this case, to address the issue of maternal mortality.

### ***Changing Contexts, Shifting Interests***

Maternal mortality was a constant concern for doctors in the interwar period primarily because it raised questions about the ability of medical science to prevent the death of the mother in childbirth. This concern surfaced initially because of a desire to limit infant mortality since doctors acknowledged a connection between infant and maternal mortality when they recognized that maternal health was integral to infant health. One of the most significant links between infant and maternal health was the push for pre-natal care to ensure not only a healthy mother, but also a healthy baby.<sup>8</sup> However, as doctors investigated the causes of maternal deaths, they increasingly began to connect these with abortion. For instance, Dr. Gordon Grote Copeland, Consulting Obstetrician and Gynecologist of Toronto Western Hospital, reporting on trends in maternal mortality in 1934 suggested that, “maternal deaths not associated with a live-birth, were 51% of the total, demonstrating the great seriousness of infected abortions, many of which are

---

<sup>8</sup> For instance see R.E. Wodehouse, “Maternal Deaths,” *CMAJ*, 34 (May, 1936): 525-527; H.E. Young and J.T. Phair, “Maternal Mortality in Canada,” *Public Health Journal*, 19, 3 (March, 1928): 135-136; Editorial, “Infantile Mortality and Sterility,” *CMAJ*, 13, 9 (September, 1923): 677-678; J.T. Phair, “Why Maternal Deaths,” *Canadian Public Health Journal*, 25, 3 (March, 1934): 141-142. For a further discussion of this issue see Comacchio, *Nations Are Built of Babies*.

criminal in origin.”<sup>9</sup> Similarly, a doctor writing in *Child and Family Welfare* in 1935 noted that the Dominion Bureau of Statistics had shown a higher death rate among unmarried women (7.8 per 1000 births) than for married women (4.9 per 1000 births). This author suspected that “while other important factors undoubtedly contribute to the high maternal death rate among unmarried mothers, available evidence would seem to indicate that the hazards of abortion are incurred in a relatively high proportion of these cases.”<sup>10</sup> These observations suggest that doctors perceived that abortion was an important factor in the maternal death rate.<sup>11</sup>

As maternal mortality studies were conducted across the country, evidence of a connection between abortion and maternal mortality emerged. For instance, a 1934 study of 334 maternal deaths in one year in Ontario showed that almost 18% of all maternal deaths were due to abortion.<sup>12</sup> Further, the greatest cause of death was puerperal sepsis at 23%. These two figures, representing about 41% of all maternal deaths was significant because doctors seemed convinced that even more maternal deaths reported as being due to sepsis were the product of abortions.<sup>13</sup> “Mortality from abortion is due chiefly to sepsis following illegal interference with pregnancy”<sup>14</sup> reported the *Canadian Medical Association Journal* in its “Topics of Current Interest” column in December, 1936.

---

<sup>9</sup> Gordon Grote Copeland, “Obstetrical Fundamentals and Maternal Mortality or The Four Horsemen of Death and Damage to Motherhood Sepsis, Toxemia, Hemorrhage and Shock,” *Canadian Journal of Medicine and Surgery*, 75, 2 (February, 1934), p. 38.

<sup>10</sup> Unknown, “Need Our Mothers Die?” *Child and Family Welfare*, 11, 4 (November, 1935), p. 12.

<sup>11</sup> Cynthia Comacchio has suggested that doctors, although aware that a connection between abortion and maternal mortality existed, were reluctant to highlight it as a factor because it might “shatter the unquestioning acceptance of maternity that doctors wanted women to believe was their only ‘normal’, legitimate, and acceptable response” to pregnancy. Instead she suggests that abortion did not emerge as a “public” factor until the end of the interwar period. While there is no question that doctors were committed to upholding the norm, their mention of abortion as a causal factor in maternal mortality studies seems to suggest that they did believe it to be an important factor, albeit one among other mortality factors. *Nations Are Built of Babies*, p. 72.

<sup>12</sup> J.T. Phair and A.H. Sellers, “A Study of Maternal Deaths in the Province of Ontario,” *Canadian Public Health Journal*, 25, 12 (December, 1934), p. 566.

<sup>13</sup> A similar study conducted in Manitoba between 1928-1932 provided similar conclusions. See F.W. Jackson, R.D. Defries, and A.H. Sellers, “A Five-Year Survey of Maternal Mortality in Manitoba, 1928-1932,” *Canadian Public Health Journal*, 25, 3 (March, 1934): 103-119. For a discussion of both this and the Ontario report see McLaren and

Many case studies also appeared in the medical journals pointing to the fact that women were having abortions – in some cases, repeated abortions – to control their fertility. These case studies supported the claims that abortion was increasing the maternal mortality rate and emphasized the preventability of deaths. For instance, Dr. James Goodall, Clinical Professor of Obstetrics and Gynecology at McGill University in Montreal, reported a number of cases he had seen in 1930:

#### Case 1

A case I saw in the out-patient's department was an abortion self-induced with stove-pipe wire. The woman had aborted three weeks previously...Death occurred a few hours after admission.

#### Case 2

I was called in consultation, to give a prognosis in a case of insanity (puerperal). There was a history of self-induced abortion twenty-two days previously...Death occurred eight hours after consultation

#### Case 3

I was called to the medical wards to see a recent admission; the medical diagnosis was suspected ectopic gestation. I elicited the history of an induced abortion one month previously...Death followed a few hours after admission.<sup>15</sup>

Such cases showed that despite the illegality of the procedure women were seeking to terminate their pregnancies and that they were aware of the means. As J. Wyllie, Professor of Preventive Medicine at Queen's University in Kingston, Ontario, noted in a 1933 article in the *Canadian Public Health Journal*, "the part played by abortion in maternal mortality is at present evoking serious consideration and there is reason to believe that the practice of self-induced abortion is

---

McLaren, "Discoveries and Dissimulations."

<sup>14</sup> Topics of Current Interest: A Clinical Study of Abortion", *CMAJ*, 35 (December, 1936), p. 692.

greatly on the increase.”<sup>16</sup>

Other doctors reported that some women had had more than one self-induced abortion, which proves that it was possible for the procedure to be successful. One such report came from a 1931 article by Dr. Murray Blair of the Department of Gynecology and Obstetrics at the Vancouver General Hospital. Dr. Blair suggested that “our experience seems to show that self-induced abortions brought on by drugs, exhaustion, and other agents cause little or no more trouble than the innocent accidental abortion.”<sup>17</sup> Dr. Blair was definitely in the minority with this view as the moral of other accounts was that the woman usually died from an illegal abortion.<sup>18</sup> Despite the dangers associated with the practice, doctors realized that women sought out abortions to get rid of unwanted pregnancies which posed a problem for doctors since botched abortions were inflating the maternal mortality rate.

Doctors, in their quest to determine the causes of maternal mortality, were faced with the problem that abortion was really an unknown factor in terms of the actual death rate. Doctors assumed that abortion deaths had to play a large role in the high maternal death rates. As Dr. J.H. Duncan of Alberta noted in the *Canadian Doctor* in 1940, “we stand aghast at the horrors of war - the wastage of human life and it is unspeakable. But compared with the casualties of abortion it is as but a grain of sand in the hourglass. We think of the Great War as a calamity of the first magnitude, and yet we are killing more babies each year than the annual casualty list

---

<sup>15</sup> Dr. James Goodall, “Puerperal Infections: An Extramural Lecture,” *CMAJ*, 22, 5 (May, 1930), p. 694. It is obvious that doctors’ perception implied by these reports was that self-induced abortions were quite dangerous.

<sup>16</sup> J. Wyllie, “Sex Differences in the Mortalities of Childhood and Adult Life.” *Canadian Public Health Journal*, 24, 11 (November, 1933), p. 535.

<sup>17</sup> Murray Blair, “A Conservative Treatment of Incomplete Abortion”, 25, 5 (November, 1931), p. 578.

<sup>18</sup> For examples of accounts which detail women’s demise from abortion see William Bethune, “Inversion of the Uterus,” *CMAJ*, 29, 6 (December, 1933), p. 631; W.B. Hendry, “The Problem of Hemorrhage in Obstetrical Practice,” *CMAJ*, 30, 6 (June, 1934), p. 629; D.F. MacDonald, “Missed Ectopic,” *Nova Scotia Medical Bulletin*, 16, 4 (April, 1937), p. 208; J.H. Duncan, “Maternal Mortality in Country Practice,” *CMAJ*, 38, 6 (June, 1938), p. 551; J. Ross Vant (Chairman), “Report of the Committee on Maternal Mortality,” *Alberta Medical Bulletin*, 3, 4 (October, 1938), p. 16; B.K. Coady, “Case Reports”, *Dalhousie Medical Journal*, 4, 1 (February, 1939), p. 43.

thereof.”<sup>19</sup> But the fact of the matter was that abortion was not really quantifiable.<sup>20</sup> In other words, doctors had no way of finding out the actual number of abortion deaths because it was often difficult to confirm that an abortion had been performed.<sup>21</sup>

Doctors were also unable to determine, in many cases, whether an abortion was performed illegally or not. This was due to poor reporting of maternal deaths and because women were often reluctant to confess having had an illegal operation. This was a concern for physicians because they were well aware that any maternal death factored into the statistics on the death rate.<sup>22</sup> Dr. Ross Mitchell, Senior Obstetrician at the Winnipeg General Hospital and Associate Professor at the University of Manitoba, for instance, worried publicly about the unknown number of abortion deaths in a 1935 article in the *Manitoba Medical Review*. “Since abortions are not notifiable, and as a doctor is often not called, no one knows their frequency, or what ratio they bear to labour at term. The ratio used to be stated as one abortion to six deliveries at term. Now in Canada it is probably one to four or even one to three.”<sup>23</sup> In short,

---

<sup>19</sup> J.H. Duncan, “Can Doctors Halt Declining Rate of Births?” *Canadian Doctor*, 6, 8 (August, 1940), p. 22. Duncan was from Manyberries, Alberta and it is interesting to note that, despite being from a small community, his views on abortion and birth control were consistent with those of the profession in this period indicating that there may not have been a difference in views between rural and urban physicians.

<sup>20</sup> This point is aptly made in a response which appeared in *Canadian Doctor* to Dr. Duncan’s article. The unknown respondent noted that “because all readers are not doctors...many people might not realize the inaccuracies of certain statements. There seems to be a confusion all through the article between birth control and abortion (or murder, as it is repeatedly called). Birth control - voluntary parenthood, racial selection, spacing of children, whatever you like to call it - has no consort with abortion and reduces abortion evils. For, with knowledge, no woman would resort to or be faced with the awful alternative of abortion.” *Canadian Doctor*, 6, 10 (October, 1940), p.13. Although some forms of birth control began to be accepted publicly by some members of Canadian society in the 1930s, we know from the declining birth rate that many Canadian couples had been limiting their fertility for some time. Even still, it is clear from this exchange that the need for birth control was still not embraced by some in 1940.

<sup>21</sup> This was not a new problem in the interwar period. Doctors and legislators alike had always complained of the inability to determine when a death was the result of an illegal abortion. For doctors the concern, of course, was that abortion deaths reflected negatively on their profession. For legislators, the concern was based on their inability to prosecute the criminal abortionist. For example see Susanne Klausen, “Doctors and Dying Declarations: The Role of the State in Abortion Regulation in British Columbia,” *Canadian Bulletin of Medical History*, 13, 1 (1996): 53-82; Constance Backhouse, “Prosecution of Abortions under Canadian Law, 1900-1950,” in Jim Phillips et al. (eds.) *Essays in the History of Canadian Law, Volume 5*, Toronto: University of Toronto Press, 1994: 252-292.

<sup>22</sup> Klausen, “Doctors and Dying Declarations”; McLaren and McLaren, *The Bedroom and the State*, p. 50-51.

<sup>23</sup> Ross B. Mitchell, “New Thoughts on the Prevention of Maternal Deaths,” *Manitoba Medical Review*, 15, 12 (December, 1935), p. 3.

abortion was a factor in the maternal death rate that was largely beyond doctors' control.

For doctors, the inability to determine and differentiate between a maternal death from natural causes and one from an illegal procedure was frustrating because their inability to quantify mortality rates raised doubts about their ability to prevent maternal deaths in general. Doctors were also concerned about patients dying from complications associated with illegal operations simply because being the attending doctor at time of death meant that they could be held responsible for the deaths themselves. Sometimes these cases had additional legal consequences for the physician involved. A report in *Saturday Night* in 1921 emphasized this point.

The death of an unfortunate young woman in a hospital the other day brings prominently to the front a nice question of ethics; that pertaining between patient and physician. The young woman had been brought to the hospital in a precarious condition, and she died. It was known to the physician who attended her that there had been a criminal operation, but beyond reporting the facts to the doctor in charge of his department nothing was done until after her death, when the matter came to the ears of the police. The police complain that had the physician notified the police department of the facts while the girl was still alive she might have been interviewed by the police, her ante mortem statement obtained and the person responsible run to earth. At the inquest the physician in charge of the case stated that he considered his a personal duty to the patient; the patient's confidence was inviolable. In other words any facts disclosed by the patient to the physician must of necessity be deemed secret.<sup>24</sup>

As Dr. Mitchell aptly put it, "the case of the patient first seen with a septic induced abortion is most difficult for the attending physician. Sometimes he is damned whatever course he

---

<sup>24</sup> Editorial, "The death of an unfortunate young woman," *Saturday Night*, 37 (December 3, 1921), p. 1. For a further discussion of ante mortem statements or dying declarations see Klausen, "Doctors and Dying Declarations"; McLaren and McLaren, "Discoveries and Dissimulations." In the United States see Leslie Reagan, "'About to Meet Her Maker': Women, Doctors, Dying Declarations, and the State's Investigation of Abortion, Chicago, 1867-1940," *Journal of American History*, 77 (March, 1991): 1240-1264.

pursues.”<sup>25</sup>

Doctors’ inability to determine the frequency of abortion practices and their perception that deaths from criminal abortions were reflected in the high death rate provided them with an explanation for the high mortality statistics, as well as an opportunity to reaffirm their disciplinary power over women’s bodies. “It seems wrong that deaths from abortion,” noted Dr. W.G. Cosbie of the Department of Obstetrics and Gynecology at the University of Toronto and the Toronto General Hospital,

...should be charged against a rate which suggests the danger of childbirth. It has been conservatively estimated that two-thirds of the deaths follow criminal interference, and it is therefore unfair that the physician or institution taking charge of such a case when either sepsis or hemorrhage may have already determined the fatal outcome should accept the responsibility for these deaths.<sup>26</sup>

Dr. Cosbie’s concerns underscored a large part of the problem that abortion posed for doctors in this period – their inability to determine whether an abortion was criminally induced or not. In a 1934 editorial in the *Canadian Public Health Journal*, Dr. J.T. Phair of Toronto suggested for instance that, “abortions (the termination of pregnancy prior to accepted period of viability) contribute to a greater than often conceived extent to this death rate.”<sup>27</sup> An interesting point about what the term “abortion” meant to doctors in this period is raised by this editorial. When using the term, doctors were not always referring to criminal abortion, but sometimes meant miscarriage. The ambiguity in the terminology made it even easier for doctors to inflate the number of deaths due to actual criminal abortions. This is not to suggest that doctors did not see

---

<sup>25</sup> Mitchell, “New Thoughts on the Prevention of Maternal Deaths,” p. 3. For a discussion of doctors’ responsibilities in terms of abortion deaths see Klaussen, “Doctors and Dying Declarations”; McLaren and McLaren, “Discoveries and Dissimulations.”

<sup>26</sup> W.G. Cosbie, “Maternal Mortality,” *CMAJ*, 43, 1 (July, 1940), p.39. Other doctors shared this concern. See R.E. Wodehouse, “Maternal Deaths,”; John Puddicombe, “The Importance of Prenatal Care,” *Child and Family Welfare*, 10, 2 (1934): 10-13; Karl M. Wilson, “The Problem of Maternal Mortality,” *CMAJ*, 34, 5 (May, 1936): 518-525; O.A. Cannon, “Septic Abortion,” *CMAJ*, 12, 3 (March, 1922): 163-168.

the results of criminal abortions or that they did not play a role in the maternal mortality statistics. What it does suggest is that it was easy for doctors to lump non-criminal abortions and criminal abortions together - allowing them to ensure that the blame for the high mortality rate was removed from them and their ability to prevent them.

The main thrust of the doctors' discussions of abortion was that they should not be held accountable for maternal deaths associated with illegal operations. If doctors were not responsible for the deaths, a discovery of who was to blame was needed. Once the fault was determined, doctors could reestablish themselves as the group with the knowledge to prevent maternal deaths. Based on the case reports and maternal mortality studies, as well as their own views about women's proper role in this period, it seemed obvious to them that it was women – those too enthralled with their public lives and not interested enough in their proper role as mothers – were to blame.

Doctors had first attempted to construct women as being destined to be mothers. But after the First World War there was increased fear among the middle-class that the wrong "races" were reproducing the population. In the *Canadian Public Health Journal* in 1920, Dr. A.C. Jost, Divisional Medical Health Officer of the Eastern Health Division in Guysboro, Nova Scotia noted that:

A world emerging from the delirium of an epoch-marking war is but commencing to count the cost and to appreciate the enormity of its losses. Among these losses not the least is that entailed by the slaughter of millions of combatants of a class most essential for carrying on the world's development, for doing the world's work, a class drawn from what must be considered the most valuable, so far as productivity is concerned, of the world's population...Reconstruction demands the effort of every unit which can be put into the struggle to offset the enormous losses of human life and fortune. Even under ante-war conditions, falling birth rates indicated the appearance of a period when the old

---

<sup>27</sup> Phair, "Why Maternal Deaths," p. 142.

racial stocks were facing the prospects of gradual disappearance and their replacement by races of alien descent. The tremendous reduction of the birth rates which has accompanied and was caused by the protracted struggle has introduced an unforeseen series of conditions which will tend to hasten the process. These factors combine to bring about a condition in which is emphasized the necessity of conserving every life which science or knowledge can preserve.<sup>28</sup>

Dr. Jost's concern over declining birth rates came in the context of post-World War I and the worry over the need to prevent overpopulation by undesirable races. This quote also emphasizes his faith that scientific knowledge would aid in preventing the undesirables from over-reproducing and these sentiments are underscored in the literature in medical journals of the interwar period. While the apprehension about the health of the race was a concern that existed before 1914, it was brought into focus even more in the aftermath of the war.<sup>29</sup> Through their increasing interest in public health, initially to combat infant mortality and then later, maternal mortality, doctors continued to look for ways to build a strong and healthy nation, the most important of which was for women (particularly women of Anglo-Saxon heritage) to have babies.<sup>30</sup>

---

<sup>28</sup> A.C. Jost, "The Conservation of Child Life", *Public Health Journal*, 11, 11 (November, 1920), p. 503.

<sup>29</sup> Prior to the war, the large influx of immigrants (about 800,000 in the first decade of the twentieth century) of non-Anglo-Saxon descent had been the concern of many doctors. See Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945*, Toronto: Oxford University Press, 1990, p. 46-51. For some examples of other articles which noted the need for race regeneration after the War see Editorial, "Signs of Decadence," *Canadian Journal of Medicine and Surgery*, 54, 6 (December, 1923), p. 182; Editorial, "Birth Control," *Social Welfare*, 5, 12 (September, 1923), p. 243-244. For a fuller discussion of the connection between eugenics and medicine see McLaren, *Our Own Master Race* especially chapter 2, "Public Health and Hereditary Concerns."

<sup>30</sup> Of course French Canadian women in this period were still having large families. For a discussion of the sexual behaviour of French Canadian women see Andr e L vesque, *Making and Breaking the Rules: Women in Quebec, 1919-1939* (trans. Yvonne Klein), Toronto: McClelland and Stewart, 1994. As Katherine Arnup points out, an elaborate system of institutionalized health care was developed in Canada between 1900 and 1920 at all levels of government and constituted one of the major changes in the role of government in society. *Education for Motherhood: Advice for Mothers in Twentieth Century Canada*, Toronto: University of Toronto Press, 1994, p. 24-28. See also Paul Bator, "Saving Lives on [the] Wholesale Plan": Public Health Reform in the City of Toronto, 1900-1930," PhD thesis, University of Toronto, 1979; Heather MacDougall, *Activists and Advocates: Toronto's Health Departments, 1883-1983*, Toronto: Dundurn Press, 1990. See also MacDougall's examination of the transition of the field of public health from the "explicit moralism of the 19<sup>th</sup> century sanitary crusade to the use of science as the basis of "rational living" in twentieth century in "Enlightening the Public": The Views and Values of the Association of Executive Health Officers of Ontario, 1886-1903" in Charles Roland (ed.), *Health, Disease and Medicine: Essays in Canadian History*, The Hannah Institute for the History of Medicine, 1984, p.436-464. Cynthia

This idea that women should first and foremost fulfil a maternal role had, of course, been present in the earlier period. However, the context of doctors' discussions had changed because of the impact of the First World War. The war had emphasized to society that it was possible to annihilate large numbers of the population in a short period of time and the influenza epidemic of 1918-1919 increased that concern. The importance of mothers to the regeneration of the population, therefore, became a central concern.<sup>31</sup> "For motherhood is not only the physical source of a people," noted a 1934 editorial in the *Canadian Public Health Journal*, "but one of the foundations upon which the nation is built."<sup>32</sup> The foundation that women were supposed to create with their reproductive activity was believed by some to be weakening as women took on new roles for themselves. This was a concern that had surfaced in the early period, but really became emphasized after the losses of the war. Statistics indicated that indeed, female labor force participation was on the rise. The figures showed that 17.7 % of women worked in 1921 and by 1941 that figure would increase to 22.9%. It was more likely in the 1920s and 1930s for women to take on paid employment at some point in their lives than ever before. Many women worked to help supplement their family incomes, whether by sharing their earnings with their

---

Comacchio, in *Nations Are Built of Babies* discusses the public health movements' attempts to combat infant mortality. See especially chapters 2 and 3.

<sup>31</sup> For instance see Annah L. Prichard, "Maternity," *The Public Health Journal*, 14, 7 (July, 1923), p. 322-324; Adelaide M. Plumptre, "A Mother's Duty to the State," *The Public Health Journal*, 18, 4 (April, 1927), p. 178-181. It is important to note that nurses in this period typically conformed their views to those of the medical profession. In her study of nursing professionalization in this period, Julia Kinnear has found for instance that elite nurses' views were similar to those of the medical profession on that issue. While she suggests that those nurses on the "front lines" may have had differing opinions from those writing in the journals, it is significant to note that those of elite nurses and doctors were the same. It appears that nurses' views of abortion and the proper role of women were consistent with this finding. See "The Professionalization of Canadian Nursing, 1924-32: Views in the *CN* and *CMAJ*," *Canadian Bulletin of Medical History*, 11 (1994): 153-174. For a discussion of scientific motherhood and the prescriptions for mothers to ensure that they were performing their proper roles, see Arnup, *Education for Motherhood*; Comacchio, *Nations Are Built of Babies*; Veronica Strong-Boag, *The New Day Recalled: Lives of Girls and Women in English Canada, 1919-1939*, Toronto: Copp Clark Pitman Ltd., 1993.

<sup>32</sup> Editorial, "Puerperal Mortality: Success or Failure?" *Canadian Public Health Journal*, 25, 12 (December, 1934), p. 600. See also H.W. Hill, "Prenatal Negligence and Loss of Population," *CMAJ*, 11, 9 (September, 1921): 615-619; W.B. Hendry, "Maternal Mortality," *CMAJ*, 13, 4 (April, 1923): 252-254; Ross Mitchell, "The Prevention of Maternal Mortality in Manitoba," *CMAJ*, 19, 9 (September, 1928): 292-296; Plumptre, "A Mother's Duty to the State."

parents and younger siblings, or by helping to support their own families. While some women may have delayed childbearing a few years to work, the majority did not remain employed after marriage and their incomes, for the most part, did not allow them any financial independence.<sup>33</sup>

Nevertheless, the perception remained that women were shirking their proper roles for new opportunities outside the home. A 1936 review article in the *Canadian Medical Association Journal* noted that, "the freedom that has resulted from the achievement of economic independence of women has played and continues to play...a distinct cause in the causation of maternal mortality."<sup>34</sup> The author pointed to the "frequent" continuation of work in "unsuitable occupations late into pregnancy" and suggested that "independence has probably resulted in a marked increase in abortions."<sup>35</sup> While female labour force participation probably did not in itself heavily impact on maternal mortality rates, doctors believed that women's paid labor was negatively impacting on their ability to be mothers, and, in turn, was negatively impacting on the maternal mortality rate. However, in the Depression it was really not that surprising that many mothers were attempting to limit their fertility – in many cases, they could not afford to have children.

The ongoing perception of doctors that mothers were shirking their responsibilities seemed evident in the steadily declining birth rate. The lower birth rate, coupled with maternal

---

<sup>33</sup> Strong-Boag, *The New Day Recalled*, p. 43. She notes that there was a definite drop in the general fertility rate (the annual number of births per 1000 women aged 15-49 years of age) in this period. Between 1911 and 1921 it dropped 1.4 percent, from 1921 to 1931 the drop was 22.3 percent, and from 1931 to 1941 the drop was 10.5 percent. These drops produced a 'Canadian pattern' of high marriage rates and relatively low marital fertility. Women were having fewer babies and producing them over a shorter period of time. p. 147. She also notes that women's wages were still only about 60% of those of men, and women in the interwar years typically worked in female job ghettos, employed in "traditional" female occupations like domestic work, teaching, clerical jobs, and the service industry. See chapter 2 of *The New Day Recalled*, "Working for Pay."

<sup>34</sup> Review article, "The Health of Women," *CMAJ*, 35, 5 (November, 1936), p. 572. A number of historians have addressed the entrance of women into the "public" sphere and how it impacted perceptions of femininity. For instance see Alison Prentice et. al. *Canadian Women: A History (Second Edition)*, Toronto: Harcourt Brace, 1996; Strong-Boag, *The New Day Recalled*.

<sup>35</sup> "The Health of Women," p. 572.

deaths, led many doctors to worry about the health of the nation.<sup>36</sup> One doctor, harkening back to nineteenth-century reports which suggested that even middle-class women were avoiding having children in order to make familial material gains, noted in a 1923 editorial in the *Canadian Journal of Medicine and Surgery* that, “limitation of families is now practiced by the classes from which it is desirable that the community should be recruited, and not practiced by the undesirables.” This doctor, however, was speaking from the vantage-point of post- First World War Canada. In his view, the recruitment effort during the war had shown that many of these young adults (those produced by the “undesirables”) had not only been “useless but a drag.”<sup>37</sup> Certainly the context in which doctors were discussing abortion and other issues had changed by 1919 because the lessons of the Great War were still fresh in their minds. The post-war period was also one in which the scientific regulation of behaviour was part of the modernizing trend – the desire for a more modern Canada to emerge from the losses and mistakes of the War.<sup>38</sup> Therefore, the medical profession’s overarching belief in the “truth” and progress of science continued after the War.

The mere idea that women had the knowledge of how to terminate a pregnancy, or worse, that they could perform their own procedure was still appalling for many doctors, despite the fact that it appears that doctors had always perceived that women had knowledge about fertility regulation. Doctors in the early period had also made similar laments. The prominence of this

---

<sup>36</sup> As Angus and Arlene Tigar McLaren have noted, the fear over the health of the nation came in part from demographic shifts that were occurring in Canada as in other parts of the western world. The fall in the fertility rates, generally blamed on women, “...was only a symptom of the major social and economic transformations Canada was undergoing at the turn of the century. Later commentators were to speak of the confidence and optimism of the age, but any examination of the population discussion uncovers many expressions of fear and foreboding...These shifts, [from a rural agrarian society to an urbanized one] though only partly understood at the time, were seen as posing major dangers. The population increased from 4.3 million in 1881 to 8.5 million in 1920, yet much of this growth was due to foreign immigration. In 1871, 60 percent of the population had been of British stock; in 1921, only 40 percent.” *The Bedroom and the State*, p. 16.

<sup>37</sup> Editorial, “Signs of Decadence”, *Canadian Journal of Medicine and Surgery*, 54, 6 (December, 1923), p. 182.

<sup>38</sup> Comacchio, *Nations Are Built of Babies*, p. 65-66.

issue in the discourse of the interwar period is indicative of how these issues are all interrelated, affecting each other. While always present, only certain issues become central to the discourse in certain periods because of the context in which doctors discuss abortion. In the case of the interwar period, the perception that women were taking steps to terminate their own pregnancies was important to doctors because of the impact such measures had on the maternal mortality rate. This was different from the early period when doctors were much more concerned with the connection between women attempting to regulate their own fertility and the morality of the practice. While the concern in the interwar period stemmed primarily from the connection between abortion and maternal mortality, doctors were also interested in this issue partly because illegal abortions questioned their role in surgical procedures (if abortions could be obtained safely from practitioners operating outside the boundaries of what was legal), and partly because they believed these women to be shirking their responsibilities as mothers.

In one case described in the *Canadian Medical Association Journal* in 1920, Dr. E.V. Frederick of Peterborough, Ontario reported the examination of one such patient:

I was called to see Mrs. -, age twenty-eight years, suffering from sever[e] abdominal colic which had lasted several hours. The temperature and pulse were normal, tongue clean, no abdominal rigidity or tenderness of distention, no diarrhea. I did not do a vaginal examination but made a diagnosis of intestinal colic. As I was leaving the room, a neighbor woman said to the patient Mrs. -, tell the doctor everything. This made me think there was more to the case than I had found out, so I went back and made a vaginal examination. In the posterior fornix I found a sticky mass, white and chalk-like in consistency. Then she told me that menstruation not having appeared on time, she desired to use a douche with some antiseptic tablets she had, but finding her syringe broken she had inserted the tablet as high in the vagina as possible...about two and a half weeks from the onset she died.<sup>39</sup>

This case report raises two important issues. First, the difference between symptoms of an

---

<sup>39</sup> Dr. E.V. Frederick, "Bichloride of Mercury Poisoning by Vaginal Application," *CMAJ*, 10, 8 (August, 1920),

intestinal disorder and that of a fatal infection did not seem to have been obvious to Dr.

Frederick, a sign that, although doctors promoted the infallibility of science, their diagnoses were not always as reliable.<sup>40</sup> It is also a good example of “horror” reporting. Public health nurse Esther Beith noted that this type of report was commonly employed by professionals to scare their patients away from illegal operations by presenting the consequences of trying to “fix” their own problems.<sup>41</sup>

To prevent women carrying out their own abortions Dr. O.A. Cannon of Hamilton, Ontario suggested in 1922 that, "...it should be enacted that druggists are not to sell without a physician's orders such articles as male catheters and sponge tents."<sup>42</sup> He further noted that,

the prevention of abortion is a phase of their [physicians charged with the administration of public health affairs] work which has yet received very little serious attention, and any activities have not been pushed with vigor. The birth rate would be very materially increased if the slaughter of unborn children could be prevented. Many women are losing their lives and many others becoming economic burdens through chronic invalidism following abortion...The best treatment of any condition is prevention. Abortion can be prevented in most cases.<sup>43</sup>

It was clear to doctors that it was necessary to take some measure to prevent women turning to abortion.

Prevention of abortion is connected to the second issue Dr. Frederick's case raises, the idea of the “designing women.” Some doctors worried that some women would attempt to trick or manipulate them into performing abortions. For instance, Drs. Harry and James Crossen

---

p.757.

<sup>40</sup> This idea is similar to Kathryn Montgomery Hunter's assertion that medicine is not a “true” science since it is based largely on doctors' stories. See *Doctor's Stories: The Narrative Structure of Medical Knowledge*, Princeton: Princeton University Press, 1991.

<sup>41</sup> These reports, essentially, gave doctors examples to share with their patients. Esther Beith, “Prenatal Nursing Supervision,” *Canadian Public Health Journal*, 28, 12 (December, 1937), p. 592-593.

<sup>42</sup> Cannon, “Septic Abortion,” p. 166. Canadian doctors were not the only professionals to discuss this problem. As nurse Hilda Murphy noted, “A patient who does not desire her baby will soon learn that if she persists in vomiting the pregnancy will be terminated, and some patients adopt extreme measures to prevent the completion of pregnancy.” “Nursing Care in Pre-Eclamptic Toxaemia and Pernicious Vomiting”, *Canadian Nurse*, 23, 1 (January,

suggested in their medical textbook that,

the persistent manifestation by the patient of a fixed idea that she has some pelvic disease, which in fact is not present may be due to beginning melancholia. On the other hand such complaints may be due to a deliberate attempt on the part of the patient to deceive the physician...hoping that the physician may use some examination method or treatment that would lead to an abortion.<sup>44</sup>

Another doctor suggested that the profession be aware of women seeking out abortions and they should “shun the very appearance of evil.” He warned his fellow practitioners that,

sympathy with the unfortunate woman who for any reason finds the circumstances of pregnancy a hardship should never cause him to suggest that it were better that her pregnancy be terminated. She would probably seize upon this suggestion and use it to salve her conscience in further search for help. A firm, tactful refusal from her family physician will in most cases put the idea out of her head.<sup>45</sup>

Other doctors shared these views. For instance, Dr. James Goodwin of Toronto noted in a 1936 article in the *Canadian Journal of Medicine and Surgery* that, “...it must be remembered that a patient may purposely give a misleading history of bleeding in order to obscure a diagnosis of pregnancy and in such cases curettage for diagnostic procedures might be avoided by careful examination of breasts and pelvic organs.”<sup>46</sup> In other words, Dr. Goodwin was suggesting that some women might lie about their condition in order to get a doctor to perform a diagnostic D & C operation which of course would terminate an existing pregnancy.

Clearly some doctors’ concerns were based on this idea that women would try to “trick” them into performing an illegal procedure. But part of their concern likely came from their

---

1927), p. 15.

<sup>43</sup> Cannon, “Septic Abortion”, p. 165.

<sup>44</sup> Harry Sturgeon Crossen and Robert James Crossen, *Diseases of Women (Seventh Edition)*, St. Louis: The C.V. Mosby Company, 1930, p. 111. See also Sir Comyns Berkeley, J.S. Fairbairn and Clifford White (eds.), *Midwifery (Fifth Edition)*, London: Edward Arnold & Company, 1935, p. 694.

<sup>45</sup> Cannon, “Septic Abortion,” p. 165-66. See also James C. Goodwin, “Diagnosis in Gynecology”, *Canadian Journal of Medicine and Surgery*, 79, 1 (January, 1936), p. 11.

<sup>46</sup> Goodwin, “Diagnosis in Gynecology,” p. 11. See also Coady, “Case Reports”, *Dalhousie Medical Journal*, 4, 1

experiences of women attempting to regulate themselves by taking abortifacient drugs or by using a variety of instruments.<sup>47</sup> Of course, they believed that the danger that existed in such non-medical attempts negatively affected the maternal mortality figures.<sup>48</sup> Some doctors did acknowledge, though, that there were extenuating circumstances in some cases which necessitated abortion and which could prevent maternal deaths.<sup>49</sup> They recognized the difficulty some women faced due to social or economic factors in continuing their pregnancies and also realized that those factors came with consequences which contributed to the high maternal mortality rate. As an article in *Canadian Nurse* noted in 1936, "...economic and social factors [are] contributing to the high rate of abortions among both married and unmarried mothers in these times."<sup>50</sup> What doctors recognized was that not all women were seeking to terminate pregnancies for "convenience" or to shirk their responsibilities as mothers. Some women felt they were simply unable to support a child. Despite this realization by some health care professionals, the high maternal mortality rate was their chief concern, and the idea that women were involved in compromising their profession led doctors to speak out against the practice. Most doctors, therefore, continued to stress that social or economic reasons should not factor into

---

(February, 1939), p. 43.

<sup>47</sup> It is interesting to note that, in terms of women really trying to "trick" doctors into performing an illegal procedure, the evidence suggests that many women still did not believe themselves to be truly pregnant until they experienced quickening of the foetus around four months gestation as had been the traditional belief, and were therefore not performing an abortion, but were simply regulating themselves. For instance see Cannon, "Septic Abortion," p. 166; Goodall, "Puerperal Infections," p. 694; Topics of Current Interest, "A Clinical Study of Abortion," *CMAJ*, 35 (December, 1936), p. 691; Coady, "Case Reports," *Dalhousie Medical Journal*, 4, 1 (February, 1939), p. 43; Fairbairn, *Gynaecology with Obstetrics*, p. 142.

<sup>48</sup> For instance see Cannon, "Septic Abortion," p. 166; Goodall, "Puerperal Infections," p. 694; Topics of Current Interest, "A Clinical Study of Abortion," *CMAJ*, 35 (December, 1936), p. 691; Coady, "Case Reports," p. 43; J.S. Fairbairn, *Gynaecology with Obstetrics - A Text-Book for Students and Practitioners*, London: Oxford University Press, 1924, p. 142.

<sup>49</sup> Dr. Helen MacMurphy noted that the first line of defence against maternal mortality was to take care of the mother. See "Neo-Natal Mortality," *The Public Health Journal*, 17, 9 (September, 1926), p. 445. See also E.W. Montgomery, "Maternal Mortality," *Manitoba Medical Bulletin*, 99 (November, 1929), p. 4; Unknown, "Maternal Mortality in Canada," *Canadian Nurse*, 42, 5 (May, 1936), p. 214; Beith, "Prenatal Nursing Supervision."

<sup>50</sup> Unknown, "Maternal Mortality in Canada," *Canadian Nurse*, 42, 5 (May, 1936), p. 214.

the decision to perform an abortion.<sup>51</sup>

One textbook on midwifery from this period noted, “no social questions, no pressure from husbands, relatives, or friends, no objections of the patient to continuing with the discomforts and troubles of her pregnancy, must be allowed to weigh in the decision [to abort]. The question is to be settled purely on medical grounds...”<sup>52</sup> Dr. Cannon even suggested that a vigorous education campaign including publication of the Criminal Code, along with information about the dangers of abortion, needed to be undertaken by doctors to influence women not to seek out abortions.<sup>53</sup>

Rather than having to resort to abortion, the better approach would have been prevent births in the first place. However, few doctors were willing (or able, at least publicly) to provide birth control information despite the fact that a variety of methods of birth control began to be more frequently discussed in this period, especially after Drs. Ogino and Knaus correctly determined the ovulation cycle in the late 1920s and published their findings in the 1930s.<sup>54</sup> As Dr. E. W. Montgomery, Minister of Health and Public Welfare for Manitoba, noted in 1929, “to improve the record in the case of patients whose general health is unsatisfactory might mean

---

<sup>51</sup> For instance see Henry, “Mental Hygiene During Pregnancy,” p. 148; Cannon, “Septic Abortion,” p. 166; Cynthia Comacchio has suggested that doctors did not want to face the socio-economic motivations for abortion and so, did not discuss the practice. *Nations Are Built of Babies*, p. 72.

<sup>52</sup> Berkeley, Fairbairn and White (eds.), *Midwifery* p. 694. Dr. Louise McIlroy emphasized the fact that doctors should never take these factors into account at a meeting of the British Medical Association, and that only medical needs should be considered. E. Percival, “The Induction of Abortion – Its Indications,” *CMAJ*, 16, 10 (October, 1926), p. 1275.

<sup>53</sup> In *The Nature of Their Bodies*, Wendy Mitchinson suggests that one of the reasons doctors in Victorian Canada talked about abortion was to scare their female patients out of attempting the procedure while at the same time reinforce their own self-image (p.140). However, as in the early period, doctors’ discussions of the practice were not likely to influence the general public because the articles in medical journals were intended for (and most read by) their colleagues rather than lay persons.

<sup>54</sup> It should be noted that, while birth control may have been more widely discussed, McLaren and McLaren suggest that no major advances were made in the area of birth control between the 1890s and the 1930s. Therefore, the declining birth rate occurred because “more couples intent on limiting their fertility conscientiously employed traditional methods. *The Bedroom and the State*, p. 22.

instructions on the delicate subject of birth-control..."<sup>55</sup> Many doctors felt that, although birth control was not their preferred solution, its practice would alleviate both women and doctors having to make a moral decision over an abortion. Of course it should be remembered that given the illegality of providing birth control information, doctors cannot be faulted for their reluctance to do so, although some had been well aware of the value of birth control as early as the nineteenth century.<sup>56</sup>

The unavailability of information about contraception meant that women arrived at hospitals in trouble, and doctors tried to save them. This concerned the profession, not just because it negatively affected the maternal mortality statistics, but because they were concerned for their patients' well-being. "From the standpoint of maternal welfare, apart from any moral or legal objections," argued prominent public health advocate Dr. Helen MacMurchy,

abortion must be regarded as associated with considerable danger to health, mainly on account of the sepsis which not seldom accompanies it, and also because of the unhealthy condition of the pelvic organs which may be one of its sequelae. Salpingitis or pelvic infection may be set up which may lead to chronic invalidism and permanent sterility...<sup>57</sup>

This suggests that doctors were placing more emphasis on the health of mothers because of their

---

<sup>55</sup> E.W. Montgomery, "Maternal Mortality", *Manitoba Medical Bulletin*, 99 (November, 1929), p. 4.

<sup>56</sup> One example of nineteenth century birth control promotion that comes instantly to mind is Dr. George Napheys, *The Physical Life of Woman – Advice to the Maiden, Wife and Mother*, Toronto: The Hunter-Rose Company Limited, 1869. For a full discussion of this book see Penny, "Getting Rid of My Trouble." Perhaps the best case of birth control promotion in the interwar period is that of A.R. Kaufman's Parent Information Bureau in Kitchener, Ontario. Kaufman, a local industrialist set up his own birth control clinic and sent "nurses" around the province distributing birth control information. For a full discussion of Kaufman and the PIB see Diane Dodd, "The Canadian Birth Control Movement on Trial, 1936-1937," *Histoire Sociale/Social History*, 16, 32 (November, 1983): 411-428; Gerald Stortz and Murray Eaton, "Pro Bono Publico: The 1936 Eastview Birth Control Trial," *Atlantis*, 8 (1983): 51-60; McLaren and McLaren, *The Bedroom and the State*, chapter 5. Other historians have also documented the availability of birth control information for women, for instance, Michael Bliss, "Pure Books on Avoided Subjects: Pre-Freudian Sexual Ideas in Canada," Canadian Historical Association, *Historical Papers*, (1970): 89-108; McLaren and McLaren, *The Bedroom and the State*. In the U.S. see Linda Gordon, *Woman's Body, Woman's Right: Birth Control in America*: New York: Penguin Books, 1990; Leslie Reagan, *When Abortion Was a Crime: Woman, Medicine, and Law in the United States, 1867-1973*, Los Angeles: University of California Press, 1997.

<sup>57</sup> Helen MacMurchy, "Report of the Committee on Maternal Welfare," *Nova Scotia Medical Bulletin*, 11, 4 (April, 1932), p. 462.

need to deal with the high maternal mortality rate. To some degree, this was a pragmatic approach by the profession as they sought to do two things. First, they wanted to maintain their professional status. Abortions were perceived as a factor in the maternal mortality rate, which called into question the ability of medical science to prevent maternal deaths. Doctors were well aware of how the studies on maternal mortality and their findings reflected on their professional status, and on the reliability of medical science. Second, their interest in maternal welfare was also a regulatory measure as they endorsed that well-mothers meant that women could fulfil their duty to the state through reproduction.<sup>58</sup> Although these themes existed in the early period, a shift which incorporated doctors' new interest in maternal welfare, as well as the hopes for a new, modern era after the War, appeared in the medical discourse on abortion.

As in the previous era, this shift was closely tied to doctors' own professional interest in the practice of abortion, and their desire to continue to promote their status as professionals. Although I am not suggesting that doctors did not have any interest in their patients' welfare prior to 1919, the concern had not led to the creation of programs to assist in the lowering of the maternal death rate, like maternal benefits which were implemented in the interwar period. It should be remembered, though, that while their discussions did incorporate concerns for maternal health, those concerns seem to relate, for the most part, to doctors' desire to ensure the building of a strong and healthy nation, which gave the medical profession the power to reinforce

---

<sup>58</sup> For instance E.W. Montgomery in an article in the *Manitoba Medical Bulletin* in 1929 noted that "the general health of the mother before and during pregnancy has been found to directly influence the mortality rate, the death rates being just double in that group which comprised individuals who were designated as having 'unsatisfactory' general health. "Maternal Mortality," p. 4. The health of mothers, and the campaign to promote prenatal education was of course very prominent in this period. For instance see, K.C. McIlwraith, "Obstetrics and the State," *CMAJ*, 10, 4 (April, 1920): 305-313; R.E. Wodehouse, "Maternal Deaths," *CMAJ*, 34, (May, 1936): 525-27; H.E. Young and J.T. Phair, "Maternal Mortality in Canada," *Public Health Journal*, 19, 3 (March, 1928): 135-36; Ethel Cryderman, "Significant Facts," *Public Health Journal*, 19, 4 (April, 1928): 191-192. A variety of articles dealing with mothers' duty to the state also appeared in the medical journals in the period between 1919-39. For instance, see Violet Trench, "The Home – The First Factory of the Nation," *Public Health Journal*, 16, 11 (November, 1925): 524-29; Plumptre, "A Mother's Duty to the State," *Public Health Journal*, 18, 4 (April, 1927): 178-181. It is interesting that many of these articles are written by women, both nurses and doctors and that their discourse does

existing gender stereotypes. Cynthia Comacchio has observed, "it must be considered that, at a time when doctors were among the foremost proponents of a maternalist ideology that was essentially pro-natalist, it was important to depict motherhood in its most positive light."<sup>59</sup>

Despite doctors' promotion of motherhood as the ideal for women, the high maternal mortality rate raised questions about whether women were actually living up to their idealized roles and emphasized the need of the medical profession to address and reinforce existing gender constructions. Maternal and child health were also important issues for the medical profession, particularly for those doctors involved with the public health movement.

In response to the maternal mortality issue and the belief it was inflated by abortion practices, Canadian doctors suggested three measures: more comprehensive obstetric training; the education of women about pregnancy, specifically, pre-natal education; and more accurate reporting and classification of maternal deaths.

### *Addressing the Problem of Maternal Mortality*

The first measure that doctors advocated to assist in the lowering of the maternal mortality rate was that those members of the profession dealing with pregnancy and related problems needed to be specially trained. Many believed that too little attention was paid to such practical issues in medical school. At a combined meeting of the Section of Obstetrics and Gynecology and the Section of Preventative Medicine and Hygiene at the Toronto Academy of Medicine in 1927, W.W. Lailey argued that "education of medical students, and medical practitioners" was needed so that they would "look upon obstetrics as on an equality with medicine and surgery." Only then would an operation in obstetrics be as carefully considered as any abdominal operation. "Obstetrics is the Cinderella of medicine," noted Lailey, "and she is

---

not seem to differ from the male medical discourse of this period.

<sup>59</sup> Comacchio, *Nations are Built of Babies*, p. 73. Doctors also believed in the importance of educating mothers for

only beginning to ascend to a proper position amongst her sisters.”<sup>60</sup> Hence, doctors were increasingly providing case reports in order to train doctors to recognize symptoms like those associated with puerpura, and to deal with the issue of puerperal sepsis. This call for specialization also allowed medical science a means of increasing its power over women’s bodies. The new obstetrician, with specialized training would “...know when and how to interfere as the emergency arises.”<sup>61</sup> Further, the obstetrician would be able to compare pregnancy and a host of contraindicative illnesses and conditions, allowing him to determine who should have a baby, and who should not. Dr. Helen MacMurchy quoted Dr. Herbert Williamson, President of the British Medical Association, from an address to the organization in 1925. Dr. Williamson noted, “obstetrics is essentially a branch of preventative medicine...[and] the dangers of child-birth are to a great extent preventable...” Further, he argued that the medical profession, as well as the general public needed to more clearly grasp this concept to lower the puerperal mortality rate.<sup>62</sup> Of course abortion was not seen as the only factor contributing to the maternal mortality rate. Doctors also discussed “meddlesome midwifery” and unnecessary intervention by doctors.

Although doctors recognized that their own practices could play a role in maternal mortality they also believed that mothers, for the most part, were uneducated in the matters of pregnancy and childbirth.<sup>63</sup> Hence the discourse emphasized that, not only did doctors need the

---

childbirth. See Arnup, *Education for Mothers*.

<sup>60</sup> W.W. Lailey, “The Progress of Maternal Welfare in the United States and Canada,” *The Public Health Journal*, 18, 6 (June, 1927), p. 254. Other articles emphasizing the importance of the role of obstetrics in combating maternal mortality include, J.R. Goodall, “Maternal Mortality,” *CMAJ*, 20, 10 (October, 1929): 447-50; Wodehouse, “Maternal Deaths”; Puddicombe, “The Importance of Prenatal Care”; K.C. McIlwraith, “Obstetrics and the State.”

<sup>61</sup> Dr. Joseph N. Nathanson, “Prophylaxis in Obstetrics, with Special Reference to the Value and Importance of Prenatal Care,” *CMAJ*, 14, 6 (June, 1924), p. 495.

<sup>62</sup> Herbert Williamson, President, at the 88<sup>th</sup> annual meeting of the British Medical Association as quoted in Helen MacMurchy, “On Maternal Mortality in Canada,” *Public Health Journal*, 16, 9 (September, 1925), p. 416. For more information about other aspects of the maternal mortality discussion see Cynthia Comacchio, *Nations are Built of Babies*; Arnup, *Education for Mothers*, Strong-Boag, *The New Day Recalled*.

<sup>63</sup> Comacchio, *Nations Are Built of Babies*, p. 71, 76; Wendy Mitchinson, *Giving Birth in Canada, 1900-1950*,

proper training and scientific knowledge to assist them to solve the problem of high maternal mortality, but also that women needed to be educated to accept medical opinion as truth.<sup>64</sup> Despite acknowledging that doctors could sometimes be at fault for maternal deaths, the implication was that, in general, it was the ignorance and carelessness of mothers who did not heed the advice of the medical profession when it came to the prescriptions for pregnancy, who were responsible for the high rate of maternal mortality.

The second measure advocated by doctors to lower the maternal mortality rate was the education of women about pregnancy and the hazards associated with abortion. Doctors also considered that education about the indications for therapeutic abortion would be beneficial because it would help women to understand why it was appropriate to terminate pregnancies in certain contraindicated cases when there was a need to protect women's health. Doctors were attempting to reshape not only their own role as guides for women in pregnancy (they were moving from "moral" guides to "health" guides), but also women's perceptions of their own reproductive functions so that they would match those of the medical profession. Although they wanted women to understand when it was appropriate to terminate a pregnancy, they were certainly not suggesting that the decision to terminate should be left up to women. In effect, the opposite was true – doctors wanted to further enforce the need to consult the medical profession and these measures were an attempt to combat women who sought out termination of their pregnancies on their own. The profession wanted to ensure that women understood what was appropriate in terms of their own care during pregnancy to avoid maternal death but also for doctors to take on some responsibility in this regard. For instance, in their "Report on Maternal

---

Toronto: University of Toronto Press, 2002, chapter four.

<sup>64</sup> Certainly doctors used their knowledge/power to shape the discourse in a way that would continue to enforce their disciplinary power. All aspects of the mortality problem structured the professional discourse. In fact, the professional discourse incorporated these "problem" physicians by advocating that specialized training was

Mortality” presented by the Committee on Maternal Mortality to the annual meeting of the Association of Medical Health Officers of the province of Nova Scotia in 1928, Drs. F. E. Rice and E.E. Bissett noted that doctors needed to “take care of the mother and she will take care of the baby...Are we willing to take care of the mother? She doesn’t want to go to her doctor at the beginning of pregnancy. Can we help to change her mind? Can we explain to her what we have learned so that she will take our word for it? Will she adapt herself to new ways of saving herself in child-bearing?”<sup>65</sup> Despite such assertions, doctors knew that some women could simply not be saved because they experienced contraindications to their pregnancies.

Following Dr. Williamson’s line of thought about obstetrics being preventative, many articles were written in this period about a variety of illnesses from tuberculosis to heart disease to mental illness which doctors believed were contraindicative of pregnancy. In other words, certain conditions served as a means for doctors to decide when, or if pregnancy should be terminated. The indications for therapeutic abortion largely reflected doctors’ need to address the high maternal mortality rate and at the same time reflected their reliance on and faith in medical science. For instance, one doctor noted in 1920 how to deal with the pregnancy of a woman with tuberculosis. “Intervention after the fifth month,” he suggested, “rarely gives satisfactory results. Prior to the fourth month, it is possible that the mother’s future may be improved by emptying the uterus through the modern operation of vaginal hysterectomy under gas, ether, and anesthesia, that is by avoiding shock incident to a prolonged operation or ordinary anesthesia or loss of blood.”<sup>66</sup> An American doctor suggested in a 1920 issue of *The Canada*

---

necessary for those doctors treating women.

<sup>65</sup> F.E. Rice, “Report on Maternal Mortality,” *Public Health Journal*, 19, 12 (December, 1928), p. 577. Many other studies advocated that women needed to be educated about proper pre-natal care and their health in general. For instance see, Cannon, “Septic Abortion”; MacMurchy, “Neo-Natal Mortality”; Editorial, “Maternal Mortality and the Practice of Obstetrics,” *CMAJ*, 20, 2 (February, 1929): 180-81; Nathanson, “Prophylaxis in Obstetrics”; Dr. J.T. Phair, “Health Propaganda,” *The Public Health Journal*, 13, 4 (April, 1922): 145-148.

<sup>66</sup> Proceedings of the Ontario Medical Association, “Pregnancy and the Tuberculous Woman,” *The Canada Lancet*,

*Lancet* that, in women who suffered from toxemia in pregnancy “the treatment par excellence is induction of abortion.”<sup>67</sup> Other doctors suggested that heart disease, Addison’s disease, pernicious vomiting and even mental illness could be contraindications to pregnancy.<sup>68</sup>

The indications for therapeutic abortion were not only a topic of interest to Canadian doctors. For instance, a discussion of this issue by the British Medical Association in 1926 was reported in the Miscellaneous column of *The Canadian Medical Association Journal*.<sup>69</sup> This article reported that during the discussion Dr. T. Watts Eden noted that, “as a rule, indications for interference [in pregnancy] fall under two headings, (1) Medical, which includes phthisis, chronic nephritis, infection of the urinary tract, diabetes mellitus, heart disease and diseases of the nervous system. (2) Obstetrical, including toxæmic vomiting, vesicular mole, missed abortion and hæmorrhage.” Under the “medical” conditions for therapeutic abortion Dr. Watts

---

53, 11 (July, 1920), p. 33. See also F.H. Pratten, “Pulmonary Complications in Pregnancy,” *CMAJ*, 24, 3 (March, 1931): 391-396; Review, “Therapeutic Abortion in Pulmonary Tuberculosis,” *CMAJ*, 26, 4 (April, 1932): 500.

<sup>67</sup> Elmer S. Waring, “The Toxaemias of Pregnancy,” *The Canada Lancet*, 53, 12 (August, 1920), p. 557. Insanity was identified as a possible contraindication to pregnancy. For instance see Paul T. Harper, *Clinical Obstetrics*, Philadelphia: F.A. Davis Company, 1930, p. 570; R. Alan Brews, “General Diseases in Relation to Midwifery,” *The Canada Lancet and Practitioner*, 80, 4 (April, 1933): 111-116. However, not all doctors were convinced that insanity should be a reason for a therapeutic abortion. For examples of doctors being cautious about this contraindication see Berkeley, Fairbairn and White (eds.), *Midwifery*, p. 218; George W. Henry, “Mental Hygiene During Pregnancy,” *Manitoba Medical Review*, 18, 8 (August, 1938): 148-50. Addison’s Disease was also identified as a contraindication to pregnancy in this period. See L.G. Montgomery, “Abstract of ‘The Question of Therapeutic Abortion in Addison’s Disease,’” *CMAJ*, 28, 1 (January, 1933): 107.

<sup>68</sup> On the discussion of pregnancy and heart disease see for instance, D. Grant Campbell, “Pregnancy and Heart Disease,” *CMAJ*, 13, 4 (April, 1923): 244-249; William J. Stevens, “Recent Advances in Obstetrics,” *Canadian Nurse*, 27, 6 (June, 1932): 285-289; Arthur Birt, “More Odds and Ends,” *The Nova Scotia Medical Bulletin*, 16, 5 (May, 1938): 374. On tuberculosis see “Pregnancy and the Tuberculous Woman,” *The Canada Lancet*, 53, 11 (July, 1920): 33-34; F.H. Pratten, “Pulmonary Complications in Pregnancy,” *CMAJ*, 24, 3 (March, 1931): 391-396; Eleanor Percival, “Obstetrics and Gynaecology: Therapeutic Abortion in Pulmonary Tuberculosis,” *CMAJ*, 26, 4 (April, 1932): 500. On toxæmia see Waring, “The Toxaemias of Pregnancy.” See also Montgomery, “The Question of Therapeutic Abortion in Addison’s Disease”; S. Kobrinsky, “Pernicious Vomiting of Pregnancy with Autopsy Findings,” *CMAJ*, 19, 5 (November, 1928): 574-575.

<sup>69</sup> Regular reports from the profession appeared in *The Canadian Medical Association Journal* throughout the periods under examination including a regular column entitled, “The London Letter.” Canadian physicians had always maintained a close association with their counterparts overseas. S.E.D. Shortt has suggested that one reason for this might be because of the way the profession itself became professionalized in the nineteenth century. See “Physicians, Science and Status: Issues in the Professionalization of Anglo-American Medicine in the Nineteenth Century,” *Medical History*, 27 (1983): 51-68. F.L. Morton among others has noted how, with respect to abortion and abortion law, Canada followed Britain’s lead dating back to the original law against abortion in Canada which followed the legal precedent of Lord Ellenborough’s Act (1803). See *Pro-Choice Vs. Pro-Life: Abortion and the*

Eden also discussed the seriousness of complications like “pulmonary tuberculosis,” and “pyelitis due to *B coli*” to pregnancy.<sup>70</sup> Yet while these diseases and afflictions represented contraindications similar to those earlier noted in chapter one, it is clear that doctors questioned why they were still definite indications for the performance of a therapeutic abortion. Another doctor speaking to the same group, Dr. Louise McIlroy emphasized that, in her mind, “induction of abortion was a confession of failure” because scientific advances were limiting the number of indications for therapeutic procedures.<sup>71</sup>

Dr. McIlroy’s belief that medical indications for abortion should have declined was representative of the profession’s belief in the ability of science to “advance” medicine. Doctors’ forceful promotion in the early period of the power of science to protect the mother in childbirth helped them to establish their status as a profession. This, in essence, set the stage for them to justify their concerns that the maternal mortality rate negatively impacted that status in the interwar period. Citing a large number of contraindications to justify therapeutic abortion seemed to undermine the premise that science was advancing. Yet, how could doctors argue that science had “advanced” the human condition when they observed women dying in hospital emergency wards from maternal causes, many associated with abortion? And how could they justify that the same contraindications existed in the interwar period as had existed in the earlier years? Doctors, therefore, needed to address both the high maternal mortality rate and the issue of therapeutic abortions, recognizing that the two were connected because of the potential of therapeutic abortion to prevent at least those deaths which were the result of illegal operations. For these reasons, doctors began to acknowledge, albeit quietly, other reasons women sought out illegal operations, expanding the indications for therapeutic abortion to include those cases

---

*Courts in Canada*, Norman and London: University of Oklahoma Press, 1992, p. 17-19.

<sup>70</sup> E. Percival, “The Induction of Abortion – Its Indications”, *CMAJ*, 16, 10 (October, 1926), p. 1275.

where not only the mother's *life* was at risk, but also her *health*.

Although doctors were concerned about their patients' health in the early period, their definition of health had changed by the interwar years.<sup>72</sup> Health in the early period had been synonymous with life - to maintain a mother's health, her life had to be protected in childbirth. Regular doctors' struggle with irregulars to gain control over their profession had necessitated the view that any illness in pregnancy which might threaten the mother's life justified a therapeutic abortion. After the First World War, however, the assumption that life equalled health was questioned as medical science strove to eliminate, or at least deal more effectively with contraindications to pregnancy. At the same time, the number of women that doctors encountered who attempted illegal operations did not decline. In fact, if anything, the number of illegal operations was increasing.<sup>73</sup> The profession, then, needed to reconcile the advancement of medicine with the demand for abortion. To do so, other reasons for therapeutic abortion were considered. Dr. Frederick Taussig, writing about abortion in the interwar period, explained the situation this way.

In general one might say that since the World War there have been two movements running counter to each other. On the one hand physicians have declared with increased evidence that certain maternal conditions such as tuberculosis, heart disease, pernicious vomiting, etc., did not require therapeutic abortion as often as reports in previous decades would seem to have indicated...The other group...are trying rather to extend the indications for therapeutic abortion, particularly among the poor and ignorant by whom contraceptive measures are usually inadequately employed. The disastrous social-economic consequences of the War, necessitating the limitation of offspring at all hazards, have led a group of honest and well-meaning physicians to advocate an extension of

---

<sup>71</sup> *Ibid.*

<sup>72</sup> Of course the best example of the changing definition of health was the *Bourne* case.

<sup>73</sup> As Dr. W.A. Dafoe noted in "The Types and Treatment of Abortion," "self-induced abortions appear to be increasing in frequency. In our public wards at the Toronto General Hospital about 40 per cent of our incomplete abortions give a history of self-induction..." *CMAJ*, 22, 6 (June, 1930), p. 794. In 1935, the Canadian Council of Child Welfare estimated that 1 in 5 to 1 in 7 of all pregnancies were being terminated. *Need Our Mothers Die?* Ottawa, 1935 as quoted in Comacchio, *Nations Are Built of Babies*, p. 72.

therapeutic indications to eugenic factors, to general debility, poverty and excessively large families.<sup>74</sup>

It is perhaps not surprising that Taussig would acknowledge that some doctors were advocating eugenics as a therapeutic measure given that doctors were the single largest group of eugenic advocates. As Angus McLaren has noted, doctors played an important role in social planning because of their scientific medical knowledge which led those in authority to turn to them for assistance. And doctors rose to the occasion during World War One through their promotion of a variety of social management methods.<sup>75</sup> However, while some doctors may have recognized that socio-economic conditions could play a role in women's decisions to terminate their pregnancies, for the most part, the profession did not address such conditions beyond acknowledging that they existed.<sup>76</sup>

Besides eugenic factors, some doctors included mental illness as a consideration. For instance, Dr. Paul T. Harper in his obstetrics textbook noted that, "child-bearing and child-care are unquestionably important etiological factors in mental disease; and, with the latter developed, the patient is rendered wholly incapable of caring for her offspring. This consideration alone would seem to justify induction of abortion..."<sup>77</sup> Dr. R. Alan Brews, an Obstetrical and Gynecological Surgeon reporting in *The Canada Lancet and Practitioner* noted of insanity during pregnancy that, "this is usually transitory and the patient has generally recovered in a year's time, but it is safer that she should never be allowed to have a baby again; therefore, if pregnancy reoccurs it should be ended."<sup>78</sup> Other doctors were not convinced, however, that mental disorders justified therapeutic abortion. One doctor noted the example of a woman admitted to a maternity hospital because of a history of mental illness. In her case "the pregnancy was permitted to continue because the patient seemed in good physical health. She

---

<sup>74</sup> Frederick J. Taussig, *Abortion Spontaneous and Induced: Medical and Social Aspects*, St. Louis: The C.V. Mosby Company, 1936, p. 278-279.

<sup>75</sup> McLaren, *Our Own Master Race*, p. 29.

<sup>76</sup> In other words, although doctors recognized that class was a factor in maternal mortality, the same emphasis remained: "what was required were medical supervision and education of women." Comacchio, *Nations Are Built of Babies*, p. 71.

<sup>77</sup> Harper, *Clinical Obstetrics*, p.570; Percival, "The Induction of Abortion", p. 1275.

<sup>78</sup> Brews, "General Diseases in Relation to Midwifery," p. 116.

was not sufficiently depressed at the time to attract attention.”<sup>79</sup>

These discussions emphasized the degree of power wielded by the medical profession. In fact, many of the doctors writing about maternal mortality in this period put forth the notion that unwell mothers generally were causing an increase in the maternal mortality statistics (a convenient assertion in that it put the blame on mothers, rather than on physicians or "science" itself). It is interesting to note how doctors were setting up a win-win situation for themselves and embedding it in the medical discourse. On the one hand, they were advocating better education for mothers to encourage women to have faith in their doctors and medical science. On the other, they were creating a scenario whereby women who did not heed the advice of medical prescriptions by getting pre-natal exams, etc. were blamed for the deaths, instead of the doctors. As Dr. J.T. Phair noted in a 1921 address to the Section of State Medicine at the Academy of Medicine in Toronto, “in any discussion on the subject of Health Propaganda, probably the most important single thing to be borne to mind is, that nothing worth while in Preventative Medicine is possible without the great mass of the people being willing to accept, and aid in such a forward movement...”<sup>80</sup> What, wondered Phair, was the best way to “disseminate to every corner of the community the great mass of knowledge that now lies ready to hand, in the keeping of all Health workers.”<sup>81</sup> The specialty of obstetrics was one way of distributing this knowledge. Doctors could ensure that their profession would have the last word in deciding who could, and could not have a baby and by connection, an abortion. Some doctors even went so far as to suggest that women who were afflicted with certain medical conditions that would prevent childbearing should not marry at all. The goal was clearly to eliminate, whenever possible, the potential causes for the high maternal mortality rate.<sup>82</sup>

---

<sup>79</sup> Henry, “Mental Hygiene During Pregnancy,” p. 148.

<sup>80</sup> Phair, “Health Propaganda”, p. 145.

<sup>81</sup> *Ibid.*, p. 145.

<sup>82</sup> See D. Grant Campbell, “Pregnancy and Heart Disease.” Campbell noted that “pregnancy and marriage are not justifiable in cases of auricular fibrillation or myocarditis as here defined.” p. 249. Another article stated that “a bad heart contraindicates marriage; if married, the woman should not become pregnant, if pregnant, interruption should be considered.” William J. Stevens, “Recent Advances in Obstetrics,” *Canadian Nurse*, 27, 6 (June, 1922), p. 289. See also Birt, “More Odds and Ends.” Birt advocated that women with mitral stenosis should be equipped with “the necessary birth control knowledge and leave the decision to herself and her intended partner, who should be privy to

It is evident from the medical literature that the reason that many doctors made these suggestions was because they cared about their patients; they most often privileged the mother's life over the foetus and if a problem arose were willing to take great measures to ensure that the mother lived.<sup>83</sup> Nonetheless, they were also interested in promoting their professions' unique ability to determine not only the viability of pregnancies, but also who was physically fit to be a mother. In other words, ensuring that mothers lived was good for the status of the profession. However, not all doctors agreed on how to determine viability. As one doctor noted in 1926, "while realizing that ideally therapeutic abortion should be advised only when completion of the pregnancy would endanger the future health of the patient...one [could] not always abide rigidly by this rule." This doctor went on to question whether the medical profession had the right to put a woman through the ordeal of an unwanted pregnancy which she herself was unwilling to face. This, of course, was an ethical question which he suggested could be solved only after careful consideration of each individual case.<sup>84</sup>

One such case in Britain seemed to reinforce the power of doctors to decide what was ethical and what was not. The case occurred in 1938 and was reported in the *Canadian Medical Association Journal*. A young girl of less than fifteen who had been assaulted and raped by some soldiers became pregnant. She was taken to see an obstetric surgeon, Dr. Aleck Bourne, who admitted the girl to a hospital for observation. The report indicated that "he had a strong bias from the beginning in favor of an abortion, but he did not perform it until he had satisfied himself, by tests and observation, that the girl in all probability, if she had gone to term, would have suffered grave and lasting nerve damage which would have expressed itself in psychoneurotic and physical illness perhaps for the whole of her life."<sup>85</sup> What was at issue in the case was whether there was a difference between danger to life and danger to health of the

---

the special risks and advice given..." p. 374.

<sup>83</sup> Especially since a live mother meant that the mortality statistics would not rise. In other words, ensuring that mothers lived was good for the status of the profession. A number of articles, therefore, discussed when it was appropriate to perform a therapeutic abortion. For instance, see Bowers, "Justifiable Artificial Abortion"; Report, "The Induction of Abortion as a Therapeutic Measure."

<sup>84</sup> Percival, "The Induction of Abortion," p. 1275.

<sup>85</sup> Topics of Current Interest, "Therapeutic Abortion and the Law", *CMAJ*, 39, 4 (October, 1938), p. 402.

mother for the justification of the performance of a therapeutic abortion. The judge in the case ruled that “no line can be drawn between danger to life and danger to health: that no doctor knows whether life is in danger until the patient is dead; and that if on reasonable grounds, based on adequate knowledge, after consultation with colleagues, a doctor forms the opinion that the probable consequences of the continuance of pregnancy would make the woman a physical or mental wreck, then he is not only entitled, but it is his duty, to perform an abortion.”<sup>86</sup>

The *Bourne* case is particularly interesting because it demonstrates the shift that occurred in the medical discourse of the interwar period. Doctors in the late nineteenth and early twentieth centuries had promoted the idea that abortion was morally wrong at any point in the pregnancy and this was reflected in the law - the law and doctors’ rhetoric, went hand-in-hand. In the interwar period, although the law on abortion did not change, the medical profession was much more outspoken about the practice, particularly therapeutic abortion. This was because it was clear to them that the legal constraint on the performance of such procedures set them up for professional failure when women died and their deaths were reflected in the high maternal mortality figures. It is important to recognize that, although therapeutic abortion was part of their necessary practice in the earlier period as well, it was not an explicit part of the rhetoric surrounding abortion. What changed in the interwar period, of course, was doctors’ focus on maternal mortality. This led them to look for concrete ways to prevent maternal deaths, and they believed that one was their ability to perform therapeutic abortions. This is not meant to imply that doctors were completely comfortable with their legal position on the matter.

Despite the precedent which the *Bourne* case seemed to set, doctors still questioned their legal ability to perform therapeutic abortions. Even before *Bourne* doctors recognized the fact that the law did not clearly address therapeutic abortion. For instance, Dr. J.S. Fairbairn had noted in his British gynecology textbook in 1921 that, “though the law does not forbid the procurement of abortion when necessary on medical grounds, neither does it recognize therapeutic induction of abortion or premature labour, and the onus of proof of the need for such

---

<sup>86</sup> *Ibid.*

a measure may, therefore, be said to rest on the shoulders of the practitioner or practitioners who advise and carry it out.”<sup>87</sup> Another medical text from this period noted the importance of ensuring that there were indeed therapeutic indications for the termination of a pregnancy (as opposed to “social questions...pressure from husbands, relatives, or friends...[or] objections of the patient to continuing with the discomforts and troubles of her pregnancy”) and that the question of abortion “be settled purely on medical grounds.”<sup>88</sup> The discourse held that doctors alone could, and indeed, should determine when it was morally and ethically justifiable to perform an abortion, based of course, on their scientific knowledge.<sup>89</sup> What the *Bourne* case confirmed, therefore, was that ultimately, it would be the doctor with his scientific methods, who would decide when and if an abortion should be performed, rather than the law or the legal profession, a shift which began to entrench the medicalization of the issue which would impact heavily on later legislation. However, in cases where a doctor was not involved in the decision to abort and a death occurred (presumably the fault of the mother), the issue was raised as to how doctors classified these deaths, and where abortion deaths factored into the maternal mortality statistics.

Beyond special training in obstetrics for doctors and education for women about pregnancy and the hazards of abortion, the third measure that doctors advocated for lowering the maternal mortality rate was a more effective way of classifying maternal deaths. Essentially, it was an accounting measure since the number of women dying did not change, but how those

---

<sup>87</sup> J.S. Fairbairn, *Gynaecology with Obstetrics - A Text-Book for Students and Practitioners*, London: Oxford University Press, 1924, p. 141.

<sup>88</sup> Berkeley, Fairbairn, and White (eds.), *Midwifery*, p. 694. A number of texts and articles dealt with the medical grounds for the performance of abortion in this period. See Percival, “The Induction of Abortion - Its Indications”; Book Review, “Ante-Natal Care,” *CMAJ*, 24, 4 (April, 1931): 618; Nathanson, “Prophylaxis in Obstetrics, with Special Reference to the Value and Importance of Pre-Natal Care”; Montgomery, “Abstract of ‘The Question of Therapeutic Abortion in Addison’s Disease’”; Kobrinsky, “Pernicious Vomiting of Pregnancy with Autopsy Findings”; Birt, “More Odds and Ends”; Stevens, “Recent Advances in Obstetrics”; Campbell, “Pregnancy and Heart Disease.”

<sup>89</sup> An interesting example of a doctor believing an abortion was medically indicated but who had difficulty persuading the woman to provide consent to the procedure can be found in S. Kobrinsky, “Pernicious Vomiting of Pregnancy with Autopsy Findings.” The woman was apparently a Catholic and it went against her religious beliefs to consent to the procedure. p. 574 Doctors generally viewed the life of the mother as taking precedence over the foetus in this period. For instance see a review of W.F. T. Haultain et. al., “Ante-Natal Care,” *CMAJ*, 24, 4 (April, 1931), p. 618.

deaths were classified did. In all of the studies conducted, doctors found that it was not easy to pin down the number of abortion deaths. How a maternal death was classified depended ultimately on the differing judgements and conflicting concerns of doctors, coroners, and magistrates. As Angus and Arlene Tigar McLaren have observed, the difficulty in determining the rate of abortion deaths as compared to the overall maternal death rate exists because not all deaths known to medical authorities as being due to illegal abortion were reported to either vital statistics or the legal authorities. They suggest two reasons for this. First, medical authorities did not necessarily always report maternal deaths from abortion. This may have been because an ante-mortem or deathbed statement was not taken, because the death certificate was not filled out completely and/or accurately, or an autopsy may not have been performed. Whether intentional or not, this lack of accurate reporting meant that the figures for deaths from illegal operations were inaccurate and underestimated. Second, sometimes doctors simply did not want to report abortion deaths. Their refusal to report was to protect their own reputations, their colleagues, or their patients because of the moral stigma attached to the practice, much less its illegality.<sup>90</sup> Another reason is that the category of abortion itself could encompass statistics for spontaneous abortion or miscarriage as well as induced abortion where differentiation between the two often did not exist. In the case of spontaneous abortion, the cause of death could be hemorrhage which could be listed under either category. However, induced abortions were certainly more likely to cause death from sepsis.<sup>91</sup> For these reasons, Toronto doctor K.C. McIlwraith in a 1919 address delivered to the Section of Obstetrics and Gynecology at the Academy of Medicine in Toronto entitled, "Obstetrics and the State," called for "more fully classified reports [to be] issued on the causes of maternal deaths"<sup>92</sup> in order to better determine more precisely how women died. This would help, the medical profession suspected, to demonstrate that many of the deaths contributing to the high maternal mortality rate, were due to causes (like abortion) beyond the

---

<sup>90</sup> McLaren and McLaren, *The Bedroom and the State*, p. 45-50.

<sup>91</sup> Comacchio, *Nations Are Built of Babies*, p. 71.

<sup>92</sup> McIlwraith, "Obstetrics and the State," p. 311; Phair, "Maternal Mortality – A General Survey"; F.E. Rice, "Report on Maternal Mortality", *The Public Health Journal*, 19, 12 (December, 1928): 577-579.

attending physicians' control. Part of the problem in the existing classification system was that doctors were often hesitant to explain the cause of death if it was suspicious in order to protect his or her patient. Not only that, if a doctor had failed to obtain a dying declaration or deathbed statement from the woman in his care indicating who had performed their abortion, it was entirely possible that the attending doctor at time of death could be charged with the crime. More accurate death certificates, then, were certainly an issue, especially when a death was classified as caused by puerpera. And they would also help to clarify the issue of under-reporting of abortion cases; quantification of abortion deaths would be possible and a clear link between abortion and maternal mortality could be established, exonerating the doctors by indicating that many of the deaths were beyond their control.

In response to the inaccuracy of death certificates because they either were incomplete or did not clearly indicate the cause of death, McIlwraith called on the state to regulate how they were filled out, to standardize coroners' reports, and to include more information on the cause of maternal deaths. He argued that more accurate death certificates could help to classify a death that was noted as being due to puerperal causes. Puerperal causes indicated that sepsis, or blood poisoning had occurred. Although this condition could stem from other factors, most often it was linked to an abortion and he was advocating that they be classified as such. As one doctor noted in 1930, "in my experience it [puerperal infection] has occurred most frequently after self-induced abortion."<sup>93</sup> Doctors believed that standard reporting methods of maternal deaths needed to be created, and that state agencies regulating the recording of deaths needed to assist in this matter.<sup>94</sup>

The issue of state intervention in assisting doctors to more fully classify reports was an important one that was discussed frequently in medical journals. The desire by doctors for state intervention in these issues suggests that they were soliciting support for their role in

---

<sup>93</sup>Goodall, "Puerperal Infections," p. 694; Copeland, "Obstetrical Fundamentals and Maternal Mortality or The Four Horsemen of Death and Damage to Motherhood Sepsis, Toxemia, Hemorrhage and Shock."

<sup>94</sup> For instance see Klausen's discussion of municipal and provincial state agencies and abortion deaths in her article, "Doctors and Dying Declarations."

reproduction. In essence, the state could reinforce their disciplinary power. Some doctors requested maternity benefits to help ensure that women had access to proper prenatal care, as well as assistance to support their families during confinement. They also wanted assurance of the power to remove their patients to hospitals for care in the event that the medical profession felt it warranted. Most of the support from governments in this period, though, came in the form of educational programs to train mothers to accept the scientific knowledge of doctors.<sup>95</sup>

Doctors could benefit from maternity benefits, of course, because they would ensure that women would have the means to pay for prenatal exams, etc, an issue particularly important during the Depression. This meant that doctors would then have the opportunity to shape women's perceptions of childbirth by providing them with scientific information about the process and so enforce the primary role of doctors. Of course, doctors also argued that these measures would help to more accurately determine the maternal mortality rate by classifying some puerperal deaths as abortions. These classifications would confirm that induced abortion deaths were the women's fault, not the doctors, demonstrating that it was not a lack of scientific knowledge/power causing death, but a factor beyond the control of the attending physician.

This chapter has argued that there was a shift in the medical discourse on abortion from the late nineteenth and early twentieth centuries to that of the interwar period. After the First World War doctors were forced to restructure the discourse in light of a static, high maternal mortality rate. The high death rate had become an issue largely because of the changing societal context which emphasized the demographic losses of the war and need for regeneration of the population, while the period was viewed by the medical profession as a new, modern era.

Doctors' perception that abortion practices were contributing to the high death rate which called into question their scientific ability to protect women from the dangers of childbirth, together

---

<sup>95</sup> Dr. K.C. McIlwraith discusses such benefits in his article, "Obstetrics and the State," as well as provides "case studies" of impoverished patients who he deemed would benefit from the antiseptic environment of a hospital. For a discussion of doctors' increasing promotion of hospitals as the safest place to give birth in this period see Veronica Strong-Boag and Kathryn McPherson, "The Confinement of Women: Childbirth and Hospitalization in Vancouver, 1919-1939," *BC Studies*, 69/70 (Spring/Summer 1986): 142-174. See also Jo Oppenheimer, "Childbirth in Ontario: The Transition from Home to Hospital in the Early Twentieth Century," *Ontario History*, 75, 1 (March, 1983): 36-60.

with the fact that abortion deaths called into question how women viewed their roles in society, encouraged them to discuss the issue because their perception simply did not fit within the context of a post-War society that placed a great deal of emphasis on the rebuilding of the nation, and the importance of protecting the ideal motherhood to do so. This led them to ensure that they were the ones who had the power to speak about abortion procedures in this period. They did this by enforcing the hierarchy that had been established in the late nineteenth century with their regulation of the profession, giving them the authority to define what constituted wellness and illness, and determining what actions could be deemed "unphysiological." These enforcements ensured that medicine, rooted in "scientific" knowledge, was empowered to continue to define gender roles and to emphasize the central role of doctors' disciplinary power over women's bodies. Doctors used their scientific knowledge to shape the discourse on abortion in this period in terms that continued to regulate reproduction while at the same time legitimizing the scientific knowledge of the medical profession.

But they also called for assistance in this legitimization. Doctors increasingly encouraged the state to legislate ways to more effectively classify maternal deaths. More accurate death certificates, they believed, would help to differentiate between maternal deaths from natural causes, and those from illegal operations. In addition to more fully classified reports, doctors called on the state to legislate assistance to mothers in the form of maternity benefits. Not only would benefits assist mothers in receiving proper prenatal care, but they would also help to affirm the belief that doctors' scientific knowledge was integral to childbirth, in some cases, that their knowledge could help to prevent maternal deaths by determining contraindications to pregnancy prior to conception. The message of the profession in this period was clear. If women did not heed the advice of the professionals, doctors could not be held responsible for their deaths.

How doctors spoke about, and indeed conceptualized abortion and its connection with the maternal mortality rate in the interwar period demonstrates how doctors changed their discourse. They moved it away from one which had focused on the morality of the practice and regulation

of the medical profession in the late nineteenth and early twentieth centuries, to one which attempted to use abortion as a means of explaining why Canada had such a high maternal mortality rate. The discourse of the interwar period, therefore, emphasized that doctors (and medical science) were not to blame for the high maternal death rate. Their knowledge/power, which was rooted in scientific "truths" about women's bodies and their proper role in society, allowed them to promote the regulation of reproduction and this provided a forum for the continued construction and justification of gender differences. In the case of women in the late nineteenth and early twentieth centuries, it had been said that they were "made to be mothers." While the same sentiment existed in the interwar period, the losses of the War, the continuing decline of the birth rate and the concern over the high maternal mortality rates of this period encouraged the medical profession to reshape and reinforce the stereotypes to fit changing societal contexts.

The unchanging maternal mortality rates in the context of the interwar period led doctors to conclude that women continued to seek out illegal abortions in the case of unwanted pregnancies, and that their deaths, were "artificially" inflating the maternal death rates. To combat this problem, doctors promoted proper training on the part of individual physicians in the specialty of obstetrics and education for women approaching childbirth to devise more effective ways of recording and classifying maternal deaths in maternal mortality statistics. All of these measures served to ensure that it was the doctor who determined, not only who could have a baby, but also who could have an abortion. The *Bourne* case shifted doctors' perceptions about what the legal indications for abortion were and suggested that they had the right to determine the criteria for therapeutic abortion - criteria which allowed doctors to expand their definition of health. The importance of the *Bourne* case would be seen in the period between 1940-1969 as doctors struggled to determine, not only what their legal rights as medical professionals was in terms of abortion, but also how their definition of health would evolve.

Doctors reinforced their power to speak in the interwar period using abortion as a means to combat their fears about the high maternal mortality rate. Because of their belief in the truth

of science, doctors felt they had the right to speak and assumed that right. In the next chapter, the legacy of doctors' disciplinary power is explored. Although the maternal death rate was lowered and stabilized by 1940, doctors continued to discuss maternal mortality and, by connection, abortion.

### Chapter Three

#### ***“They Die Smiling”: Doctors, Maternal Welfare and Abortion, 1940-1969***

A 1946 editorial in the *Canadian Medical Association Journal* reflected on the measures implemented to combat the high maternal mortality rate in the interwar period. It noted that,

there has been a marked and gratifying decrease in maternal mortality since 1931, the rate for 1943 reaching the figure of 2.8 [per 1000 live births], as against 4 for 1940. This is attributed to several factors, such as educational efforts (especially the Maternal Mortality Survey of 1926 and 1927); the increase in prenatal services; more and better hospital facilities; and improved obstetrical technique.<sup>1</sup>

Educational efforts which included the promotion of the specialization of obstetrics, the promotion of prenatal care including indications for therapeutic abortion and dangers of criminal abortion, and more accurate classification of maternal deaths had contributed to the lowering of the maternal mortality rates in the interwar period. Doctors were keen to build on their success after 1940. To wipe out maternal mortality altogether was an ambitious goal, although one that doctors believed was within reach as medical science continued to advance. Indeed, medical improvements had allowed them to limit the number of contraindications to pregnancy so that conditions like heart disease and tuberculosis no longer posed a threat to expecting mothers. New drugs, like sulfonamides which began to be generally used to treat infections after 1936, continued to improve one's chances if an infection had set in.<sup>2</sup>

---

<sup>1</sup> Editorial, “Maternal and Infant Mortality in Canada,” *CMAJ*, 54 (May, 1946), p. 493. Improvements in socio-economic conditions also had a positive impact on the maternal death rate. See Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945*, Toronto: McClelland and Stewart, 1990, p. 35.

<sup>2</sup> Despite the use of such drugs, a rise in deaths from sepsis in 1936 had occurred which puzzled at least one doctor. “It was rather curious that there was a sudden sharp rise in the mortality from sepsis in 1936, about the time that the sulfonamides first began to be generally used” he noted. Looking back, this is probably not that curious because widespread use of the drug had probably not yet been adopted. The same doctor indicated that “on the other hand,

Overall, doctors witnessed a decline and stabilization of maternal mortality rates which they believed was largely a result of their reliance on and promotion of scientific medicine. Indeed, the measures taken in the interwar period had all contributed to the reduction of the death rate while at the same time assisting the profession to ensure that their disciplinary power remained. Their power was, of course, derived from their ability to reduce maternal mortality - a sign of scientific progress.

Although doctors were happy with the progress being made with respect to maternal mortality, claiming that the profession was saving thousands of lives with new methods of practice, both preventive and practical, they were cautious in their optimism, suspecting that, despite improvements in the death rates, they had not reached the ideal reduction in maternal mortality. These deaths could negatively impact the professional status that they worked so hard to achieve. For instance, Winnipeg's Dr. Ross Mitchell noted in 1941 that "a maternal death is the climax of sorrows, and every effort must be made to reduce such deaths to the irreducible minimum."<sup>3</sup> Other doctors echoed Dr. Mitchell's sentiment and called for further reductions in the maternal mortality rate.<sup>4</sup> A preliminary report from Vital Statistics in 1940 had stressed the need for vigilance by doctors in their quest to reduce the maternal mortality rates because no clear explanation for its decline could be found. The report suggested that,

we have no reason to feel assured that the momentarily brighter picture [of maternal mortality] will continue, but it behooves those whose particular job lies in this field to inquire into the observed

---

the mortality rate fell steadily from that year on" which seems to support this view. See Editorial, "Maternal and Infant Mortality in Canada," p. 493.

<sup>3</sup> Ross Mitchell, "Maternal Deaths in Manitoba," *CMAJ*, 45 (August, 1941), p. 161.

<sup>4</sup> For instance, see W.G. Cosbie, "Maternal Mortality," *CMAJ*, 43 (July, 1940): 38-44; Presley A. McLeod, "Maternal Mortality from the Viewpoint of the Obstetrician," *CMAJ*, 42 (January, 1940): 53-56; F.W. Jackson, N.R. Rawson, E. Couture, "Maternal Mortality in Manitoba, 1933-1937 (Second Five-Year Period)," *Canadian Public Health Journal*, 31 (July, 1940): 307-321; H.B. Atlee, "Some Life-Saving Procedures in Obstetrics," *CMAJ*, 49 (November, 1943): 378-382; Ernest Couture, "Maternal Hygiene in Wartime," *Canadian Journal of Public Health*, 35 (May, 1944): 175-180; Jean F. Webb, "Observations on Maternal and Infant Health in Canada," *Canadian Journal of Public Health*, 45 (January, 1954): 1-6.

facts further...If this improvement [in maternal mortality] is to be maintained, and not sporadic, however, it is desirable that some light be thrown on the most probable answer to our question: What is the explanation of the observed decline?<sup>5</sup>

Toronto Professor Dr. H.B. VanWyck shared this sentiment. "It will continue to be the aim of all those who by research, teaching and practice endeavour to attain the highest possible standard to reduce maternal mortality to the vanishing point."<sup>6</sup> Throughout the 1940s, 1950s and 1960s, doctors continued their quest to reduce maternal deaths by building on the measures implemented to combat the problem in the interwar period. Despite their efforts and the advances which followed, one factor limited doctors' ability to totally reduce maternal mortality. That factor was criminal abortion. As Kingston doctor Presley A. McLeod noted at the fifty-ninth Annual Meeting of the Ontario Medical Association, "abortion is the third greatest cause of maternal deaths."<sup>7</sup> Although Dr. McLeod did acknowledge that some abortions were spontaneous,<sup>8</sup> he suggested that many abortions were induced (and, therefore, criminal) and that induced abortions were of the greatest concern to doctors because "post-abortal sepsis is the great factor in causing these deaths."<sup>9</sup> Put in these terms, doctors of this period remained concerned about the connection of abortion to the maternal mortality rate and continued to look for ways to address the problem. This chapter, therefore, examines how, in the 1940s, 1950s and 1960s, doctors attempted to improve on the advances they made as a profession in the interwar period as they related to maternal mortality. First, doctors encouraged the completion of detailed

---

<sup>5</sup> A. Hardisty Sellers, "Vital Statistics: The Recent Improvement in Maternal Mortality in Canada," *Canadian Public Health Journal*, 31 (1940), p. 39. Although this report was printed in 1940 the preliminary statistics were from 1938.

<sup>6</sup> H.B. VanWyck, "Recent Advances in Obstetrics of Interest to the General Practitioner," *CMAJ*, 62 (February, 1950), p. 119.

<sup>7</sup> McLeod, "Maternal Mortality from the Viewpoint of the Obstetrician," p. 54.

<sup>8</sup> Spontaneous abortions are also referred to as miscarriages.

<sup>9</sup> McLeod, "Maternal Mortality," p. 54. See also Cosbie, "Maternal Mortality," p. 39; D.B. Stewart, "Abortions," *The Manitoba Medical Review*, (November, 1941), p. 211; Editorial, "Maternal Deaths in Manitoba," *CMAJ*, 45 (August, 1941), p. 160.

maternal mortality surveys which they believed would further improve the classification of maternal deaths. Second, with better classification of deaths doctors hoped they would be able to more clearly differentiate between abortion and non-abortion deaths. By doing so, it became evident that women induced their abortions in specific ways. Doctors investigated and reported abortifacient use hoping that not only would the profession be better able to determine such cases when they were presented with them, but also that such information would help them to deter other women from attempting to end their pregnancies. Third, doctors continued to promote increased educational efforts about the benefits of prenatal care, including proper facilities in which to deliver their babies,<sup>10</sup> and the risks of criminal abortion in order to reduce the problem of maternal mortality. The need for these measures and their discussion in the medical journals of this period suggest that doctors continued to be concerned about maternal mortality. What is also significant about their discussions of maternal mortality and abortion in this period was that the statistics they gathered about this problem demonstrated that there was indeed a connection between illegal abortions and maternal mortality.

The scientific examinations of the maternal death rate that were undertaken in Canada between the 1930s and 1960s proved conclusively that illegal abortion did in fact play a role in maintaining the high maternal mortality rate. The ongoing presence of abortion in the maternal mortality figures suggested to the profession that there was more to the abortion issue than

---

<sup>10</sup> These measures were related to the larger overall effort to medicalize pregnancy and childbirth. See Wendy Mitchinson, *Giving Birth in Canada, 1900-1950*, Toronto: University of Toronto Press, 2002; Katherine Arnup, *Education for Motherhood: Advice for Mothers in Twentieth Century Canada*, Toronto: University of Toronto Press, 1994; Cynthia Comacchio, *Nations Are Built of Babies: Saving Ontario's Mothers and Children, 1900-1940*, Montreal: McGill-Queen's University Press, 1993; Catherine Lesley Biggs, "The Response to Maternal Mortality in Ontario, 1920-1940," MSc thesis, University of Toronto, 1983, p. 47, 49 as quoted in Arnup, *Education for Motherhood*, p. 137. Jo Oppenheimer, "Childbirth in Ontario: The Transition from Home to Hospital in the Early Twentieth Century," in Katherine Arnup, Andree Levesque, and Ruth Roach Pierson (eds.), *Delivering Motherhood: Maternal Ideologies and Practices in the 19<sup>th</sup> and 20<sup>th</sup> Centuries*, London: Routledge, 1990. Suzann Buckley, "The Search for the Decline of Maternal Mortality: The Place of Hospital Records," in Wendy Mitchinson and Janice Dickin McGinnis (eds.), *Essays in the History of Canadian Medicine*, Toronto: McClelland and Stewart, 1988. See

women shirking their responsibility as mothers. The statistical reality of abortion caused them to shift their discussions of the practice from one which criticized women for their part in abortion practices to one which sought ways to improve women's overall health to ensure maternal welfare. The centrality of women's welfare was new in this period and doctors addressed the idea that not only was women's health important but that factors outside the body also influenced women's well-being. While the idea of the welfare of mothers was present in the medical profession's discussions of abortion, their main discussions of women's welfare emerged in their discussions of birth control as they began to acknowledge the need to provide women with some way to avoid having to resort to abortion to control their fertility. Improving women's welfare, it was thought, would reduce the need for criminal abortion. At the same time this shift from a focus on abortion within the context of maternal mortality to discussions of abortion in the context of improved maternal welfare allowed doctors to continue to regulate reproduction albeit in a seemingly more women-centered way. It also allowed them to continue to address their concern for women's health in connection to their professional status which would later be evident in their recommendations for changes to the legislation on abortion.

### ***Studying Maternal Mortality***

Despite a reduction in maternal mortality by the 1940s, doctors still discussed ways to improve the maternal death rate and based their discussions on the ongoing study of maternal mortality in individual provinces, most notably Manitoba and Ontario, but also Nova Scotia, Saskatchewan, Alberta and British Columbia.<sup>11</sup> These studies sought indicators for maternal

---

also Veronica Strong-Boag and Kathryn McPherson, "The Confinement of Women: Childbirth and Hospitalization in Vancouver, 1919-1939," *BC Studies*, 69/70 (Spring/Summer 1986): 142-174.

<sup>11</sup> W.T. Noonan and D.E. Cannell, "A Seven-Year Study of Maternal Deaths in Ontario (1958-1964)," *Ontario Medical Review*, 32 (1965): 705-707; Jackson, Rawson, and Couture, "Maternal Mortality in Manitoba"; Noel R. Rawson, "Maternal Deaths in Manitoba: The Findings of the Pregnancy Survey Conducted by the Department of Health and Public Welfare from May 1, 1938 to April 30, 1940," *Canadian Public Health Journal*, 32 (1941): 55-69; M.G. Tompkins, "Maternal Mortality Study," *The Nova Scotia Medical Bulletin*, 37 (1958): 69-71; L. Kawula,

deaths in the hopes that, once indications were found, further reduction in the maternal death rate would be possible. Clear identification and classification of maternal deaths was needed because, as we saw in chapter two, doctors wanted to ensure that deaths that were not preventable, such as those caused by illegal abortions, were not attributed to physicians' inability to prevent the death of the mother in childbirth. Their ability to "prove" that doctors were not responsible was more possible by 1940 as the studies they conducted reflected the scientific nature of medicine by providing statistics on the causes of maternal deaths.<sup>12</sup>

Statistics from a pregnancy survey conducted by the Department of Health and Public Welfare of Manitoba from May 1, 1938 to April 30, 1940 provided evidence, for instance, that a major factor in deaths from haemorrhage and puerperal sepsis, the second and third largest causes of death in the 1940s, was illegal abortion. Abortions headed the list of causes of death from puerperal sepsis with just over twenty-two percent of the deaths attributed to the practice.<sup>13</sup> Prominent physician and Professor of Medicine, Dr. H.B. Atlee of Halifax put it another way when he noted that, "the two death-producing factors in abortion are sepsis and haemorrhage."<sup>14</sup> By 1940, therefore, statistical proof that abortion contributed to the maternal mortality rate existed which meant that the issue could be viewed as a real problem.

In order to address this issue, doctors began to not only investigate the causes of maternal deaths but to assign a measure of responsibility. Dr. W.G. Cosbie first noted that studies in the

---

"The Evolution of Maternal Mortality Study in Saskatchewan," *Saskatchewan Medical Quarterly*, 22 (September, 1958): 62-68; J. Ross Vant, "The Contribution Made by Maternal Mortality Study Committees," *CMAJ*, 82 (June, 1960): 1303-1308; J. Ross Vant and Ronald H. Horner, "Maternal Mortality in Alberta, 1935-1958," *Alberta Medical Bulletin*, 25 (May, 1960): 49-53. In Ontario a number of reports on a variety of causes of maternal deaths were published in the *Ontario Medical Review*, with the larger maternal mortality reports being published in the interwar period. British Columbia's first report on maternal mortality in that province seems to have come much later than the other provinces mentioned in 1965. See C.W. Carpenter and F.E. Bryans, "Maternal Mortality in British Columbia: A Study of 145 Deaths from 1955 to 1962," *CMAJ*, 92 (January, 1965): 160-170.

<sup>12</sup> Cynthia Comacchio has noted that the maternal mortality studies of the interwar period were intended to reflect the scientific nature of medicine. That the intent was the same in the period spanning 1940-1960 is certain. See *Nations Are Built of Babies*, p. 73.

<sup>13</sup> Rawson, "Maternal Deaths in Manitoba," p. 56. See also Editorial, "Maternal Deaths in Manitoba," p. 160.

United States, in particular a study conducted by the New York Academy of Medicine in 1933, had made an effort to “ascribe the responsibility for the mortality to either the physician or the patient.”<sup>15</sup> A similar study in Canada, suggested Cosbie to the profession, would show errors in the accuracy of death certificates, and that “incorrect diagnoses were most numerous when death was due to abortion or septicaemia.”<sup>16</sup> This claim certainly supported the suspicions of earlier researchers that abortion was a hidden cause of high maternal mortality rates. Indeed, Dr. Cosbie suggested that abortion was “a major factor in contributing to the death rate.”<sup>17</sup> This sentiment was shared by other doctors of this period as it had been earlier.

As we have seen, doctors in the interwar years made a number of suggestions about ways to deal with the high maternal mortality rates such as improved obstetrical training, more accurate classification of maternal deaths, and prenatal education for women. These measures were designed to address the problem of criminal abortion deaths without drawing too much attention to the fact that they were occurring.<sup>18</sup> In the 1940s, 1950s, and 1960s, doctors built on the maternal mortality studies to more accurately differentiate between the causes of maternal deaths and to assign responsibility for those deaths. In many cases, doctors were concerned that members of the profession erred in their treatment of women. There can be no question that doctors recognized the importance of case reports in order to ensure that their practices were up-to-date and to ensure that members of the profession were capable of saving mothers in a variety of trying circumstances. Of course in the case of criminal abortion, this was problematic since women were often reluctant to admit to having either attempted to induce their own miscarriages or to having had a procedure performed for that purpose. Doctors were also often not consulted

---

<sup>14</sup> H.B. Atlee, “Some Life-Saving Procedures in Obstetrics,” *CMAJ*, 49 (November, 1943), p. 378.

<sup>15</sup> Cosbie, “Maternal Mortality,” p. 38.

<sup>16</sup> *Ibid.* See also Comacchio, *Nations Are Built of Babies*, p. 72.

<sup>17</sup> Cosbie, “Maternal Mortality,” p. 39.

about abortion. Rather, many women self-diagnosed their need to terminate their pregnancies, which of course went against what the medical profession promoted given their desire to be at the centre of all health care issues.<sup>19</sup> A 1964 maternal mortality report from the *Ontario Medical Review* recounted the following case which helps to show this point:

A married 15-year-old patient, approximately eight weeks pregnant with her first pregnancy, was admitted to hospital with a suspected septic abortion, although she denied interference with the pregnancy...Autopsy showed a puncture through the top of the uterus, and the uterus contained *no identifiable pregnancy tissue*...Death was presumed due to perforation of the uterus, with massive infected haemoperitoneum with *B. Welchii* septicemia, and septic shock with renal shutdown.<sup>20</sup>

This particular case was one of eight reviewed in this maternal mortality report. The symptoms presented by this unfortunate young woman were consistent with a criminal abortion. As the report noted, “we must all be aware of the extreme dangers of criminal abortion, dangers because it is usually carried out by semi-skilled individuals or unskilled individuals under conditions which, while making for secrecy, deny asepsis.”<sup>21</sup> Indeed, the other cases consisted of abortions by some form of douching, so this particular case stands out as being different. The most likely explanation for the perforation of the uterus was that someone, the woman or an abortionist, had inserted something into the uterus to procure an abortion. As an earlier report noted, one of the lessons to be learned in such cases was that physicians should be highly suspicious of any abortion that presented itself for treatment because it might have been criminally induced. Those

---

<sup>18</sup> Comacchio, *Nations Are Built of Babies*, p. 72-73.

<sup>19</sup> This is still true today. Currently, evidence-based medicine which is the practice of determining appropriate courses of treatment based on current medical research, is becoming more and more popular especially among HMOs in the United States. While in theory this approach seems to be sound, the problem is that the medical literature and research changes very frequently. Not only that, many doctors do not like being “removed” from the practice of medicine where they often rely on intuition as well as indicators which vary from patient to patient to determine the appropriate courses of treatment. The point is that, with respect to abortion in this period, doctors wanted to be involved in any decision to terminate pregnancy and to be able to determine whether an abortion was indicated in any given patient. I would like to thank Dr. Michael Clarke of the Faculty of Medicine at the University of Western Ontario for pointing out the issues around evidence-based medicine to me.

abortions were much more likely to become infected and require treatment and “more abortions are indeed criminally induced than any of us realizes.”<sup>22</sup> Doctors continued to be highly suspicious of women who arrived for treatment in septic states because despite advances in the treatments for infections, the risk was still high that women who attempted illegal abortion would die from the procedure. Given the risks associated with illegal abortion for both women and physicians, ongoing study into maternal deaths was needed.

The maternal mortality studies undertaken between 1940 and 1960 were similar in approach to those of the interwar period. What was different in the studies of this period was the attention paid to the importance of “social aspects of maternal mortality.”<sup>23</sup> Investigators noted the boom in both population and the birth rate which had occurred during the post-war years while at the same time, noting the death rate was decreasing. Coinciding with this was an increase in the abortion rate which seemed to stand out in their investigations into maternal deaths. As Dr. James Mitchell, Chairman of the Manitoba Medical Association’s Maternal Welfare Committee reported in *The Manitoba Medical Review* in 1964, the maternal mortality rate in Canada had dropped to between 3 and 6 deaths per 10,000 live births from a rate of 50.8 in 1930.<sup>24</sup> Initially, doctors felt that an “irreducible minimum” in maternal death rates had been achieved and, therefore, provincial maternal mortality committees needed only to report their own provincial statistics on maternal mortality and to remind the profession of a variety of hazards associated with pregnancy like haemorrhage, toxæmia, as well as other health-related

---

<sup>20</sup> Maternal Mortality Report No. 19, “Abortion”, *Ontario Medical Review*, 31 (April, 1964), p. 289.

<sup>21</sup> *Ibid.*, p. 290.

<sup>22</sup> Maternal Mortality Report No. 7, “Septic Abortions – ‘They Die Smiling,’” *Ontario Medical Review*, (January, 1962), p. 43.

<sup>23</sup> Carpenter and Bryans, “Maternal Mortality in British Columbia,” p. 169.

<sup>24</sup> James R. Mitchell, “Maternal Welfare – A Challenge,” *The Manitoba Medical Review*, 44 (October, 1964), p. 461.

contraindications to pregnancy as they had in the earlier period.<sup>25</sup> “However,” Dr. Mitchell continued,

it was noted on review of deaths that 50 to 75 per cent of the deaths each year could have been prevented, and therefore in 1958 a national committee of the Canadian Medical Association was set up with each province represented by the chairman of the provincial maternal mortality committee.<sup>26</sup>

In fact, the national Maternal Welfare Committee was actually established in 1957 at a meeting of the Canadian Medical Association to investigate the causes of maternal deaths, a process which, until that time was undertaken by the individual provinces. The Committee, after having met on several occasions that summer, was able to make a number of recommendations. They recommended that a “central coordinating unit for the analysis of all maternal deaths in Canada...” be organized so that all maternal deaths could be investigated in a uniform manner. This was related to the recommendations from the interwar period. The Committee further noted that,

We envisage that this would best be done by The Canadian Medical Association, as this is the only central organization in Canada taking in all provinces and all types of practitioners in medicine. Certain provinces already have such schemes in local use and some have not, and we have had the benefit of the suggestions from those provinces who already have such schemes in operation...we hope that, by the pooling of their collective experience of all Canada, certain facts will emerge which will be of benefit to all Canadian mothers and their children.<sup>27</sup>

---

<sup>25</sup> Most provinces had their own Maternal Mortality Committees who investigated provincial maternal deaths. Manitoba seems to have led this initiative, followed by Ontario.

<sup>26</sup> Mitchell, “Maternal Welfare – A Challenge,” p. 461.

<sup>27</sup> “Report of the Committee on Maternal Welfare,” *Annual Minutes of The Canadian Medical Association, 1957*, p. 50. Resolution A read: “1. Every maternal death should be investigated to ascertain the cause of death. 2. A Committee to accomplish this should be set up in units representing 10,000 annual live births as a district. Provincial branches to be responsible for this organization. 3. The case should be surveyed by the local practitioners in the first instance but these may, at the discretion of the local Committee, be discussed anonymously. 4. It is suggested that an independent observer be invited to sit in at this discussion. The observer should be one with special skills in the field to be discussed, e.g. toxicology or biochemistry. 5. A permanent record of the proceedings is to be made with two copies filed with the Provincial Maternal Welfare Chairman, who will in turn forward one copy with any comments he deems necessary to the Central Maternal Welfare Committee Chairman. 6. It is

On the one hand, the Committee took a national approach to maternal welfare. This seems to suggest that doctors were continuing their attempts to increase the status of professional medicine in this period, particularly as it was related to maternal mortality.<sup>28</sup> On the other hand, the Committee was also careful in this recommendation to ensure that, "...in no circumstance, do we envisage the collection of this data as ever serving a punitive purpose..."<sup>29</sup> This comment was clearly related to earlier concerns about doctors being charged with deaths from abortion. They wanted to continue to increase their status and at the same time this meant that they needed to ensure that they protected their members from being accused of performing illegal operations. It was also related, however, to the fact that doctors recognized that they sometimes made mistakes in their practices and they were therefore interested in collecting data about errors that the profession made with respect to maternal deaths.<sup>30</sup> Overall, it would seem that doctors were keenly interested in continuing to regulate their profession when it came to maternal mortality.

One of the best ways of regulating the profession was to improve on the recording and classification of maternal deaths because clear reporting would assist in determining which deaths were preventable, assisting the profession to improve its practice. Again this was an idea which had its roots in the recommendations from the interwar period. Indeed the first National Conference of the Committee on Maternal Welfare held in December, 1960 listed classification of deaths as its main goal. The chairman of the Committee, Dr. Thomas Primrose noted that the

---

submitted that the definition of a maternal death include all women who die while pregnant or within thirty days of the termination of their pregnancy."

<sup>28</sup> Comacchio has noted of the interwar period that, "in an era when the 'scientific' was held in great popular esteem, the publication of careful statistical surveys was an effective stimulus to social reform." *Nations Are Built of Babies*, p. 73. Indeed, as we have seen, doctors had always been keen to establish themselves as a profession and by supporting national maternal mortality surveys they increased their status as a profession. Increased status would allow them to influence gender roles.

<sup>29</sup> "Report of the Committee on Maternal Welfare", p. 50.

<sup>30</sup> A.C. McInnis referred in 1962 to "factors of responsibility" in maternal deaths which included professional factors, professional and hospital factors, hospital factors, and patient factors in judging maternal deaths in

aim of the national Committee on Maternal Welfare was to help "...the women of Canada to have bigger and better babies and not to lose their lives doing it."<sup>31</sup> Further reductions in maternal mortality were crucial to this goal. Several suggestions were made, therefore, for improvements to current reporting methods including revised case report forms including a separate sheet for identification, the addition of a copy of autopsy or post-mortem reports, as well as a separate sheet for results of biochemical work. The participating doctors at the Conference also stressed the importance of calling in independent investigators presumably appointed by the Committee in the cases of maternal death, rather than the attending physician. This would ensure continuity in the completion of the necessary forms.

The fact-finding procedures in each province were also outlined. Terminology and definitions for mortality studies and a classification system for maternal deaths were also provided. Deaths were to be categorized as having "direct obstetric causes," "indirect obstetric causes," and "non-related causes." A direct obstetric cause was defined as "a death resulting from complications of the pregnancy itself, from intervention elected or required by the pregnancy, or resulting from the chain of events initiated by the complication or the intervention."<sup>32</sup> These included deaths from haemorrhage, toxæmia, infection, and vascular accidents (such as air embolism, or amniotic fluid embolism). An indirect obstetric cause was defined as "a death resulting from disease before or developing during pregnancy (not a direct effect of the pregnancy) which was obviously aggravated by the physiological effects of the pregnancy and caused the death."<sup>33</sup> These deaths included those associated with cardiac disease, vascular disease, reproductive tract disease (such as uterine tumors), urinary tract disease,

---

Manitoba. See "Review of Maternal Deaths – 1961," *Manitoba Medical Review*, (May, 1962), p. 286.

<sup>31</sup> "Minutes of National Conference, Committee on Maternal Welfare," *CMAJ*, 85 (September, 1961), p. 550.

<sup>32</sup> *Ibid.*, p. 554.

<sup>33</sup> *Ibid.*

hepatic disease, pulmonary disease, metabolic disease (such as diabetes), other (such as appendicitis or peritonitis of non-puerperal origin), and undetermined (a necessary category, suggested the Committee, but one which should be reduced as much as possible with the collection of records and the use of autopsies). A non-related cause of death was defined as “a death occurring during pregnancy or within 90 days of its termination from causes not related to the pregnancy, nor to its complications or management” such as communicable and infectious diseases, malignancy, suicide, murder, accident, etc.<sup>34</sup>

Finally, the minutes outlined factors of responsibility for the death. “Responsibility should be determined whenever possible and assigned as appropriate to the attending physician, consultant, midwife, hospital, patient, or any combination” and were classified under three headings: “Professional Factors,” essentially those cases where it appeared that the physician made an error in treatment, “Hospital Factors,” cases which seem to indicate that there was an inadequacy in terms of facilities, personnel or equipment, and “Patient Factors,” or those cases where a death could likely have been prevented if the patient had sought treatment or followed a physician’s prescriptions.<sup>35</sup> Patient factors are particularly interesting given that the committee outlined that such factors should “be recognized but not as an excuse for professional inadequacy” which seems to indicate that doctors were continuing to regulate their profession in

---

<sup>34</sup> *Ibid.*

<sup>35</sup> “A. Professional Factors: These are concerned with cases where there appear to be shortcomings in diagnosis, judgement, management, and technique, and include failure to recognize the complication and evaluate it properly. They also include instances of injudicious haste, delay or timing of operative intervention, and failure to utilize currently acceptable methods of treatment. Finally, they would include services which were technically inept, and those failures which could have been averted by proper and timely consultation. B. Hospital Factors: These are concerned with facilities, equipment or personnel which are inadequate. In terms of modern obstetrics, the hazards of delivery cannot be met successfully unless the hospital provides, among other things, (1) a separate, well-directed maternity section; (2) a complete blood service; (3) adequate twenty-four hour anaesthesia facilities; (4) suitable x-ray facilities; (5) adequate twenty-four hour laboratory facilities; (6) adequate twenty-four hour operating facilities. C. Patient Factors: These should be recognized, but never as an excuse for professional inadequacy. They are concerned with death resulting from a complication for which there is generally successful treatment but which the patient denied herself by delaying her initial visit to the physician, by delaying obtaining medical care after the symptoms were obvious at a layman’s level, or finally, by not following the advice and instructions of her

this period, and wanted to ensure that doctors who did not perform their duties well were located. This also seems to be an indication, however, that doctors wanted to enforce their status as health care providers by pointing out cases where women died because they had not sought out professional help. But, it is also an indication of their ongoing desire to improve on their ability to treat their patients, a chief concern in this period as they began to consider maternal welfare in their work.

Although the provincial committees had been collecting data on maternal deaths, they still believed that improvements could be made which the new classifications could assist. Doctors had begun the process of determining who was at fault for maternal deaths in the interwar period, but the new classification system established in the late 1950s helped to further pinpoint those causes like abortion which were most responsible in keeping the maternal death rate high. In the interwar period doctors sought ways to confirm that it had not been their lack of medical knowledge which led to maternal deaths but that it was those patients seeking out illegal operations who inflated the death rate by shirking their responsibility as mothers. However, with the decline in maternal mortality, together with more specialized care, particularly from obstetricians, doctors could be even more specific in how they classified maternal deaths.<sup>36</sup> Again, this would help them to point fingers in the right direction (presumably, for the most part, away from themselves), especially in terms of treating women arriving at hospitals who were deathly ill. As Dr. C.W. Carpenter and Dr. F.E. Bryans, Assistant Professor and Professor and Head respectively of the Department of Obstetrics and Gynecology at the University of British

---

physician." *Ibid.*

<sup>36</sup> It should be remembered, however, that although the specialization of obstetrics had come a long way by this period, some doctors still lamented the fact that not enough attention was paid to this field of medicine as others. In her article on Canadian obstetrics between 1900-1950, Wendy Mitchinson points out the case of Dr. A.B. Nash, Chairman of the Committee on Maternal Welfare who acknowledged in 1950 that the perception that medical education in obstetrics was deficient was still widely held among the medical community. See "The Sometimes Uncertain World of Canadian Obstetrics, 1900-1950," *Canadian Bulletin of Medical History*, 17, 1-2 (2000), p. 195.

Columbia noted in their 1965 study of maternal deaths in British Columbia, in 44 per cent of all direct obstetric deaths, the patient was the “responsible party” in the deaths which were mainly hemorrhagic, infective and vascular deaths, which “primarily represent deaths due to induced abortion and Indian deaths.”<sup>37</sup>

Certainly doctors perceived that women who had criminal abortions were in the gravest danger. The medical journals indicate that doctors were still frustrated at receiving women for treatment after it was too late to save them.<sup>38</sup> They were also concerned because it did not seem that women were aware of the risks they faced in choosing to try to terminate an unwanted pregnancy. For this reason, the National Maternal Welfare Committee also recommended that they take “feasible steps whereby the authority of The Canadian Medical Association will be used to counter the increasing use of abortifacient drugs in Canada.”<sup>39</sup> Whether the use of abortifacients was really increasing is still in question. There can be no doubt, however, that women were at least continuing to use a variety of means to terminate unwanted pregnancies as they always had.

### *Examining Abortifacient Use*

As in earlier periods, the variety of methods available to attempt to induce abortion included use of herbal drugs, patent medicines, and instruments. Doctors were certainly aware

---

<sup>37</sup> Carpenter and Bryans, “Maternal Mortality in British Columbia,” p. 169.

<sup>38</sup> For instance see, Cosbie, “Maternal Mortality,” p. 39; W.M. Paul, “Case Report: Death from Induced Abortion,” *Ontario Medical Review*, 25 (1958): 809-810, 851; O.M.A. Maternal Welfare Committee, “Report No. 1,” *Ontario Medical Review*, 27 (September, 1960): 916-917, 923, 959; Maternal Mortality Report No. 7, “Septic Abortions – ‘They Die Smiling,’” *Ontario Medical Review*, (January, 1962): p. 42-43.

<sup>39</sup> “Resolution B. Resolved that: 1. Representation be made to the Provincial and Federal Government agencies that preparations containing oil of apiol be prohibited from manufacture in Canada. 2. It is recommended that a useful project for Divisional Committees on Maternal Welfare would be a survey of abortifacients in current use in their areas. They also recommend that the Committee, together with other interested committees (of the CMA) survey ‘...the minimum requirements necessary for the equipment...’ in delivery rooms and nurseries ‘...taking into account the local population and bed space available.’” Resolution C reads as follows: “Resolved that in conjunction with other Committees interested, a survey of the minimum requirements necessary for the equipment to be carried in case rooms and nurseries be prepared, taking into account the local population and bed space available. The findings of this survey to be subsequently incorporated in a bulletin to assure the safety of the mother

of these methods. For instance, a review by Dr. D.B. Stewart of 326 cases of abortion from the Public Gynecology Wards of the Winnipeg General Hospital between 1936-1940 revealed that 82 of the cases (nearly 30%) gave a history of interference with the pregnancy.

In sixty-eight there had been direct interference per vaginam, including douches and various medications applied locally. Slippery elm still appears to be the favourite. In the other fourteen cases the interference was allegedly purely medical, as by quinine or ergot, purgatives or enemata, etc.<sup>40</sup>

Other reports cited use of crochet hooks, soap and lysol douches and pills.<sup>41</sup> Information about how to terminate a pregnancy was not necessarily limited to the medical profession but also known to the general public. This is not surprising given that, not only was there a “wife’s tale” knowledge about a variety of patent medicines, but there was a history of newspaper articles condemning the practice which surely must have “tipped” women off about how to at least attempt their own miscarriage.<sup>42</sup> Increased abortifacient use by women after 1940, is questionable, however, since we have evidence that women were well-aware of how to procure their own miscarriages in earlier periods. The difference in this period is that doctors, desirous of ensuring that the maternal mortality rate was reduced, continued to establish measures which

---

and child in childbirth.” “Minutes of National Conference, Committee on Maternal Welfare,” p. 551.

<sup>40</sup> Stewart, “Abortions,” p. 211-212.

<sup>41</sup> Maternal Mortality Report No. 7, “Septic Abortions – ‘They Die Smiling,’” p. 42; Maternal Mortality Report No. 19, “Abortion”, *Ontario Medical Review*, 31 (April, 1964), p. 289; Paul, “Case Report – Death from Induced Abortion”, p. 809. Recollections of abortion experiences from the time also provide insight into similar experiences. See The Childbirth by Choice Trust (ed.), *No Choice: Canadian Women Tell Their Stories of Illegal Abortion*, Toronto: Childbirth by Choice Trust, 1998.

<sup>42</sup> For instance, Emily Murphy had noted in a 1932 article in the *Vancouver Sun* that, “everywhere abortifacients are openly advertised with apparently no prosecution pending or even feared.” Murphy also noted that, “many people in Canada adopt this shockingly crude and wicked method of abortion – especially as practiced by many of our foreign immigrants.” As this article indicates, interpretations about birth control and abortion changed over time to reflect the historical context. In this case, Murphy links birth control and abortion to “immigrant” practices which fits with the concerns of the time about immigration and eugenics, especially in the trying times of the Depression. Murphy (writing as Janey Canuck), “Birth Control: Its Meaning – Practical and Humanitarian Side of Controversy,” August 27, 1932, p. 5. Of course, women did not only resort to patent medicines to procure their abortions. Abortifacientists could often be found to perform a surgical procedure. Dr. William McCallum recalling his own abortion practice in Vancouver between 1948 and 1968 noted that many of his patients were referred to him by other doctors who refused to perform the procedure themselves. Dr. William McCallum in The Childbirth by Choice Trust (ed.), *No Choice*, p. 114-118.

allowed them to survey much more closely the causes of maternal deaths. The new ways of classifying maternal deaths introduced in this period may explain doctors' recognition of a problem with a variety of abortifacients.

Potassium permanganate was one of the abortifacients identified in the medical literature in this period. Although not a new drug, its use did seem to be on the increase.<sup>43</sup> Dr. Percy Ryberg, author of *Health, Sex and Birth Control* discussed the prevalence of its use, noting that it was not uncommon to see cases where "the girl, in her desperation, will try to bring about an abortion herself by the use of some instrument, or by the insertion of tablets of potassium permanganate. We have seen severe burns and bleeding from the vagina by inserting these tablets, which can seriously endanger the life of the woman."<sup>44</sup> Indeed, a study conducted at the Montreal General Hospital for the years 1935-1954 indicated that thirty-seven cases of potassium permanganate burns of the vagina, with the majority of the cases occurring after 1949, suggested that "the use of this drug as an abortive agent is on the increase."<sup>45</sup> However, despite a 30% success rate in the use of potassium permanganate in producing abortion in the Montreal General survey, Drs. Lindsay and Ward noted that there was "no way of ascertaining whether or not other agents may have been used as well" to procure the miscarriages. This meant that the seemingly high rate of effectiveness was negated by the small sample in the series. Another larger study found that the chemical at best had only about a 9% effectiveness rate which was "in accord with

---

<sup>43</sup> Dr. W.A. Dafoe, Fellow in Obstetrics and Gynaecology at the University of Toronto, had noted of abortifacient use in 1930 that, "strong douches of lysol, potassium permanganate, vinegar, mustard, carbolic acid and mercury bichloride are used, with the resulting caustic effects, followed by excoriation, ulceration and absorption." "The Types and Treatment of Abortion," *CMAJ*, 22 (1930), p. 794.

<sup>44</sup> Percy E. Ryberg, *Health, Sex and Birth Control*, Toronto: The Anchor Press, 1942, p. 56-57.

<sup>45</sup> C. Crawford Lindsay and C.V. Ward, "Potassium Permanganate as an Abortifacient," *CMAJ*, 71 (November, 1954), p. 465. Drs. Lindsay and Ward inspected the records of the Montreal General Hospital between 1935-1954 to test the findings of J.C. Shull and J. F. McDonough in their articles on the subject in the *American Journal of Obstetrics and Gynaecology*, 41 and the *New England Journal of Medicine*, 232 respectively that potassium permanganate burns of the cervix and vagina were increasing.

the expected spontaneous abortion rate.”<sup>46</sup> An article in the *MD of Canada* confirmed similar findings by doctors in California in 1962 and noted that “...the actual incidence of potassium permanganate misuse is probably much higher than statistics indicate, since it is usually very difficult to persuade patients to admit that they have been using the chemical.”<sup>47</sup> This in itself is not surprising given that procuring or attempting to procure an abortion was still illegal. What is perhaps surprising are the lengths that some women would go to terminate unwanted pregnancies.

The belief that potassium permanganate was an abortifacient apparently stemmed from the fact that the corrosive action which occurred when it was placed inside the vagina led to extreme bleeding, although several medical articles confirmed that there was no evidence that it actually caused miscarriage. Some professional abortionists also seem to have thought that this was an effective way of terminating a pregnancy. As one woman noted in her recollection of her own abortion experience in the 1950s, the “acid tablets” used by “someone who would perform an abortion for a horrendous amount of money” did nothing more than cause her to bleed. “I bled so much that I went to a doctor, who, upon examining me, told me that I was haemorrhaging – but not from the uterus. In other words, I was still pregnant [and] the blood came from the arteries in my vagina, the acid tablets having embedded themselves in and eaten

---

<sup>46</sup> *Ibid.*, p. 466.

<sup>47</sup> “Pseudo-Abortifacient,” *MD of Canada*, 3 (February, 1962), p. 25. This article reported that “since the first such case was reported in 1936, some 500 cases have been mentioned in medical literature, the peak incidence apparently occurring between 1955 and 1958, followed by a marked slackening since the chemical was placed on the prescription list by the Food and Drug Administration [in the United States].” Other case reports and articles discussing abortionists and abortifacient use include Dr. A. T. Gowron, “Septic Abortion and Lung Abscess Treated with Penicillin,” *The Manitoba Medical Review*, (January, 1945): 14-15; D.F. Osborne, “Attempted Abortion with Retention of an Intrauterine Foreign Body,” *CMAJ*, 90 (February, 1964): 494-495; Basab K. Mookerjee, Ralph Bilefsky, Alan G. Kendall and John B. Dossetor, “Generalized Shwartzman Reaction due to Gram-Negative Septicemia after Abortion: Recovery after Bilateral Cortical Necrosis,” *CMAJ*, 98 (March, 1968): 578-583. See also F. Munroe Bourne, Samuel O. Freedman and Guy E. Joron, “Intoxication By Aminopterin Used as an Abortifacient,” *CMAJ*, 76 (March, 1957): 473-475. This study suggests that their case is the first case of potassium permanganate used as an abortifacient.

through the walls of the vagina.”<sup>48</sup>

As with many other methods used by women in this period, the severe reaction from either the chemical ingested (or inserted in this case) or the mere quantity of foreign substances introduced could cause a miscarriage to occur as a by-product of severe illness. These were not guaranteed methods, however, and the experience of having failed was probably a common one. Still, many women were still clearly desirous of ending their unwanted pregnancies. Another woman recalled her mother’s abortion in the same period. She awoke in the night to find her mother lying in blood in the bathroom. “The neighbouring farm wives [had] ‘shared their secret.’ It was quite simple. You went to the drugstore, bought quinine and took a massive amount of it. That caused a miscarriage and everything went back to normal, provided the mother didn’t die from a heart attack.”<sup>49</sup> It seems logical to suspect that if women knew of the variety of abortifacients available, they may also have known, at least to some degree, the risks associated with trying to procure their own abortions. And yet, many women in this period (as in earlier ones) still tried to do so.<sup>50</sup> In many cases, it was married women who were seeking ways to limit their family sizes who attempted their own abortions. Their desire to limit their number of offspring was not typically because of a selfish desire not to become a mother. Rather, they had determined some social, economic, or physical reason to end their pregnancies. Indeed, after the Depression, social and economic changes had made it impractical for working-class women to have large families. It should be remembered that, even during the post-war “baby boom” the numbers of children per family were not staggering - the three-child family became the norm

---

<sup>48</sup> Childbirth by Choice Trust (ed.), “Eloise” in *No Choice*, p. 102.

<sup>49</sup> *Ibid.*, “Gillian,” p. 104.

<sup>50</sup> In a recent collection of women’s recollections of their illegal abortion experiences, women recall their need for abortions for a variety of reasons including rape and being “very fertile” thereby needing to limit family size. In most of their recollections, however, it is clear that the experience of illegal abortion was overall not a positive one. See Childbirth by Choice Trust (ed.), *No Choice*.

displacing the two child family.<sup>51</sup>

Women's abortifacient use indicates that they were, in most cases, willing to accept the dangers that went along with trying to procure their own miscarriage. Despite the fact that it seems that most women were aware that illegal abortion was dangerous, they sometimes, even when deathly ill, did not recognize or were not willing to recognize the consequences of their actions. A report by the Ontario Medical Association's Committee on Maternal Welfare in 1962 entitled, "Septic Abortions - 'They Die Smiling'" illustrates this point. "Older practitioners," the report noted, "can remember the awe with which the case of septic abortion was regarded in the pre-antibiotic era. For a time it seemed as if the advent of antibiotics had removed the terror from these cases." However, the report indicates that a number of cases were called to the attention of the Committee "because they have been occurring in our maternal mortality committees as *deaths*...The frightening thing is that these girls appear to be only mildly ill at one moment and are dead the next." The report continued, "clinically, and this is the important and dangerous part, these patients *do not* appear nearly as sick as they are. Indeed they speak up well, have a good colour and are conscious up to the moment of their death. Truly, they 'die smiling.'"<sup>52</sup> It is clear from this report and others that doctors were interested in obtaining reliable mortality statistics, but also, in this period, that they were interested in finding ways to prevent these deaths. "The challenge to the medical profession," reported Ontario's Maternal Welfare Committee in 1960, "is to find a way to reduce, or better still, to prevent altogether such hazardous and illegal interference."<sup>53</sup> How to accomplish this goal, however, was a challenge.

### ***Maternal Welfare: Doctors Educating Women***

One solution to the problem of women "dying smiling" promoted in this period was

---

<sup>51</sup> Angus McLaren, *Twentieth-Century Sexuality: A History*, Oxford: Blackwell, 1999, p. 148-149.

<sup>52</sup> Maternal Mortality Report No. 7, "Septic Abortions - 'They Die Smiling,'" p. 42.

education. Although doctors were always concerned about their patients' welfare, when it came to criminal abortion and the risks associated with the procedure, in earlier periods that concern was directly linked to their desire to regulate their profession. For instance, in the late nineteenth and early twentieth centuries, although women's health was important, particularly as it was related to their ability to reproduce the race, doctors' need to establish their profession in a position of power was what most led them to discuss the issue of illegal operations. By the interwar period, doctors reshaped their discussions on abortion because, although their power was cemented which allowed them to define both their own profession and women's roles, they still needed to address high maternal mortality rates. Their discussion of abortion practices in that period was certainly related to maternal mortality which was undoubtedly connected to women's health and well-being, but underlying that was concern about their own status as professionals in not being blamed for the high maternal mortality rates.

The decline in maternal mortality by the 1940s, however, left doctors confident in their status and their ability, with the help of medical science, to prevent maternal deaths from naturally occurring causes like heart disease, tuberculosis,<sup>54</sup> and infection. They also attributed the declining rates to their ability to educate mothers about pregnancy and childbirth, particularly of the benefits of prenatal care, such education beginning in the interwar period. By the Second World War, advice literature to women about both pregnancy and motherhood was widely available in Canada. In fact, scientific "expert" advice had been prominent for at least twenty

---

<sup>53</sup> O.M.A. Maternal Welfare Committee, "Report No. 1," p. 923.

<sup>54</sup> For instance see J.E. Hiltz, "Pregnancy Complicating Pulmonary Tuberculosis," *Nova Scotia Medical Bulletin*, 22 (1943): 143-145; Ben H. Lyons, "The Heart in Pregnancy," *Manitoba Medical Review*, 27 (September, 1947): 511-514; George Schaefer, R. Gordon Douglas and Irving H. Dreishpoon, "Tuberculosis in Pregnancy," *Manitoba Medical Review*, 8 (November, 1953): 75-76; Report, "Pregnancy and Heart Disease," *Manitoba Medical Review*, 9 (October, 1954): 75; R.M. Lane, "Tuberculosis and Pregnancy," *CMAJ*, 77 (July, 1957): 28-31; K.M. Grant, "Heart Disease in Pregnancy," *Nova Scotia Medical Bulletin*, 38 (1959): 189-193; P.H. Barnes, "Rheumatic Heart Disease in Pregnancy: A Review," *Manitoba Medical Review*, 39 (November, 1959): 683-687.

years.<sup>55</sup> As Katherine Arnup notes, “the combination of demographic changes, the shift from home to hospital for childbirth, and the assault by child-care experts on traditional methods of childrearing, created the potential for a powerful dependence on new sources of child-care information and advice.”<sup>56</sup> Indeed, in a paper read at the meeting of the Ontario Medical Association in 1949, Dr. H.B. VanWyck pointed out that a more “scientific approach to the understanding and care of pregnancy” was responsible for the improvements in maternal mortality together with what he referred to as a “change in popular opinion” about the value of medical care throughout pregnancy. He also praised the fact that

no longer is obstetrics the despised practice of midwifery, but takes its place as a fully scientific branch of practice, a field in which modern concepts of medicine and surgery have a most beneficent application to the function of reproduction. And, again, it is now recognized that this physiological function, always closely bordering on the pathological, requires for complete safety, the rich resources of the modern hospital. This is a really modern concept first held by our profession and now at last believed by our patients.<sup>57</sup>

While it is obvious that Dr. VanWyck believed that prenatal care and indeed, hospital births helped to reduce maternal mortality, historians have debated whether the transition from home to hospital really ensured better safety in childbirth. For instance, Lesley Biggs maintains that “maternal mortality rates were much higher in hospitals than in homes until the early 1940s” and that the eventual decline in maternal mortality rates “can be attributed to the introduction of sulfa drugs and to improved socioeconomic conditions,” rather than to the efforts of the educational

---

<sup>55</sup> It is interesting to note, however, that much of the “scientific” advice changed through the years leaving many women unsure of how to handle both their pregnancies and motherhood, especially for women whose childbearing could span up to twenty years. See Arnup, *Education for Motherhood*, p. 143-144.

<sup>56</sup> *Ibid.*, p. 127. Although she focuses on the advice that women received with respect to child-rearing, there is no doubt that women were also barraged with advice from health professionals about their pregnancies. And it is likely that women came to rely on that advice. As Arnup notes, “the shift in the location for parturition from home to hospital may also have contributed to women’s reliance on expert advice.” p. 126. Certainly doctors had been promoting themselves as professionals for years and women (and patients in general) regarded them that way.

<sup>57</sup> VanWyck, “Recent Advances in Obstetrics of Interest to the General Practitioner,” p. 109.

campaign.<sup>58</sup> In contrast, Wendy Mitchinson suggests that because the conditions that existed in a home birth could vary substantially, hospital births, which were more regulated in terms of antiseptic conditions and procedures that were followed, “were not always to the woman’s detriment.”<sup>59</sup> Whether improvements were due to hospital births, new antibiotics or better prenatal care, the distribution of information through radio broadcasts, newspapers, magazine columns, advice books and prenatal clinics certainly meant that women had easy access to the prescriptions for pregnancy and childbirth being promoted by the medical profession.<sup>60</sup>

At the same time, traditional family support networks were breaking down as Canada became more urbanized and family size continued to decline. As Sheila Kitzinger has observed, “the expectant mother in contemporary industrialized Western society may never have touched, or even seen, a newborn baby before.”<sup>61</sup> One mother noted that, “my own experience, as the youngest of two, was never to have contact with any babies or young children until my sister produced some - and even then the contact was *minimal*.”<sup>62</sup> This unfamiliarity with babies would have gone hand-in-hand with an unfamiliarity with pregnancy. Despite this ignorance, doctors preferred women to seek advice from them, rather than from female family members or friends.<sup>63</sup> As June Callwood’s 1953 survey of doctors for an article in *Chatelaine* magazine

---

<sup>58</sup> Catherine Lesley Biggs, “The Response to Maternal Mortality in Ontario,” p. 47, 49 as quoted in Arnup, *Education for Motherhood*, p. 137. Jo Oppenheimer presents a similar assessment in “Childbirth in Ontario.” Suzann Buckley attributes improvements in maternal death rates to improved prenatal nutrition. See “The Search for the Decline of Maternal Mortality.” See also Strong-Boag and McPherson, “The Confinement of Women.”

<sup>59</sup> Mitchinson, *Giving Birth in Canada*, p. 282.

<sup>60</sup> At least women in urban areas. Arnup and others have noted that access to prenatal clinics and information in general was often much more difficult for rural women to obtain.

<sup>61</sup> Sheila Kitzinger, *Women as Mothers*, New York: Vintage Books, 1970, p. 170 as quoted in Arnup, *Education for Mothers*, p. 124.

<sup>62</sup> Alison Prentice, written comment on Katherine Arnup’s thesis proposal, April 26, 1985 as quoted in *Education for Motherhood*.

<sup>63</sup> Wendy Mitchinson notes the ongoing struggle that doctors faced to promote the value of scientific approaches and, therefore, their approach to medicine, even in this period when they had established their status as professionals. See *Giving Birth in Canada*, chapter one. Despite the desire of health care professionals for women to get “expert” advice with respect to pregnancy, it is clear that women continued to solicit advice from female family members and friends when possible. This “tradition” certainly dates at least as far back as the middle ages when women were the

indicated, physicians regarded grandmothers (and probably any other woman who was not a health care professional) as “a species [who] are the natural enemies of modern science.”<sup>64</sup> In fact, it was advice about abortion that women still seemed to receive through traditional networks of female family members and friends that most concerned the medical profession between 1940 and 1969. It is interesting to note that, although traditional networks seemed to be breaking down with respect to childbearing because of the extensive advice literature available, they remained for abortion. This indicates two things. First, pregnancy does not seem to have been thought of as a “problem” by most women despite doctors’ attempts to medicalize the process. Therefore, most women may not have been overly concerned by a lack of “hands-on” information, given that pregnancy was supposed to be a “natural” event. Since they had access to the advice literature, it is likely that many women felt comfortable in the knowledge they did have in order to proceed through their pregnancies. This indicates that the education campaign, spearheaded by doctors many of whom provided expert advice in the literature to women, was successful. Second, in the case of abortion, an “unnatural” course of action, women seem to have been quite resourceful in tracking down the information they needed about either abortifacients or abortionists, and when in really desperate circumstances, took matters into their own hands. The difference between the two experiences was that doctors had long since promoted that women seek out their help to get them safely through their pregnancies, but with abortion, had traditionally discouraged women from seeking out their help because of the illegality of the procedure.

In this period, however, some doctors and nurses emphasized the need to convince

---

“experts” on health. Throughout the periods discussed here, evidence suggests that women turned to their mothers, sisters and friends for information about how to procure a miscarriage. For a discussion of women as midwives in the medieval period see Kellough, *Aborting Law: An Exploration of the Politics of Motherhood and Medicine*, Toronto: University of Toronto Press, 1996, p. 46-48.

women, through education and advice from medical professionals, that abortion was not a good option in the case of an unwanted pregnancy. For instance, Dr. W.G. Cosbie noted in an article about maternal mortality in Canada that, “considerably more women die each year in Canada from abortion than from puerperal haemorrhage, and undoubtedly the number of reported deaths from abortion is only a fair percentage of the actual number. The solution of this problem lies in the education of the public as to the danger of criminal abortion.”<sup>65</sup> Finding a way to evade illegal operations altogether was definitely a challenge for doctors.<sup>66</sup>

The challenge was perhaps most obvious when doctors encountered women who had illegal procedures procured either by an accomplice or by themselves, like the women who used potassium permanganate to bring on their miscarriages. As indicated earlier in the discussion of abortifacients, the medical journals are full of case reports and maternal mortality studies which indicate that women were taking their reproduction into their own hands. As the Ontario Medical Association’s Maternal Welfare Committee reported in 1960, “deaths resulting from infection have become much less common since the introduction of antibiotics, and the majority of those that are still occurring are due to criminal or self-inflicted abortions. Most of these are beyond help when they are first presented for treatment. The tragedy of these deaths is that they would not have happened had their [sic] been no interference.”<sup>67</sup> Indeed, doctors had always witnessed the problem of women arriving for treatment after attempts at an illegal operation. In this period, though, probably because their status was established, doctors seemed very concerned about how to deal with this problem as it was related to the health of women. Dr. Presley McLeod noted in 1940 that “abortion is the third greatest cause of maternal deaths. It is

---

<sup>64</sup> June Callwood, “What to Do after the Doctor Leaves,” *Chatelaine*, May, 1953, p. 33.

<sup>65</sup> Cosbie, “Maternal Mortality,” p. 39.

<sup>66</sup> The first report of the Ontario Medical Association’s Maternal Welfare Committee raised exactly this point. See “O.M.A. Maternal Welfare Committee Report No. 1,” p. 923.

a common condition and it is regarded much too lightly..." with the most hazardous results occurring when induced.<sup>68</sup> Although not always fatal, such results were definitely gruesome ranging from lesions in the mouth, vagina or cervix caused by chemicals with supposed abortive properties, to women dying smiling, unaware that measures taken to end their pregnancies were killing them.

While doctors had long acknowledged that socio-economic factors could affect a woman's decision about terminating a pregnancy, it was not until after 1940 that they actually began to examine the range of factors that might lead some women to seek out an abortion. For instance, Florence Emory, the Associate Director and Associate Professor of Nursing at the University of Toronto pointed out the necessity of addressing these problems in 1953. As she noted,

the problem of self-induced abortion among married and single women is a serious one, both as to numbers and as to ill effects, leading as they do to maternal deaths or permanent injury and to the loss of future lives...the public health nurse must realize her responsibility in trying to prevent these abortions. She should be quick to sense the case where for social, financial or other reasons the coming child is not wanted and do her utmost to correct the underlying cause before any drastic step may be taken.<sup>69</sup>

How a public health nurse could correct the problems faced by a working mother with many children to care for and not enough money is unclear. But Nurse Emory was not the only health care professional to make this suggestion. In a 1958 case report detailing a death from induced abortion, Dr. W.M. Paul, a member of the Attending Staff at Toronto Western Hospital and a Clinical Instructor of Obstetrics and Gynecology at the University of Toronto, noted that "the medical aspects of this tragedy are probably overshadowed by some social implications." He

---

<sup>67</sup> *Ibid.*

<sup>68</sup> McLeod, "Maternal Mortality from the Viewpoint of the Obstetrician," p. 54.

further suggested that of all of the women who died from induced abortions, "...almost ninety percent were married with families. The typical patient with an induced abortion is not a desperate single woman, she is more likely to be married with a young family."<sup>70</sup> The desperation women must have felt to take such extreme measures was surely obvious to the physicians who had to treat them. What was also surely challenging for doctors recognizing this problem in the postwar period was that it went totally against what was being promoted as "normal" behaviour for women. As Doug Owram notes, the parents of the baby boom generation (children who were born between 1946 and 1962) "operated by a code of family values that was firm and surprisingly uniform." At the heart of that code were children.<sup>71</sup> There is no doubt that doctors helped to promote the importance of children to their female patients. To witness first hand attempts to avoid childbirth was troublesome, not only because it appeared that some women did not want to be "normal", but because it placed the medical profession in an awkward situation given the illegality of abortion.

Doctors, because of their close connection with the women who arrived at hospitals in states of septic shock, along with a variety of other complications, sometimes found it difficult to justify not performing therapeutic abortions. As Dr. William McCallum of Vancouver noted of his abortion practices between 1948-1968,

the thing is that when I procured abortions way back in the dark ages, I did it not for myself, but for women. The only reason I did it actually, was this young woman who came to my office and she wanted me to do an abortion and I said to her, no, no way. Go, you've done your sinning, why should I help you out, eh? And this...must have been very crushing to her...she couldn't find anybody, and she went and killed herself, and about a month later her father did the same thing.

---

<sup>69</sup> Florence H.M. Emory, *Public Health Nursing in Canada*, Toronto: Macmillan Company, 1953, p. 290.

<sup>70</sup> Paul, "Death From Induced Abortion," p. 810.

<sup>71</sup> Doug Owram, *Born At The Right Time: A History of the Baby Boom Generation*, Toronto: University of Toronto Press, 1996, p. 6.

I suppose it was the shame of his daughter being pregnant and he couldn't face up to that...The next young woman that came into my office and asked for assistance and an abortion, got it.<sup>72</sup>

Certainly other doctors in this period shared Dr. McCallum's frustration with the current abortion law, especially when they witnessed such horrendous results due to illegal abortions, although the majority, rather than take the law into their own hands, discussed ways to better educate women about the dangers associated with the procedure.<sup>73</sup> However, doctors were not stupid and the 19<sup>th</sup> Report of Ontario's Maternal Welfare Committee noted the dangers of illegal abortion,

Infection, perforation of the uterus or vagina, haemorrhage, septic shock, peritonitis, septicaemia, air embolism, or chemical embolism are all possible causes of a fatal result. If death does not occur, at least sterility or chronic pelvic pain may be late or persistent sequelae. Criminal abortions are still the most common cause of preventable maternal deaths in all major centres. This deplorable fact probably will not change until our laws, our philosophy, or at least our methods of communication with the public change.<sup>74</sup>

As this quote establishes, doctors had shifted their discourse on abortion substantially, which allowed them to acknowledge the need for abortion.

Not only had doctors shifted how they viewed abortion, but how they viewed women and their roles. During the 1940s, 1950s and 1960s, doctors began to recognize that in many cases, women were not trying to shirk the responsibilities of motherhood by seeking out abortion, but were instead trying to space or limit their number of children so that they could afford them.<sup>75</sup>

The statistics indicate that the marriage rate was increasing and many women (and men) were

---

<sup>72</sup> Dr. William McCallum, "Interview," *As It Happens*, CBC Radio, January 29, 1988 as quoted in *Childbirth by Choice* Trust (eds.), *No Choice*, p. 114.

<sup>73</sup> As we will see in chapter five, however, it is clear that some doctors tended to "bend" the rules with respect to the performance of therapeutic abortions.

<sup>74</sup> Maternal Mortality Report No. 19, "Abortion," *Ontario Medical Review*, 31 (April, 1964), p.290. This particular article provided case histories of eight different women's abortion experiences.

<sup>75</sup> Paul, "Death from Induced Abortion," p. 810.

marrying earlier than they had before.<sup>76</sup> The marriage rate soared from a low point during the Depression of below 65,000 per year (5.9 per thousand people) to 104,000 (8.5 per thousand) in 1944, to 148,000 (nearly 11 per thousand) in 1946.<sup>77</sup> Not only were women marrying earlier, they were typically only waiting two years before having children and by the 1950s only waited 1.5 years. These women were also joined in their procreative activities by older women who had postponed having children until after the war's end.<sup>78</sup> The fertility rate climbed to from 120 per thousand for women aged thirty to thirty-five before the war to 150 per thousand in 1947. As Doug Owrain has observed, "society seemed to revolve around babies."<sup>79</sup> Given this seeming preoccupation with maternity, doctors were more willing to discuss the reasons why those women who were choosing to limit their fertility were doing so.

This willingness to discuss family size did not mean, however, that doctors ignored the maternal death rate. Indeed, they continued to worry about maternal deaths and the connection of abortion to those statistics. In earlier periods, their inability to address the abortion problem was that they did not have concrete proof that it existed. As we have seen, statistical study of maternal mortality really only began in the 1930s, so doctors did not possess statistical proof of the problem until near the end of the interwar period.<sup>80</sup> However, by 1940 doctors were seeing statistical proof of the role of abortion in the maternal mortality rates which provided them with a reason to begin instigating change. While their status as professionals was still at the heart of their discussions of abortion as they continued to be vocal about their unhappiness that abortion

---

<sup>76</sup> Doug Owrain notes that at the beginning of the war, half of the women were married by the age of 23.2 years with men waiting until the age of 26.4. Ten years later the ages had dropped to 22 and 24.8 respectively and by 1956 to 21.6 and 24.5. *Born At The Right Time*, p. 18.

<sup>77</sup> This was the highest figure ever recorded. *Ibid.*

<sup>78</sup> *Ibid.*, p. 4-5.

<sup>79</sup> *Ibid.*, p. 5. For a discussion of the trends in the western world generally, see McLaren, *Twentieth-Century Sexuality*.

<sup>80</sup> In *Nations Are Built of Babies*, Cynthia Comacchio suggests that doctors did not recognize that abortion played a role in the maternal mortality rate until the end of the 1930s. However, this misconception is likely due to the fact

deaths should be included in the overall maternal mortality figures, they were also desirous of determining why abortions were being sought out in the first place. In large part the shift in their discussions is likely connected to their overall willingness to examine socio-economic factors in maternal welfare. Doctors recognized that the causes of both toxæmia and puerperal sepsis, for instance, could be related to women's access to proper nutrition and access to prenatal care.

While doctors advocated the education of women in the interwar period as a means of reducing the maternal mortality rate, they began to recognize that, in some instances, women could simply not afford either medical advice in the form of prenatal care or proper nutrition, even when they had access to such services. This was evident in the statistics which indicated that deaths from preventable causes remained high. In other words, even though prenatal care was available, many women could either still not afford it, or else did not have access to it, as was the case in many rural areas.<sup>81</sup>

Despite their calls for better prenatal education and proper nutrition as ways to address the issue of maternal mortality, doctors in the 1940s still did not pay much attention to the role of socio-economic factors in the maternal mortality rates, at least in their professional discussions about maternal mortality and abortion.<sup>82</sup> In those articles where such issues were mentioned, doctors do not seem to have been overly interested in exploring such factors. For instance, Dr. H.B. Atlee of Nova Scotia noted in 1943 the need for haemoglobin tests of women in prenatal check-ups to ensure that iron could be administered if necessary. "Probably most women in the lower economic groups require to take iron during pregnancy in order to maintain their blood in

---

that there really was not statistical proof until that time.

<sup>81</sup>For instance, see Biggs, "The Response to Maternal Mortality in Ontario"; Oppenheimer, "Childbirth in Ontario"; Buckley, "The Search for the Decline of Maternal Mortality"; Mitchinson, *Giving Birth in Canada*, p. 133-134.

<sup>82</sup> While the medical profession does not seem to have focused on socio-economic factors for abortion in the 1940s, this became much more a part of their discussions of abortion in the later 1950s and 1960s.

a proper state.”<sup>83</sup> Similarly, an editorial in the *Canadian Medical Association Journal* reporting on maternal deaths in Manitoba noted that of seventeen toxæmic patients, ten had been “classed as poor.” In the same study, twenty abortions were recorded (the leading cause of death) and nineteen of those patients had been unmarried.<sup>84</sup> In fact, relatively few articles dealing with abortion actually acknowledged that there were class differences or even racial differences which was in contrast to articles on childbirth in this period. However, articles which focused on family planning were different.

A number of articles appeared throughout this period which indicated the need for legalized birth control in Canada. Alfred Henry Tyrer, author of a popular marriage manual, *Sex, Marriage and Birth Control* noted in 1943 that “no intelligent person will approve the practice of infanticide, nor of unrestricted abortion. But we shall have to continue our dependence on such means unless we can find some simple and harmless substitute for them. Fortunately we have such a substitute in modern scientific birth control.”<sup>85</sup> The problem with Tyrer’s solution, of course, was that birth control was illegal. Not only that, not all doctors agreed with this course of action, at least not for all patients. Catholic physicians, for instance, were faced with unclear religious direction from their Church about whether or not birth control was sanctioned. Pius XI’s papal encyclical *Casti connubii* of 1930 had taught that the three blessings of marriage were offspring, conjugal faith, and the sacrament. The blessing of offspring was governed by natural law theory which taught that any non-procreative act was intrinsically wrong. “This form of moral reasoning...” notes Brenda Margaret Appleby, “...evaluates the material content of the biological act of human intercourse while excluding its situation, circumstances, and foreseeable

---

<sup>83</sup> Atlee, “Some Life-Saving Procedures in Obstetrics,” p. 378.

<sup>84</sup> Mitchell, “Maternal Deaths in Manitoba”, p. 160.

<sup>85</sup> Alfred Henry Tyrer, *Sex, Marriage and Birth Control, 10<sup>th</sup> Edition*, Toronto: Marriage Welfare Bureau, 1943, p. 64. Angus McLaren has noted Tyrer’s connection to the eugenics movement in Canada. See *Our Own Master*

consequences.”<sup>86</sup> Birth control, therefore, was not considered natural, regardless of the reasons for the limitation of births, even to save the life of the mother threatened by childbirth. The encyclical expressly noted that the life of an innocent in the womb could not be taken to save a mother’s life. “Bearing children was described as ‘the office allotted to [women] by nature,’ and in the face of risks, women were called on to risk their lives with ‘heroic fortitude.’”<sup>87</sup> Despite this pronouncement of women’s proper role within marriage, the encyclical did provide two loopholes to non-procreative sexual activity. In one instance, the Church did not condemn a spouse who wished to follow Catholic doctrine but whose spouse refused to cooperate as long as an attempt was made to persuade the dissenting partner to comply with the Church’s teaching. The second, and perhaps best known loophole, allowed couples “to seek sexual intimacy during periods of non-fertility and in cases of persistent infertility.”<sup>88</sup> This loophole was interpreted in different ways by different theologians but, for the most part, it was taken to mean that it was permissible for couples to calculate the fertile and non-fertile days within a woman’s menstrual cycle in order to determine when it was “safe” to have intercourse and when to refrain.<sup>89</sup> This, of course, has been referred to as the “rhythm” method of birth control, a means that many

---

*Race*, p. 76-77.

<sup>86</sup> Brenda Margaret Appleby, *Responsible Parenthood: Decriminalizing Contraception in Canada*, Toronto: University of Toronto Press, 1999, p. 164.

<sup>87</sup> *Ibid.*, p. 165.

<sup>88</sup> *Ibid.*

<sup>89</sup> Appleby has noted in *Responsible Parenthood* that the United Church of Canada interpreted these loopholes as an acceptance of the Catholic Church of birth control and viewed this as a shift in Catholic doctrine. No papal statement about the use of the “rhythm” method was made, however, until 1951 when Pope Pius XII commented publicly on the observance of sterile periods in order to prevent conception. In an address given to the Italian Catholic Society of Midwives, the Pope noted that only for “serious motives” could couples limit their sexual contact to the infertile period. Couples also had to engage in intercourse during both periods because always and consistently denying the conjugal right to fertile periods would constitute a “defect” in the consent to marriage, invalidating it. Couples needed always to have a willingness to accept new life. While the address focused primarily on the duty to procreate, promoting that married women had the vocation of motherhood and that married couples were to support the conservation of the human race, he did acknowledge that serious medical, eugenic, economic or social reasons could exempt spouses from their procreational duties for an extended period or even for the duration of the marriage. p. 165-166.

Catholics were prepared to accept.<sup>90</sup> Given the lack of clarity in papal documents and addresses about the use of birth control, it is not surprising that Catholic doctors were unsure about the role of birth control, even if employed to avoid recourse to abortion.

Other groups too, were unsure about the promotion of widespread birth control. A 1940 article entitled, "Eugenics and the Family," reported, for instance, on the National Family Conference on Family Relations held in Philadelphia in 1939. It noted explicitly that birth control should not be advertised to all patients. While the conference dealt with the conditions in the United States, its recommendations applied equally well to Canada. The birth rate, which was still declining in the early 1940s, was a concern for many, especially given that there was a belief that the "wrong" families were reproducing while the "right" families were limiting their births. This particular article suggested that support especially among "doctors, nurses, ministers, and leaders of all sorts" was needed in order to "encourage large families among certain parents, and small families among others."<sup>91</sup> These writings early in the 1940s reflected the eugenic position which had gained popularity among doctors and others in the 1930s.<sup>92</sup> However, as the atrocities of the Nazi regime became evident during and in the immediate postwar era, the focus on eugenics became less acceptable.

The postwar era focused on the importance of family and "home"<sup>93</sup> and, therefore, traditional eugenics in the late 1940s and early 1950s lost its popularity.<sup>94</sup> However, the

---

<sup>90</sup> The most notable example of this in Canada is the SERENA (Service de regulation des naissances) group in which lay members (both English and French) teach couples the natural method of birth control which involves reading temperatures daily to determine when ovulation is occurring, representing the fertile period (and hence, the period in which to abstain from intercourse if birth control is being sought). For a description of the history of this movement see Appleby, *Responsible Parenthood* p. 167-169. This method of birth control is also referred to as Natural Family Planning (NFP).

<sup>91</sup> Unknown, "Eugenics and the Family," *Canadian Public Health Journal*, 31 (1940), p. 201-202.

<sup>92</sup> See McLaren, *Our Own Master Race*.

<sup>93</sup> Owrarn, *Born At The Right Time*, p. 7.

<sup>94</sup> Again, as the events that occurred in Nazi Germany during the war became public, eugenics became an unpopular approach if not an embarrassing one.

importance of the mother in upholding the ideal of the family was highlighted in the medical discourses. In terms of abortion, this was significant, especially as it became evident that many women dying as a result of botched abortions were not single, but married. Dr. D.F. Smith, Chairman of the Committee on Maternal Welfare and Lecturer in Obstetrics and Gynecology at Dalhousie University, noted in 1968 that one of the two most common reasons for criminal abortion was that “women have had too many children”<sup>95</sup>

Doctors began to publicly suggest that providing access to birth control was a lesser evil than illegal (and very likely unsafe) abortions. Dr. Gordon W. Perkin, Associate Medical Director of Planned Parenthood in New York, for instance, noted in a 1965 editorial in *The Canadian Medical Association Journal* that,

If any other public health problem assumed such proportions and was associated with such high morbidity and unnecessary mortality it would be attacked ruthlessly in an attempt to reduce the tragic sequelae. A logical first step in attempting to reduce the frequency of this problem would be to make effective birth control methods widely available to all medically indigent as well as private patients throughout Canada.<sup>96</sup>

Given the emphasis in this period on social welfare, it is not surprising that many doctors and welfare organizations began advocating the need for legalized birth control. For instance, in 1965 Toronto’s City Council authorized the city’s welfare department to make birth control freely available to all citizens while at the same time drafting a resolution to the federal government requesting amendment of the Criminal Code on the issue. This was not the first time that city acted to provide birth control to families in need. A year earlier they had

---

<sup>95</sup> The other reason was that conception had occurred out of wedlock. D.F. Smith, “Legislation Regarding Abortion,” *The Nova Scotia Medical Bulletin*, (August, 1968), p. 155. See also, S.C. Robinson, “Induced Abortion,” p. 13.

<sup>96</sup> Gordon W. Perkin, “Physicians and Contraception,” *CMAJ*, 92 (March, 1965), p. 632.

authorized the welfare department to provide progesterone pills to families on welfare providing they were prescribed by a physician.<sup>97</sup>

Other cities began to establish family planning clinics. For instance, a series of articles appeared in the *Canadian Public Health Journal* in the 1960s detailing such efforts. What is clear from such reports was that there was a strong emphasis among medical professionals of the need for family planning among those less fortunate.<sup>98</sup> Some doctors suggested that their colleagues were partly to blame for the lack of birth control information provided to patients. One doctor suggested that, "more often than not the physician misses or avoids opportunities in which he could be most helpful."<sup>99</sup> Indeed, this was a concern for many doctors who recognized that in medical school they had not received adequate training about this important aspect of practice.

In an editorial discussing the CMA's 97<sup>th</sup> Annual Meeting where the recommendation of the Committee on Maternal Welfare that section 150 of the Criminal Code which criminalized contraception be either amended or removed was approved, the issue of training doctors in contraceptive practices was raised. It noted that,

A recent survey has demonstrated that doctors are reluctant to bring up the subject of birth control with a patient unless requested and that, on their part, physicians find it difficult to ask for such help. At least part of the reason on the physician's

---

<sup>97</sup> "Toronto Authorizes Distribution of Birth Control Information," *MD of Canada*, 6, 5 (May, 1965), p. 50.

<sup>98</sup> H.H. Washburn, "The Administration and Operation of the Norfolk County Family Planning Clinic," *Canadian Public Health Journal*, 58 (1967): 277-279; C.J.G. MacKenzie, "The Vancouver Family Planning Clinic: A Case Study," *Canadian Public Health Journal*, 58 (1967): 53-60; E. Aenid Dunton, "A Family Planning Clinic in a County Health Unit," *Canadian Public Health Journal*, 58 (1967): 181-185; C.J.G. MacKenzie, "The Vancouver Family Planning Clinic: A Comparison of Two Years' Experience," *Canadian Public Health Journal*, 59 (1968): 257-265; Connie Gray Ptolemy, "Family Planning Interpretation - The Nurse's Role," *Canadian Public Health Journal*, 60 (1969): 402-408. See also, "Ian Bain, "The Development of Family Planning in Canada," *Canadian Public Health Journal*, 55 (1964): 334-340; Editorial, "The Physician and Family Planning," *CMAJ*, 95 (September, 1966): 689-690. Family Planning was also part of the movement toward population control in this period. For instance see Editorial, "Population and Family Planning in Public Health," *Canadian Public Health Journal*, 59 (1968): 278-280; Editorial, "The Population Bomb," *CMAJ*, 87 (December, 1962): 1204-1205; Editorial, "Control of World Population," *CMAJ*, 94 (March, 1966): 503-504. See also Appleby, *Responsible Parenthood*.

<sup>99</sup> Editorial, "The Physician and Family Planning," p. 689.

side is the lack of preparation in such counselling in medical schools.<sup>100</sup>

In response to this editorial, Dr. Donald J. Dodds, Chairman of the Medical Advisory Committee of the Planned Parenthood Association of Toronto noted that, indeed, surveys indicated that the level of instruction on birth control “appears to vary [widely] from one school to another.”<sup>101</sup>

Some schools, for instance, only provided information briefly about demographics and the “population explosion” in the context of other lectures while others provided no mention of these issues at all. The level of information varied from no instruction at all in some schools, to one school in which “five hours of lectures, films, and demonstrations with anatomical models were given in the third and fourth years, and clinical practice was obtained in postpartum clinics.”<sup>102</sup>

Given the range of knowledge possessed by physicians about contraception and family planning it is not surprising that access to birth control by women also varied substantially. What was important for the discourse on abortion was that doctors were beginning to publicly discuss ways to protect women’s welfare. The emergence of the family planning movement in Canada in the late 1950s and early 1960s was certainly evidence of this recognition.

The shift which occurred in the medical discourse after 1940 demonstrates that doctors felt comfortable with their own status as professionals, and in the public’s reliance on their scientific knowledge to keep them well by preventing, and when necessary, treating illness. The decline in the maternal mortality rate certainly indicated that science was indeed allowing doctors to both protect against and limit maternal deaths. However, the fact that abortion deaths continued to strongly impact the maternal death rate led doctors to examine both their own approaches to cases of botched abortions, arriving as they did in hospital emergency rooms for

---

<sup>100</sup> Editorial, “Physicians and Contraception,” *CMAJ*, 91 (October, 1964), p. 820.

<sup>101</sup> Donald J. Dobbs, “Physicians and Contraception,” *CMAJ*, 92 (November, 1964), p. 1080.

<sup>102</sup> *Ibid.*

treatment, as well as the social factors which led women to seek out illegal operations. Both of these issues indicated doctors' concern for their patients' welfare. There can be no question that some doctors began to inquire about why women would feel the need to terminate their pregnancies in the first place. The conclusion of the profession was that women were either unaware of the risks associated with the procedure (pointing to the need for better education on the matter) or that the social factors impacting their decision to terminate outweighed the risks to undergo such procedures.

To acknowledge that women felt there were reasons for seeking out an abortion was a huge leap for doctors to make. Indeed, their willingness after 1940 to consider women's welfare in their discussions of abortion would be reflected in their recommendations to Parliament for changes in the law with respect to abortion. Changes to the law would help women to avoid having to make such dangerous choices. Certainly their acknowledgement of a variety of factors influencing women's decisions was an important step - one that can be seen in the maternal mortality studies done at the beginning of the period.

## Chapter Four

### *“Are We Doing Too Many Therapeutic Abortions?” Doctors Discussions, 1940-1969*

“We would not today think of interrupting pregnancies in many situations” noted Dr. D.

Laurence Wilson of the Department of Medicine at Queen’s University in 1959,

where in the past abortion would have been widely held to be the safest method of management...one cannot [but] feel that abortion is sometimes recommended on doubtful medical grounds which the doctor may accept as a quasi-legal method of extricating his patient from some serious environmental difficulty for which he has a good deal of sympathy. This is of course to admit through the back door, social and economic grounds for abortion”<sup>1</sup>

This statement underscores the fact that many doctors in the 1940s, 1950s and 1960s paid more attention to non-medical factors affecting women’s decision to terminate their pregnancies than they had in earlier periods, and that attention caused many doctors to argue that they needed to be able to perform therapeutic abortions to save the mother’s life or health.

It was certainly not new for doctors to be discussing the performance of therapeutic abortions. As we saw in chapter one, although the regular medical profession in the late nineteenth and early twentieth centuries viewed abortion as immoral, they recognized that, in some instances, contraindications might necessitate a therapeutic abortion. By the interwar period, the discourse shifted to focus on abortion within the context of the high maternal mortality rate. Doctors continued to recognize the need to be able to perform therapeutic abortions when contraindications arose, but their discussions of therapeutic abortion were also

---

<sup>1</sup> D. Laurence Wilson, “Medical Indications for Therapeutic Abortion,” *Ontario Medical Review*, 26, 8 (August,

constrained by their promotion of scientific medicine because they needed to recognize contraindications within the profession's belief of progress. This meant that while they could acknowledge the existence of some indications for therapeutic abortion, they also needed to show how some contraindications to pregnancy had been eliminated.

At the same time, there was some indication that they recognized some non-medical contraindications (socio-economic factors) for therapeutic abortions, although these were less prominent than medical indications. In both these periods, the issue of the legality of performing a therapeutic abortion in order to save the life of the mother loomed. However, the *Bourne* decision in 1938 seemed to cement doctors' legal status in this regard when the judge determined that a doctor could perform a therapeutic abortion not only when a woman's life was threatened, but also to protect a mother's "health." The word health implied that a woman's overall well-being could be a deciding factor in a doctor's decision to perform a therapeutic abortion. This was an important distinction, particularly as doctors began to articulate their concern over women's welfare, and to look for ways to protect women's health from the risks associated with illegal operations.

The concept of protecting mothers from such risks was related to their definition of health and this impacted the medical profession's decision to terminate a pregnancy for therapeutic reasons. In the early period, doctors did not really understand the impact of certain contraindications to pregnancy like heart disease or tuberculosis, on women's health. More investigation and reporting of cases of women with such conditions was necessary before doctors would learn that their intervention in such circumstances was not always needed. Not only that, fetal viability was limited as was evident by the high infant mortality rate. In other words, doctors could not usually save an undeveloped fetus when a mother went into labour early as the

---

1959), p. 733-734.

result of a contraindication. Therefore, for the most part, doctors believed they had a better chance of saving a woman's life by terminating a pregnancy than by not. However, by the interwar period a number of advances had occurred which began to limit the number of contraindications to pregnancy, and which increased fetal viability. Yet doctors still believed they needed to be able to perform therapeutic abortions in some circumstances when they determined a contraindication existed. What the *Bourne* case seemed to clarify for doctors was that they had the power to make the determination about whether a therapeutic abortion was indicated. And, after the *Bourne* ruling, doctors in Canada assumed that they could legally make the decision to terminate a pregnancy, even though no similar cases had been decided in Canada.

The lack of a precedent in Canada to indicate that the *Bourne* decision would *not* apply to doctors<sup>2</sup> and their increased concern with women's health and welfare caused their discussions to shift. They moved away from blaming the women who sought out criminal abortions for the increase in the maternal mortality rate as they had in the interwar period, to beginning to acknowledge and attempt to understand the reasons why some women would seek out illegal abortions in the first place. This shift was made possible largely by the decrease in the maternal mortality rate by 1940, and by their increasing ability to influence their patients' behaviour

---

<sup>2</sup> The historiography surrounding the legal history of abortion seems to suggest that no Canadian cases applied the *Bourne* decision in this period. For instance, in her examination of Canadian abortion cases between 1900-1950, Constance Backhouse notes that approximately fifty abortion cases were reported in the different law reports published across Canada in that period, although these were only a small proportion of the number of cases since Statistics Canada tabulated 980 cases between 1922 and 1950. Of these cases it would appear that, for the most part, they were prosecutions of abortionists (many of whom were not doctors) and women who procured their own abortions. None of these cases as reported by Backhouse, even, it appears, those that were of doctors applied the *Bourne* precedent. "Prosecution of Abortions under Canadian Law, 1900-1950," in Jim Phillips, Tina Loo, and Susan Lewthwaite (eds.), *Essays in the History of Canadian Law: Crime and Criminal Justice, Volume 5*, Toronto: University of Toronto Press, 1994, p. 253, 278. Jane Jenson notes that the *Bourne* decision provided a precedent for the existence of "legal" abortions in Canada, although she does not cite any cases. In all likelihood the lack of such cases contributed to the ambiguity that doctors felt about their position in providing therapeutic abortions which she suggests they attempted to clarify by consulting their colleagues on abortion cases. "Getting to Morgentaler: From One Representation To Another," in Janine Brodie, Shelley A.M. Gavigan and Jane Jenson, *The Politics of Abortion*, Toronto: Oxford University Press, 1992, p. 24-25. Shelley Gavigan has suggested that the *Bourne* decision reinforced the view in England as well as Canada that all therapeutic abortions are lawful. "The Criminal Sanction

which pointed to their established clout as a profession.<sup>3</sup> Advances in medical science had also drastically reduced the need to terminate pregnancies for certain medical indications and many doctors began to question the need for such procedures in light of the advances. The shift in the discourse on abortion by doctors in their attempt to address maternal welfare, particularly in terms of the education of women about the importance of the medical profession in pregnancy and the risks associated with abortion, significantly impacted their position on therapeutic abortion in this period because it led doctors to consider the overall situation of the mother.

While some doctors considered that therapeutic abortion could be indicated to protect the mother's *health*, which could include her physical and her mental health, the issue of the legality of their actually performing an abortion was raised again in the 1950s. A change in the wording of the section of the Criminal Code dealing with abortion in 1958 caused them to question their legal right to perform the procedure to protect women's life *and* health. This chapter explores first the issue of therapeutic abortion in the context of maternal welfare. Specifically, it discusses the contraindications to pregnancy as doctors viewed them in this period and places the medical discourse on therapeutic abortion in this period within doctors' changing views of women, motherhood and medical science. Second, the issue of the legality of doctors performing therapeutic abortion in this period is examined, placing doctors' ongoing desire to regulate their own profession within the context of their desire to protect themselves from legal prosecution for performing therapeutic abortions.

### ***Contraindications Threatening Women's Health and Welfare***

In earlier periods, doctors discussed contraindications to pregnancy and their threat to the

---

as it Relates to Human Reproduction: The Genesis of The Statutory Prohibition of Abortion," *Journal of Legal History*, 5 (1984), p. 36.

<sup>3</sup> One indication of this was the ability of the medical profession to convince women to have their babies in hospitals, rather than at home. Wendy Mitchinson notes that by 1940, 45.3% of births in Canada took place in

life of the mother as a means of deciding when to perform therapeutic abortions. Conditions like heart disease, tuberculosis, toxæmia, and even mental illness were cited as reasons for the performance of a therapeutic abortion. By the 1940s, however, doctors realized that many of the conditions previously viewed as contraindicative to pregnancy were manageable. For instance, Dr. J.E. Hiltz, Assistant Medical Superintendent of the Nova Scotia Sanatorium, noted in 1943 that, “not so many years ago, every case of pulmonary tuberculosis that became pregnant was advised to have an abortion.” But in 1943, his treatment of pregnant tuberculosis patients seldom included therapeutic abortion.<sup>4</sup> Similarly, doctors reporting from Cornell University and New York Lying-In Hospital in *Modern Medicine of Canada* noted in 1953 that, “pregnancy does not usually exert a harmful effect on the tuberculous process and parity has no influence on the course of the disease.”<sup>5</sup> This sentiment was echoed by Dr. R.M. Lane, Medical Director of the Vancouver Island Chest Centre in Victoria, British Columbia. Dr. Lane’s review of the medical literature on pregnancy and tuberculosis confirmed the tradition of recommending the termination of pregnancies where tuberculosis was present, while at the same time noting that “the history of the opinion of the effect of childbearing on tuberculosis is most interesting because it has been so contradictory.”<sup>6</sup> While some physicians had believed that tuberculosis did not present a problem in pregnancy, most clinical opinion on the matter, particularly in the interwar period, held that tuberculosis was indeed contraindicative to pregnancy and hence, termination was recommended. However, noted Lane, as the severity of tuberculosis lessened and the birth rate increased around 1940, clinical opinion also shifted. Perhaps most important in this shift was the new custom of having a chest x-ray as a routine part of a prenatal exam. The

---

hospitals where only 17.8% had done so in 1926. *Giving Birth in Canada, 1900-1950*, Toronto: University of Toronto Press, 2001, p. 173.

<sup>4</sup> J.E. Hiltz, “Pregnancy Complicating Pulmonary Tuberculosis,” *Nova Scotia Medical Bulletin*, 22 (1943), p. 143.

<sup>5</sup> George Shaefer, R. Gordon Douglas and Irving H. Dreishpoon, “Tuberculosis in Pregnancy,” *Modern Medicine of*

promotion of proper prenatal care by doctors in the interwar period, resulted in the collection of clinical data on the presence of tuberculosis in pregnancy, the studying of patients through their pregnancies, and the measuring of the impact of the disease on the pregnancy and vice versa. Clinical study, therefore, contributed to a shift in the way doctors viewed some contraindications to pregnancy.

In his own study of “all known tuberculous women between the ages of 17 and 42 inclusive who had lived on Vancouver Island at any time in 1953, 1954 or 1958” Dr. Lane sought to compare his patients to those in existing studies in the medical literature. Any differences were sought between his conclusions and those of other studies given that none of the others (that he knew of) followed the patients for 12 months or more past antimicrobial treatment. His study concluded that “from these figures and those cited of others, I find it difficult to believe that therapeutic abortion is now ever indicated in a woman with tuberculosis.”<sup>7</sup> The Vancouver study noted that earlier observers<sup>8</sup> who had suggested that pregnancy did not increase the death rate from tuberculosis and that women who continued with their pregnancies while suffering from tuberculosis did as well as those who had a therapeutic abortion, had likely been correct despite a lack of clinical evidence to support their assumptions. Even when clinical studies began to suggest that termination of pregnancy in cases where tuberculosis was present was unnecessary (for instance a study by Eastman, a Professor of Obstetrics at Johns Hopkins University),<sup>9</sup> many physicians still followed earlier protocol which recommended that a pregnancy be terminated if tuberculosis was present because, suggested Lane, clinical studies were not being published in periodicals that all physicians would read.

---

*Canada*, 8 (November, 1953), p. 75.

<sup>6</sup> R.M. Lane, “Tuberculosis and Pregnancy,” *CMAJ*, 77 (July, 1957), p. 28.

<sup>7</sup> *Ibid.*, p. 31.

<sup>8</sup> Lane referred to Forssner in Sweden in 1925 and Alice Hill in 1928. *Ibid.*, p. 28.

This is an interesting point and seems to suggest that doctors relied quite heavily on the public medical discourse found in medical journals to guide their own practice.<sup>10</sup>

Doctors' discussions of other contraindications were similar to the discussions about tuberculosis.<sup>11</sup> Doctors writing about heart disease, for instance, advocated close monitoring and, on physicians' part, better understanding of such conditions as measures to prevent maternal deaths, rather than the termination of previously contraindicated pregnancies.<sup>12</sup> Dr. Ben H. Lyons noted in a 1947 article on heart disease and pregnancy in *The Manitoba Medical Review* that, "authorities concur...that proper management [of the pregnant cardiac patient] will determine the death rate in this group, and hence be a factor in mortality in pregnancy as a whole." He further noted that, "prior to 1923, 20% of all parous cardiacs died in this hospital. In an attempt to reduce this high mortality, special attention and supervision...was undertaken. The mortality took an astonishing drop from 20 to 3.5%, and has been maintained around the latter figure since." Close monitoring together with a better "understanding of the physiological

---

<sup>9</sup> *Ibid.*, p. 29, 31.

<sup>10</sup> This brings to mind for me an experience I had recently with my own children and our family physician. I brought my two daughters individually to the doctor within about a month of each other for an ear or respiratory infection that they both contracted. With the first child, the doctor prescribed an antibiotic treatment over 10 days. When I brought the second child in shortly thereafter for a similar problem, he prescribed antibiotics for 3 days indicating to me that the most recent studies he had read in the medical journals had suggested that the bacteria for which the antibiotics were prescribed were killed after 3 days of treatment. When questioned about the shorter treatment period, he advised that although the symptoms might still be present over the 10 days, there was really no need to continue with the antibiotics because the bacteria itself would be dead. This seemed to me to be a perfect example of how influential the studies in the medical journals could be in affecting a doctor's practice.

<sup>11</sup> In his discussion of some of the medical indications for therapeutic abortion, Dr. D. Laurence Wilson suggested that certain previous contraindications like German Measles (Rubella), certain heart conditions, hypertension and chronic nephritis, and breast cancer could no longer necessarily be considered medical conditions which indicated the need for therapeutic abortion. See "Medical Indications for Therapeutic Abortion."

<sup>12</sup> For instance, see Ben H. Lyons, "The Heart in Pregnancy," *The Manitoba Medical Review*, 27 (September, 1947): 511-514; James McD. Corston, "Preventative Medicine in Obstetrics," *Nova Scotia Medical Bulletin*, 32 (1953): 21-25; K.M. Grant, "Heart Disease in Pregnancy," *Nova Scotia Medical Bulletin*, 38 (1959): 189-193; P.H. Barnes, "Rheumatic Heart Disease and Pregnancy: A Review," *Manitoba Medical Review*, 39 (November, 1959): 683-687. See also, Shaeffer, Douglas and Dreishpoon, "Tuberculosis in Pregnancy," p. 75-76; Lane, "Tuberculosis in Pregnancy," p. 28-31. Although most doctors in this period seemed to believe that therapeutic abortions were not necessary in contraindicated pregnancies, some physicians still believed that not only were such conditions contraindicative to pregnancy, but to marriage itself. See H.B. Atlee, "The Way We Treat 'em," *Nova Scotia Medical Bulletin*, 35 (1956): 395-399.

changes affecting circulation in pregnancy is a prerequisite”<sup>13</sup> for preventing the death of a pregnant mother with cardiac disease. Similarly, Dr. P.H. Barnes noted of rheumatic heart disease in pregnancy in 1959 that, “the risk [of death of a pregnant woman with heart disease] in the past has been grossly exaggerated because writers based their opinions on general impressions which are notoriously fallacious.”<sup>14</sup>

The involvement of physicians in the management of “problem” pregnancies was one way that doctors’ power was manifested in everyday practice. As Dr. P.H. Barnes noted of treating pregnant women with heart disease, “the general consensus of opinion seems to be that the management of these cases is largely medical and mainly devoted to the prevention of the onset of failure and other complications with early and active treatment when they occur.”<sup>15</sup> Management of such cases consisted of close monitoring of the patient by the physician throughout her pregnancy to detect any complications. This monitoring and an understanding of all of the physiological changes which occur during pregnancy was necessary in order for doctors to determine whether the woman was experiencing normal change, or whether she was encountering difficulties due to her heart condition and whether one was aggravating the other. As Dr. Ben Lyons pointed out,

women who have heart disease should always be told to present themselves for examination at once should pregnancy occur, so that their condition may be evaluated and a decision made as to continuance of pregnancy.<sup>16</sup>

This presentation of the pregnant mother to the physician allowed the professional to determine whether the pregnancy could continue or not. Only in the event of “unfavourable” conditions would termination of the pregnancy be recommended. Dr. Lyons further noted the necessity of

---

<sup>13</sup> Lyons, “The Heart in Pregnancy,” p. 511.

<sup>14</sup> Barnes, “Rheumatic Heart Disease in Pregnancy,” p. 683.

<sup>15</sup> *Ibid.*, p. 685.

instructing the patient about the “somewhat different prenatal regime.”

Visits to the office should be at frequent intervals, such as every two weeks, and any untoward symptoms are to be reported at once. She is to get a good nights sleep plus rest periods totalling two or three hours throughout the day. If compensation is perfect, moderate exercise is desirable; but excessive exercise, prolonged shopping trips, etc. are to be avoided.<sup>17</sup>

It is interesting to note that Dr. Lyons also called for attention to be paid to the “economic and social circumstances” of the patient as well as to her age, and the size of her family.

Lyon encouraged physicians to determine whether the patient had “the ability to secure domestic help during the pregnancy...so that the mother can get the rest prescribed for her,” to consider her age and to encourage women to have their children while young because “after 35 the danger of [cardiac] failure is doubled” and to discern how many children the patient currently has and how anxious she is to have a child because “nearly all agree that two should be the maximum” although some suggestion was made to leave the option of a third child to the parents.<sup>18</sup> Of course, his suggestion would have been problematic for Roman Catholic patients who, presumably, would not agree to such a course of treatment, given their direction by the Church to procreate. Doctors’ willingness to take some of the social factors into consideration is part of the shift which occurred in the medical discourse where doctors began to think about not only the scientific side of medical practice, but also the patient side. As Dr. B. Kredentser of Edmonton put it in 1963, doctors “have become increasingly aware of the necessity of a holistic approach to a patient with a disease or disability.”<sup>19</sup> The holistic approach encouraged viewing the patient as “more than an ambulatory container of an acute disease process. He is a member of a family unit, may be a key man in a work group, a leader in his community, and his family’s

---

<sup>16</sup> Lyons, “The Heart and Pregnancy,” p. 513.

<sup>17</sup> *Ibid.*

<sup>18</sup> *Ibid.*, p. 512.

source of income. Illness is not only a disrupting influence, but a frightening experience.”<sup>20</sup>

This approach to medicine was part of a general trend for doctors to recognize the various factors that affected a patients’ health. While there can be no question that doctors still had the final say in determining a patient’s fate with respect to treatment, it is clear that a willingness existed to take into account factors other than just those associated with the condition being treated.

While doctors had experienced a great deal of success in promoting prenatal care to the pregnant mother, they noted repeatedly the importance of such care and pointed out that the maternal mortality rate for even common complications of pregnancy (toxaemia, anaemia, etc.) was “three times as great in patients without prenatal care.”<sup>21</sup> Not all doctors agreed, however, that close monitoring of contraindicated patients could allow women with conditions like heart disease to have a successful pregnancy. Dr. H.B. Atlee, writing in his monthly column about pregnancy and heart disease in the *Nova Scotia Medical Bulletin* in 1956, put it quite bluntly. “Any woman” he noted, “who has had decompensation<sup>22</sup> had better not get pregnant.”<sup>23</sup> Atlee’s view on this may have been a generational one, though, given that in 1956 he had been practicing for nearly thirty years.<sup>24</sup> Some doctors, then, held on to earlier beliefs about contraindications to pregnancy, despite new studies in the medical literature. This is not meant to suggest that the risks associated with such contraindications were exaggerated by doctors writing about them in this period, but that their concerns about women’s health continued to impact the decision to terminate pregnancies. Nevertheless, it is clear that the medical profession by the 1940s had decided that, in cases of tuberculosis or heart disease, changes to the

---

<sup>19</sup> B. Kredentser, “The Unmarried Mother and Her Doctor,” *Alberta Medical Bulletin*, 28 (May, 1963), p. 114.

<sup>20</sup> *Ibid.*

<sup>21</sup> Barnes, “Rheumatic Heart Disease in Pregnancy,” p. 685.

<sup>22</sup> Decompensation is the failure of the heart to maintain adequate circulation. Clayton L. Thomas (ed.), *Taber’s Cyclopedic Medical Dictionary, 16<sup>th</sup> Edition*, Philadelphia: F.A. Davis Company, 1989, p. 463.

<sup>23</sup> Atlee, “The Way We Treat ‘em,” p. 395.

<sup>24</sup> See Harry Oxorn, *Harold Benge Atlee, M.D.: A Biography*, Hantsport, N.S.: Lancelot Press, 1983.

management of the pregnancy like more vigilant prenatal care and increased bed rest could allow a woman to continue with her pregnancy where before the pregnancy would have been terminated. For women, this often meant an increased presence of the medical professional in her pregnancy.<sup>25</sup>

In the case of women who sought therapeutic abortions as a means of avoiding complications, the ability of the medical profession to feel confident in their aptitude to monitor such conditions meant that the control of women over their own bodies was further restricted. As Dr. Robert A.H. Kinch, Professor of Obstetrics at the University of Western Ontario, put it in 1959,

...current therapeutic advances in medicine and surgery have made us realize that the best method of dealing with most acute or chronic medical or surgical conditions complicated by pregnancy is to treat the disease appropriately, and allow the pregnancy to take care of itself. We are at last able to define such previously inexact and therefore meaningless terms, as added strain, extra load or increased burden of pregnancy. Having measured same, in many cases this added load is not nearly as frightening as we previously thought. This has allowed us to revise much outmoded thought and opinion with reference to this difficult problem.<sup>26</sup>

While their ability to measure pregnancy and the physiological changes associated with it may have made complicated pregnancies less frightening for doctors, it may not have been so for the woman who had to bear the burden of continuing with a pregnancy that might threaten her own life or lifestyle. In *No Choice: Canadian Women Tell Their Stories of Illegal Abortion*, women reported various reasons for wanting to terminate their pregnancies in this period including wanting to avoid dealing with devastating post-partum depression, wanting to limit fertility

---

<sup>25</sup> Of course, women had to make the decision to go to a physician for medical help in the first place. Wendy Mitchinson has pointed out that, in this regard, women often exercised agency over their own bodies. See "Problematic Bodies and Agency: Women Patients in Canada, 1900-1950," in Franca Iacovetta and Wendy Mitchinson (eds.), *On the Case: Explorations in Social History*, Toronto: University of Toronto Press, 1998: 266-288.

<sup>26</sup> Dr. Robert A.H. Kinch, "Are We Doing Too Many Therapeutic Abortions?" *Ontario Medical Review*, 26

either due to a feeling of overburden from previous children or due to age (either they were young and unmarried or older and married), out of a desire to develop their own careers or because they were raped. Many of the women also reported having repeated abortions in this period.<sup>27</sup> While the availability of clinical data on a variety of diseases and their relationship to pregnancy had led many doctors to conclude that therapeutic abortion was not indicated in many of the conditions that had previously been believed to threaten the life of the mother, there were clearly other circumstances that led women to seek a way to terminate their pregnancies. While there were still some conditions which were contraindicative to pregnancy, doctors were becoming less inclined to perform therapeutic abortions for them before trying to manage the pregnancy together with the contraindicative disease.

Overall, then, it would seem that doctors believed that medical contraindications were declining. A number of studies presented statistics which indicated the decrease in maternal deaths due to conditions like tuberculosis and heart disease. For instance, Dr. R.M. Lane, Medical Director of the Vancouver Island Chest Centre in Victoria, British Columbia, noted in 1957 that a tremendous drop in the female death rate from tuberculosis had occurred and that in British Columbia specifically, the death rate was “less than one-third the rate of 10 years ago.”<sup>28</sup> Similarly, Dr. P.H. Barnes and Dr. Ben Lyons both reported drops in the maternal death rate due to heart disease.<sup>29</sup> Because a number of contraindications to pregnancy were becoming more manageable and, hence, decreasing, doctors increasingly discussed social factors as a means of

---

(August, 1959), p. 279.

<sup>27</sup> The Childbirth by Choice Trust (ed.), *No Choice: Canadian Women Tell Their Stories of Illegal Abortion*, Toronto: Childbirth by Choice Trust, 1998.

<sup>28</sup> Lane, “Tuberculosis and Pregnancy,” p. 28.

<sup>29</sup> Lyons reported that the Boston Lying-In Hospital had experienced a drop in maternal deaths due to cardiac disease from 20% in 1923 to 3.5% in the 1940s which was maintained due to “proper management” of such patients. Similarly, Barnes reported that a researcher in England and Wales had shown a “35% decrease in maternal deaths from cardiac diseases from 1935 to 1948” with the caveat that “the proportion of maternal deaths due to cardiac disease has risen from 5 to 11%” likely due to a reduction in the maternal death rate from other causes. “The Heart

determining when to terminate a pregnancy. For instance, a member of the Medical Committee of the Sanatorium Board writing about termination as it was connected to the contraindication of tuberculosis in the *Manitoba Medical Review* noted,

I cannot recall advising termination of pregnancy for purely medical reasons...I feel that in most cases where termination is considered that social and economic factors loom fairly largely and are considered to be such that continuation of pregnancy would definitely endanger the mother's life. It is often easier to terminate the pregnancy than to remove the social and economic difficulties.<sup>30</sup>

This is a fascinating statement given that the majority of doctors up until this period had stressed, at least publicly, that the performance of abortion should only occur to save the mother's life or health. Perhaps this statement is an articulation of the way doctors had always operated, an indication, as has been already suggested, that the discourse did not necessarily represent practice. What this statement also indicates is that by the 1940s, at least some doctors were willing to take into consideration social factors in the decision to terminate a pregnancy.<sup>31</sup>

Medical textbooks used in some Canadian medical faculties from this period certainly made this addition in their discussions of therapeutic abortion noting that doctors needed to consider not only recognized medical indications but also eugenic and economic factors. For instance, one obstetrics and gynecology text published in 1940 noted that,

the interruption of a pregnancy for purely social or economic indications is not legal. Unfortunately, the remuneration for terminating a pregnancy for the convenience of the patient is too often a temptation which is not resisted.<sup>32</sup>

The first part of this quote suggests that doctors needed to consider carefully the legality of their

---

in Pregnancy," p. 511. See also Barnes, "Rheumatic Heart Disease in Pregnancy," p. 683.

<sup>30</sup> Medical Committee of the Sanatorium Board, "Tuberculosis Complicated with Pregnancy," *Manitoba Medical Review*, 21 (March, 1941), p. 47.

<sup>31</sup> For example see Alan F. Guttmacher, "The Problem of Therapeutic Abortion," *Modern Medicine of Canada*, 10 (1955), p. 71-72.

<sup>32</sup> Fred L. Adair (ed.), *Obstetrics and Gynecology, Volume I*, Philadelphia: Lea & Febiger, 1940, p. 666, 672. See also Archibald Donald Campbell and Mabel A. Shannon, *Gynecology for Nurses*, Philadelphia: F.A. Davis

performance of therapeutic abortions and this point will be discussed in greater detail below.

The second part of the quote, however, suggests that doctors still believed that some members of the profession were lured into performing abortions by the temptation of earning extra money for the procedure. Likely this kind of statement was aimed at protecting the profession as a whole by indicating that only a few practitioners succumbed to such temptations, but it was also a warning to doctors that performing a therapeutic abortion for any reason other than to save the life of the mother was not acceptable. Yet many doctors did provide their patients with abortions. “Dr. Marianne N.,” completing a pathology residency in the early 1960s, noted to her mentor that she had heard that there was at least one abortionist in the city and that the police generally allowed this. “My mentor promptly told me the name and address of the abortionist.”<sup>33</sup> Similarly, “Penny” reported that while working as a nurse on the gynecology ward in Toronto that there was evidence to suggest that some women secretly obtained abortions disguised as D&Cs. Many, she notes, were admitted as “emergencies in the middle of the night for functional uterine bleeding or vaginal bleeding.” While she could not confirm whether these patients’ abortions had been performed prior to or during the D&C, “there is no doubt that abortion was the name of the game.”<sup>34</sup> What these accounts suggest is that, in some circumstances, doctors were indeed “stretching” the indications for the provision of therapeutic abortion.

There was certainly not consensus, though, about whether or not the indications for therapeutic abortion should be widened and many doctors railed against the idea that the law be revised.<sup>35</sup> But many doctors did realize that women were seeking out abortions for a variety

---

Company, 1946, p. 64-65.

<sup>33</sup> “Dr. Marianne N.” in Childbirth by Choice Trust (ed.), *No Choice*, p. 120.

<sup>34</sup> “Penny,” *No Choice*, p. 137.

<sup>35</sup> For instance see J.C. Whyte, “The Rubella Syndrome of Congenital Malformations,” *CMAJ*, 87 (September, 1962), p. 571; Editorial, “Therapeutic Abortion,” *CMAJ*, 98 (March, 1968), p. 513; J.W. Mullner, “Abortion and the Law,” *CMAJ*, 97 (December, 1967), p. 1613; Colin P. Harrison, “Abortion and the Law,” *CMAJ*, 98 (May, 1968), p. 971.

reasons, and that there was a need for doctors to address this issue. One common argument found in a medical text from the period was that some women simply had too many children.

All that can be advocated is that the problem be recognized more universally and dealt with more humanely and judiciously. It must be solved either by improving the economic status of the families, by restricting the size of the families, or by a combination of the two plans.<sup>36</sup>

The example of women with multiple children who could not afford to have any more (either financially or mentally), while common in doctors' discussions of therapeutic abortion in this period, was not necessarily a factor in advocating the procedure.<sup>37</sup> Instead, many doctors, as we have seen, promoted the need for legalization of birth control in order to avoid such situations and the need for therapeutic abortions. As Brenda Margaret Appleby has noted, doctors "faced requests for information, advice, and prescriptions or instructions" nearly every day and many physicians provided such information to their patients or referred them to newly formed family planning clinics that did, despite the fact that doing so was illegal.<sup>38</sup>

Many doctors also advocated that the profession should be able to provide such information in order to avoid having to perform therapeutic abortions since therapeutic abortion was not a pleasant procedure.<sup>39</sup> Dr. S.C. Robinson, Assistant Professor of Obstetrics and Gynecology at Dalhousie University, approached the issue in a slightly different way. Writing in 1963, he suggested that improved treatment of many diseases along with improvement in the quality of obstetric care had narrowed the list of indications for abortion. Because of this, he

---

<sup>36</sup> Adair, *Obstetrics and Gynecology*, p. 672.

<sup>37</sup> *Ibid.* See also Wilson, "Medical Indications for Therapeutic Abortion," p. 734; Editorial, "Therapeutic Abortion," p. 513; S.C. Robinson, "Induced Abortion," *Dalhousie Medical Journal*, 16 (Spring, 1963), p. 11.

<sup>38</sup> Brenda Margaret Appleby, *Responsible Parenthood: Decriminalizing Contraception in Canada*, Toronto: University of Toronto Press, 1999, p. 208. See also Angus McLaren and Arlene Tigar McLaren, *The Bedroom and the State: The Changing Practices of Contraception and Abortion in Canada, 1880-1997*, Toronto: Oxford University Press, 1997.

<sup>39</sup> Wilson, "Medical Indications for Therapeutic Abortion," p. 766; Kinch, "Are We Doing Too Many Therapeutic Abortions?" p. 732. As Dr. Wilson noted, "...we must remember that when therapeutic abortion is carried out, the

argued “so-called ‘therapeutic’ abortion...is today scarcely a problem for most practitioners.”<sup>40</sup> Instead, the problem was criminal abortion. Dr. Robinson felt, as did other doctors, that rather than widen the indications for therapeutic abortion, the problem of criminal abortion needed to be addressed.<sup>41</sup> “This means,” he noted, “preventing these ‘awkward’ pregnancies and this of course means making available safe, simple and effective contraceptive knowledge and techniques.”<sup>42</sup> He went on to suggest that “easily available good contraceptive practices would go a long way toward preventing the sorry toll of life and health which we at once tolerate and condemn.”<sup>43</sup> Other doctors were more blunt. An editorial in the *Canadian Medical Association Journal* suggested that “instead of sharpening his curette, the doctor will serve his patients better by being ready at all times to discuss, and offer advice in, matters of contraception”<sup>44</sup> and an edition of “The London Letter” dealing with therapeutic abortion in the same journal noted that “...if a child is better not born it is better not conceived.”<sup>45</sup>

Despite the fact that doctors increasingly discussed social and economic factors as determinants, at least in part, of therapeutic terminations when birth control had failed or had not been available, some doctors still insisted that only medical indications which threatened the life of the mother, rather than her overall health, should be considered. As Dr. D. Laurence Wilson of the Department of Medicine at Queen’s University noted, “we as a profession [should] avoid therapeutic abortion as a solution for difficulties which are basically economic and social rather than medical...It is beyond...the scope of science - to decide whether economic and social factors

---

foetal mortality rate is 100% - a fact which surely deserves some weight in the scale of our judgement...” p. 736.

<sup>40</sup> Robinson, “Induced Abortion,” p. 12.

<sup>41</sup> See also H.B. Atlee, “Legislation Regarding Abortion,” *Nova Scotia Medical Bulletin*, (June, 1968), p. 127.

<sup>42</sup> Robinson, “Induced Abortion,” p. 13. See also D.F. Smith, “Legislation Regarding Abortion,” *Nova Scotia Medical Bulletin*, (August, 1968), p. 155, Wilson, p. 766.

<sup>43</sup> Robinson, p. 13.

<sup>44</sup> Editorial, “Therapeutic Abortion,” p. 513.

<sup>45</sup> The London Letter, “Therapeutic Abortion,” *CMAJ*, 94 (February, 1966), p. 403.

justify abortion.<sup>46</sup> According to Dr. Wilson, the responsibility of the medical profession during pregnancy was simply “to preserve life – both maternal and foetal.”<sup>47</sup>

Even in those cases where a medical indication seemed to exist, doctors could not agree on the protocol for performing a therapeutic abortion. The cases of women who contracted rubella (German measles) during the first trimester of pregnancy, heightening their chances of giving birth to a deformed baby, was one example of this. Some doctors, despite contradictory statistics about the rate of congenital defects associated with rubella,<sup>48</sup> continued to advocate termination of pregnancy in any woman who contracted the disease in early pregnancy. Others considered such terminations unnecessary. For some, the idea of terminating a potentially burdensome pregnancy seemed too much like the approach taken to the unfit in Germany during the war. Dr. J.W. Mullner of The Ontario Hospital in Brockville wondered, for instance, whether a risk of congenital defect due to German measles, if there even was a risk, justified denying life to a child. “These children may constitute a burden and be an unproductive element in society, but so are thousands of the mentally and physically ill and old people. How far are

---

<sup>46</sup> Wilson, “Medical Indications for Therapeutic Abortion,” p. 766. See also Henricus J. Stander, *Williams Obstetrics: A Textbook for the Use of Students and Practitioner (Eighth Edition)*, New York: Appleton-Century Company, 1941, p. 1113.

<sup>47</sup> Wilson, “Medical Indications for Therapeutic Abortion,” p. 766.

<sup>48</sup> There was quite a range in the statistics about defects in the case of rubella and pregnancy. Dr. D.F. Smith, Chairman of the Committee on Maternal Welfare of the Medical Society of Nova Scotia and Lecturer in Obstetrics and Gynecology at Dalhousie University reported in 1968 that “research has demonstrated that women who have *rubella* in the first four weeks of pregnancy will give birth to infants with severe congenital anomalies in 61% of the pregnancies if the foetus does not die prior to term.” “Legislation Regarding Abortion,” *Nova Scotia Medical Bulletin*, (August, 1968), p. 155. Dr. J.W. Mullner of The Ontario Hospital in Brockville, Ontario, however, suggested that “although German measles has been much maligned as a cause of mental defect, the danger is practically non-existent.” “Abortion and the Law,” p. 1613. An earlier article by Dr. D. Laurence Wilson suggested that while early studies of German measles and pregnancy purported to show an incidence of deformities in children 80% of the time, more recent studies of mothers who suffered from German measles in the first trimester and who were followed throughout their pregnancies to childbirth showed that, although the disease was a serious threat to the foetus, the actual incidence of major anomalies in living infants whose mothers contracted the disease in the first trimester was only about 10%. “Medical Indications for Therapeutic Abortion,” p. 734-735. Even during the hearings of the Standing Committee on Health and Welfare with respect to abortion in 1968, a geneticist testified that it was still difficult to determine conclusively whether a woman would give birth to a deformed child in such a situation. See testimony of Dr. F. Clarke Fraser, Director of Medical Genetics at Montreal Children’s Hospital and Professor of Genetics at McGill University, Standing Committee Minutes, 9 (November 21, 1967), p. 253-254. See

we prepared to go to reduce this burden? The National Socialist Government of Germany passed laws to solve such problems and ended up with extermination camps.”<sup>49</sup> This quote suggests that some doctors were hesitant to promote therapeutic abortion as a way to “unburden” society, especially in the context of the postwar period when the ideal was to promote home and family and when Canadians remembered the atrocities of Nazi Germany.

Despite the reluctance on the part of some doctors, by the 1960s, the issue of population control was often discussed, particularly in the campaigns for widening the access to birth control methods. As Angus and Arlene Tigar McLaren have argued, many of the birth controllers in the postwar period were keen to promote fertility regulation both at home and in developing nations as a way to combat the “population explosion.”<sup>50</sup> Indeed, many Canadians, including doctors writing in the medical journals of the day, worried that “the uncontrolled fertility of the Third World posed a greater threat to world stability than the risk of nuclear war.”<sup>51</sup> In this cultural climate, many of the discussions of contraindications to pregnancy had a clear eugenic undertone. With the need to control population ever-present in the medical literature, it is no wonder that therapeutic abortion was presented by some doctors as a way to avoid the risk of congenital deformities and to produce “quality people.”<sup>52</sup> Some doctors even argued that a risk of a deformed child put at risk the mother’s mental health.<sup>53</sup>

---

also Whyte, “The Rubella Syndrome of Congenital Malformations.”

<sup>49</sup> Mullner, “Abortion and the Law,” p. 1613. For another connection of therapeutic abortion and Nazi Germany, see Colin P. Harrison, “Letter to the Editor – Abortion and the Law,” *CMAJ*, 98 (May, 1968), p. 971.

<sup>50</sup> McLaren and McLaren, *The Bedroom and the State*, p. 134.

<sup>51</sup> *Ibid.* See also Editorial, “The Population Bomb,” p. 1074; Editorial, “Control of World Population,” *CMAJ*, 94 (March, 1966), p. 503. Many doctors, while not making reference to population control and nuclear war specifically, did discuss the need to deal with the world population issue. For instance, see R.W. Shepherd, “Letter to the Editor - The Population Bomb,” *CMAJ*, 87 (December, 1962): 1204-1205; Editorial, “Oral Contraceptives,” *CMAJ*, 89 (August, 1963): 270-271; C.A. Douglas Ringrose, “Current Concepts in Conception Control,” *CMAJ*, 89 (August, 1963): 246-248; C.A.D. Ringrose, “Letter to the Editor - Conception Control,” *CMAJ*, 89 (December, 1963): 1199; Editorial, “Control of World Population,” *CMAJ*, 94 (March, 1966): 503-504.

<sup>52</sup> Colin P. Harrison, “Letter to the Editor...,” p. 971.

<sup>53</sup> See Dr. Benkarn, “Letter to the Editor – The Rubella Syndrome of Congenital Malformations,” *CMAJ*, 86 (1962), p. 1215. Other doctors, however, actively disputed that the birth of a deformed child presented a danger to a

Not all doctors agreed, though, with the idea that the possibility of a birth defect causing mental instability was reason to justify a therapeutic abortion. Dr. Wilson, for instance, noted that rubella itself was not even a threat to a mother's life or health but that the potential for foetal damage caused by the disease was the reason it was listed as a possible contraindication to pregnancy. Even at that, he pointed out that recent studies had shown that the incidence of serious abnormalities in living infants who were exposed to the virus in utero was only about 10 percent. "One would have indeed to be an enthusiast for therapeutic abortion," he wrote, "to recommend that nine healthy infants be sacrificed in order to destroy one who would be deformed."<sup>54</sup> A letter to the editor of the *Canadian Medical Association Journal* addressing the issue of rubella from Dr. J.C. Whyte, Chairman, Division of Obstetrics and Gynecology at the Ottawa Civic Hospital helped to sum up the various arguments about contraindications and therapeutic abortion. Dr. Whyte wrote,

The danger of advocating therapeutic abortion for conditions which may produce congenital abnormalities in a minority of cases, and which *may* produce some degree of psychic trauma in the mother (a most difficult thing to prove before the event), leads inevitably to further widening of the indications. Should unmarried girls be entitled to therapeutic abortion because of the effect the pregnancy may have on their mental health? In addition, many forget that a D and C for therapeutic abortion is a considerably more hazardous procedure than a D and C for other indications, and carries a small but definite morbidity and mortality. A few such patients never achieve pregnancy again. What is the effect on the mental health of such a woman who goes through life with the guilt of having consented to the removal

---

mother's mental health. Dr. J.C. Whyte noted in response to Dr. Benkarn's letter that, "in my 30 years in the practice of obstetrics and gynecology I have found them [women suffering from psychic trauma] to be rare indeed, and discussions with other obstetricians and psychiatrists leave me with the impression that they [mothers] have responded to the extra challenge with courage, self-sacrifice and devotion." "Letter to the Editor – The Rubella Syndrome of Congenital Malformations," *CMAJ*, 87 (September, 1962), p. 571,

<sup>54</sup> Wilson, "Medical Indications for Therapeutic Abortion" p. 734-735. It is interesting to note that I have a friend who contracted German measles in the late 1980s in her first trimester and who was advised at that time that she should terminate her pregnancy because of the risk of fetal abnormalities. She chose not to terminate her pregnancy and gave birth to a perfectly healthy baby. This seems to indicate that, despite the discussion among some doctors of the minimal risk associated with this virus and pregnancy, the idea that such pregnancies should be terminated continued to be prescriptive.

of a pregnancy which had better than a 50% chance of being normal? For the record, these convictions are not based on religious beliefs, and I have performed therapeutic abortions, but I believe the indications are rare and that danger to the mother's health, physical or mental, must be clearly proved.<sup>55</sup>

Dr. Whyte's arguments clearly pointed to the danger of doctors prescribing therapeutic abortion in the case of rubella, although there was certainly no consensus about the risk of deformity.<sup>56</sup> But he also raised some important issues that were a large part of the discussion of therapeutic abortion in this period. The first was the issue of using the mother's welfare, including her mental well-being, as indications for performing the procedure. The second was the legality of using either of these arguments to justify its performance, in essence protecting doctors from prosecution. Given that some doctors did perform abortions, it was clear that the validity of using any indication to justify a therapeutic abortion had become problematic for the profession because they could not agree on what those indications were.

Mental illness was believed by some to threaten the mother's health and welfare and, therefore, necessitated the performance of therapeutic abortion. Although this reason for termination was mentioned in earlier years, its discussion became more frequent in the 1950s. Dr. Alan F. Guttmacher, a well-known American expert on abortion and on general health matters, writing in *Modern Medicine of Canada* in 1955 noted that, "nervous and mental diseases recently have become prominent indications" for therapeutic abortion.<sup>57</sup> Mental illness as a contraindication to pregnancy likely emerged in this period as a prominent factor for two reasons. The first and perhaps most obvious reason was that other contraindications to

---

<sup>55</sup> Whyte, "The Rubella Syndrome of Congenital Malformations," p. 571. It is interesting that Whyte made a point of making a distinction between where his beliefs stemmed from by stressing that they were not religious beliefs. This is one of the few examples of a doctor clearly dissenting from the discourse by questioning what constituted a reason for terminating a pregnancy.

<sup>56</sup> For instance, Dr. D.F. Smith noted in 1968 that "...women who have *rubella* in the first four weeks of pregnancy will give birth to infants with severe congenital anomalies in 61% of the pregnancies if the foetus does not die prior to term", "Legislation Regarding Abortion," p. 155.

pregnancy used in earlier periods to justify a therapeutic abortion were declining. Given that doctors could not necessarily use other medical conditions to justify the procedure, they turned to mental health reasons. As P.N.B. Flemming, a Lecturer in International Institutions in the Faculty of Law at Dalhousie University, noted in 1968, “because the physical dangers connected with childbearing and allowing pregnancy to go to term are diminishing annually, there is no doubt that psychological reasons will account for nearly all abortions.”<sup>58</sup> The *Bourne* decision in the late 1930s certainly opened the door for doctors to include protection of the mother’s mental health in their rationale for performing the procedure. The second reason that mental illness was discussed as a justification for the procedure was doctors’ desire to protect their patients’ welfare. As we have seen, this was due in part to increased emphasis on the more holistic approach to patient care which encouraged the examination of not only of the symptoms of illness but the overall condition of the patient.

It is clear that many physicians recognized the need for therapeutic abortions. Given the illegality of the procedure they looked for medical indications which justified the performance of a therapeutic abortion.<sup>59</sup> That some doctors needed to resort to, as Dr. Wilson called them, “quasi-legal” methods to assist their patients, suggests that the abortion law was becoming more and more problematic in Canadian society. Nevertheless, doctors still sought ways to work within the law as it stood and the use of psychiatric indications for abortion fit this approach. However, as Dr. Wilson alluded to in his article, a clear protocol for allowing the termination of a pregnancy due to psychiatric indications had to be followed by practitioners.

Dr. Kenneth Gray, Associate Professor of Psychiatry and a Lecturer in Medical

---

<sup>57</sup> Guttmacher, “The Problem with Therapeutic Abortion,” p. 72.

<sup>58</sup> P.N.B. Flemming, “Medical-Legal Inquiries – Legislation Regarding Abortion,” *Nova Scotia Medical Bulletin*, (August, 1968), p. ,154.

<sup>59</sup> Adair, *Obstetrics and Gynecology*, p. 666; Campbell and Shannon, *Gynecology for Nurses*, p. 64-65; Guttmacher,

Jurisprudence at the University of Toronto, tried to address the concerns of practitioners like Dr. Wilson who were unsure of the use of psychiatric indications for therapeutic abortion by setting out four principles which needed to be applied to any pregnant patient suffering from mental illness in determining whether a therapeutic abortion should be performed. First, the existence of mental illness needed to be established. Given the newness of using mental illness as an indication for therapeutic abortion, this could be problematic because the symptoms were not always recognizable. Doctors needed to consider if mental illness had been present before the pregnancy, and if so, determine the likelihood of a recurrence. Doctors also considered whether a problem had occurred during or after a previous pregnancy, indicating that the woman might suffer in a similar fashion with subsequent pregnancies. One woman reporting on her own experience with post-partum depression decided that subsequent pregnancies were not possible. After becoming pregnant despite the use of a diaphragm she went to two physicians who refused to help her. Desperate, she phoned ARCAL (Association for the Reform of the Canadian Abortion Law) after reading in the newspaper about their lobbying efforts for revision to the Criminal Code. They first put her in touch with a church minister in Ottawa (where she was living) who asked why she wanted to terminate her pregnancy. After telling him her story, he provided her with a Montreal phone number which then connected her with Dr. Henry Morgantaler's clinic. After questioning both she and her husband about why they desired to terminate the pregnancy, he performed the procedure. "If every woman who wanted an abortion could have my experience" she noted, "they would be very fortunate indeed."<sup>60</sup> Of course, we know that many more women were less fortunate in their attempts to procure their own abortions. Since doctors' endeavoured to base their decisions on clinical data, it is not surprising

---

"The Problem of Therapeutic Abortion," p. 71-72; Wilson, "Medical Indications for Therapeutic Abortion," p. 734; Editorial, "Therapeutic Abortion," p. 513; Robinson, "Induced Abortion," p. 11.

that many physicians did not feel comfortable using psychiatric conditions as an indication for abortion.<sup>61</sup>

The second step in determining whether an abortion should be performed for mental health reasons was to examine of the relationship of the mental illness to the pregnancy. For instance, doctors considered whether the pregnancy itself was the cause of the mental illness, and whether the pregnancy would increase the severity of the condition. Third, consideration of whether the continuation of the pregnancy would pose a serious threat to the mental health of the patient needed to be undertaken. Some doctors questioned this in particular given that it was difficult to predict whether continuation of the pregnancy would indeed produce some kind of psychosis.<sup>62</sup> Fourth, Dr. Gray advocated that there should be a reasonable probability that the termination of the pregnancy would substantially improve the patient's mental condition.<sup>63</sup> Once again, this was difficult to determine. Many doctors, in fact, argued that the termination itself could leave some women with deep regret which could in turn lead to some form of mental illness.<sup>64</sup> These four criteria certainly appear to have been less than concrete ways of

---

<sup>60</sup> "Ellen," Childbirth by Choice Trust (ed.), *No Choice*, p. 148-150.

<sup>61</sup> As Dr. D.E. Zarfes noted in a 1958 article on the psychiatric indications for the termination of pregnancy, clinical studies which examined the connection between pregnancy and mental illness were needed in order to determine whether there were specific indications which, without exception, could be considered to be indications for abortion. "It would be necessary" he noted "for research to find specific constellations of factors which include pregnancy as a pathogen..." "Psychiatric Indications for the Termination of Pregnancy," *CMAJ*, 79 (August, 1958), p. 234.

<sup>62</sup> In comments on Dr. Zarfes' article, Daniel Cappon, an Associate in the Department of Psychiatry at the University of Toronto suggested that what was needed was research about this issue taken from two perspectives: the examination of the psychodynamics of the individuals together with the sociodynamics of society to "clarify the workings of the mind of women seeking abortion" as well as to examine the societal values surrounding the issue of abortion. Cappon predicted, though, that "very likely there is no absolute psychiatric indication for therapeutic termination of pregnancy other than the comparatively rare syndrome...or schizo-affective gestational psychosis, in which pregnancy per se plays a major etiologic role." Indeed, he suggested that the woman who presented herself for abortion was the "least likely to break down if the abortion is refused." "Psychiatric Indications for the Termination of Pregnancy – Comments," *CMAJ* 79 (August, 1958), p. 235-236.

<sup>63</sup> K.G. Gray, "Psychiatric Indications For Therapeutic Abortion," *Ontario Medical Review*, 25 (December, 1958), p. 1098.

<sup>64</sup> Whyte, "The Rubella Syndrome of Congenital Malformations," p. 571. Dr. C.P. Harrison, in an article discussing the legalization of abortion, quoted the Council of the Royal College of Obstetricians and Gynecologists in Britain which noted that "the incidence of *serious* permanent psychiatric sequelae is variously reported as being between 9 and 59%" for patients who underwent a legal therapeutic abortion. "On the Futility of Legalizing Abortion," *CMAJ*,

determining whether a therapeutic abortion should be performed.

Since it was clearly difficult to determine the mental consequences of either continuing a pregnancy contraindicated because of psychiatric illness or whether mental illness would result from therapeutic abortion itself, some doctors argued that in Canada, as in other countries, social and economic indications for abortion needed to be considered. In an article presented to the Journal Club in the Department of Psychiatry at the University Toronto, Dr. D.E. Zarfes of Hamilton, Ontario reviewed the state of the law in a number of countries including Canada in terms of mental illness being an indication for therapeutic abortion. Dr. Zarfes confirmed that medical practice was finding fewer and fewer medical indications for abortion and that common contraindications to pregnancy like heart disease and tuberculosis were now rarely considered. He went on to note that in countries like Denmark, Sweden, Norway, Japan and Russia, social and economic factors were being considered as reasons for legal abortion, but that mental illness itself did not provide an indication for the procedure. Zarfes noted that the Swedish Abortion Act first passed in 1938 and modified in 1946 allowed for the termination of pregnancy for "medical indications" to save the mother's life or health; for "medical-social indications" such as the case of "worn-out mothers" who, on account of the birth of a child would "entail serious danger to her life or health; for "social-medical indications" of the "foreseen weakness" clause where the birth and subsequent care of a child would impair a woman's physical and mental condition or for humanitarian indications such as a pregnancy due to rape or another sexual offence; and for eugenic indications where a genetic condition might be passed from the mother or father to the offspring. In eugenic cases, the parents were required to submit themselves for sterilization.

Similar legislation with corresponding indications existed in Denmark, Norway, Japan

---

95 ( August, 1966), p. 363.

and Russia. These countries did not sanction abortions for psychiatric reasons per se but for indications related to social and economic factors, what Zarfes referred to as “eugenic and humanitarian conditions.”<sup>65</sup> However, he pointed out that such indications were not considered in England, the United States and Canada. That the above indications for therapeutic abortion were not considered to be implicit in the existing law on abortion in Canada posed a serious legal issue since doctors relied on the *Bourne* decision which seemed to indicate that they could perform a therapeutic abortion to protect the life or health of a mother. Many doctors assumed that the need to protect a mother’s health could be based on both medical indications, and other factors that might impact her well-being. Articles like those written by Dr. Zarfes, however, seemed to question whether social and economic factors, even though they could be shown to impact a mother’s mental health, qualified as medical indications for therapeutic abortion.<sup>66</sup>

### ***Therapeutic Abortion and the Law***

Despite the longstanding interpretation of the *Bourne* decision that doctors could perform a therapeutic abortion to protect the life or health of the mother, some doctors began to question its legality in the 1950s and 1960s. Perhaps the first article to deal with this issue came from Dr. Kenneth Gray of the University of Toronto in 1958. Dr. Gray alerted the profession to changes in the wording of the section on abortion in the Criminal Code of 1955. The old section (s. 303) had read as follows:

303. Every one is guilty of an indictable offence and liable to imprisonment for life who, with intent to procure the miscarriage of any woman, whether she is or is not with child, unlawfully administers to her or causes to be taken by her any drug or other noxious thing, or unlawfully uses on her any instrument or other means whatsoever with the like intent.

---

<sup>65</sup> Zarfes, “Psychiatric Indications for the Termination of Pregnancy,” p. 230-231.

<sup>66</sup> Gray, “Psychiatric Indications for Therapeutic Abortion,” p. 1097-1098. See also Zarfes, “Psychiatric Indications for the Termination of Pregnancy”; Cappon, “Psychiatric Indications for the Termination of Pregnancy – Comments.”

As Dr. Gray noted, the comparable section of the new Criminal Code, section 237 (1) had been changed slightly to read as follows:

237. (1) Procuring miscarriage. Every one, who with intent to procure the miscarriage of a female person, whether or not she is pregnant, uses any means for the purpose of carrying out his intention is guilty of an indictable offence and is liable to imprisonment for life.

The issue, suggested Dr. Gray, was that the word “unlawful” had been omitted in the new section. This brought into question whether or not there were any situations in which an abortion could be “lawfully” performed for therapeutic purposes. He further pointed out that in the *Bourne* decision the word “unlawful” was the “essence of the judgement” because it noted that an abortion was not unlawful when performed to save the life of the mother or to prevent a serious deterioration of her health.<sup>67</sup>

Given the absence of any similar case in Canada and the reliance by Canadian doctors on the *Bourne* decision, doctors believed that consideration of the effect of the new wording by legal authorities was needed. “In view of the implications for the practice of medicine,” wrote Dr. Gray, “I suggest that the appropriate medical bodies might direct an inquiry to the Minister of Justice for clarification of this point.”<sup>68</sup> Similarly, other doctors began to question the legality of performing therapeutic abortions for any reason other than to literally save the life of the mother. As mentioned above, this was a serious issue for doctors, particularly since they had relied on the *Bourne* decision to guide their practice for nearly thirty years. Doctors certainly discussed their legal status, particularly in those investigations into indications which threatened

---

<sup>67</sup> The judge in the *Bourne* case ruled that an early termination of pregnancy was “lawful to preserve not only the fact of the mother’s life but also the quality of her life. The quality of life is described as health and includes both physical and mental aspects.” Rebecca J. Cook and Bernard M. Dickens, *Abortion Laws in Commonwealth Countries*, Geneva: World Health Organization, 1979, p. 8-9.

<sup>68</sup> Kenneth G. Gray, “Has the Law of Abortion Been Changed?” *Ontario Medical Review*, 25 (1958), p. 515.

the mothers' health, like mental illness. As Frederick C. Irving noted in his 1936 obstetrics textbook, for instance, "medical ethics justify therapeutic abortion only to save the life, health or reason of the mother."<sup>69</sup> Given that doctors discussed their ability to perform therapeutic abortions to address a number of contraindications to pregnancy before the *Bourne* case, it is not surprising that doctors were confident that the precedent set in the *Bourne* case would have legal standing in Canada. Not only that, no cases had been decided in Canada to suggest that *Bourne* did not apply, and cases of a similar nature in the United States had been upheld by *Bourne*. After the changes to the wording in the Criminal Code in 1955, however, doctors debated the issue as they appear to have become much less confident in the legality of performing an abortion.

In a 1962 article, Dr. J.J. Lederman, a trained doctor and lawyer, wrote "in the course of medical practice doctors are often confronted by conflicts between duty to serve the patient and duty to obey the law. One such conflict, of which doctors may even be unaware, arises from the subject of 'therapeutic abortion.'"<sup>70</sup> Dr. Lederman's paper on the "medico legal dilemma" facing doctors who performed abortion for therapeutic reasons responded to an article he had seen in 1961 which suggested that the law in Canada permitted doctors to perform operations (specifically, therapeutic abortions) when the patient's life was in danger. Lederman disputed this point. The law of Canada, he suggested, did not contain any sanction for abortions in any circumstances. "Nowhere does the law make provision for the grounds upon which an abortion may be lawfully procured" he argued. Further,

---

<sup>69</sup> Frederick C. Irving, *A Textbook of Obstetrics – For Students and Practitioners*, New York: The Macmillan Company, 1936, p. 473. See also J. Clarence Webster, *A Textbook of Obstetrics*, Philadelphia: W.B. Saunders & Company, 1903, p. 659; J.S. Fairbairn, *Gynaecology with Obstetrics – A Textbook for Students and Practitioners*, London: Oxford University Press, 1924, p. 141. The ethical issue comes directly from the Hippocratic Oath which states that doctors are not to administer or provide any means to terminate a pregnancy. "I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give a woman a pessary to produce abortion." "The Hippocratic Oath," as found at <http://members.tripod.com/nktiuro/hippocra.htm>

...even when the life of the mother is threatened by the continuation of her pregnancy, and even when consultations are obtained confirming this threat to the mother's life, and even when all consents to the operation are obtained and valid, and even when the operation is performed by a qualified and registered doctor in a recognized hospital - even when all these conditions have been met, an abortion performed would appear to this writer to be, in the present state of law, as much a crime as any "criminal" abortion...this is not generally understood by the medical profession...It appears that the law as it stands, and the medical profession's interpretation of it are at variance. If the foregoing submission of the state of the law of abortions is correct - and the evidence supports it strongly - then doctors may be disturbed to discover that they are performing services which are criminal.<sup>71</sup>

Dr. Lederman's concerns (and indeed those of many other doctors and lawyers) arose out of the context of their discussions about abortion in the 1960s, but clearly it was not a new discussion. As we have seen, throughout the period of its illegality, therapeutic abortions were performed for mothers whose lives were believed threatened by pregnancy. And while Lederman's forceful paper pointed out that, in reality, the law had never explicitly allowed doctors to perform therapeutic abortions, the justification for such procedures had always existed, shifting over the course of the twentieth century to fit with the changes which occurred in the larger medical discourse on abortion.

Doctors had established a dialogue with the state to promote their interests as was evident from their calls for more accurate means of reporting maternal deaths and legislation to ensure women access to proper prenatal care. It seems to have become clear to doctors that the current Criminal Code did not adequately protect their interests when it came to abortion. As Dr. J.J. Lederman noted in the *Canadian Medical Association Journal* in 1962, the ambiguities that existed in the Criminal Code caused doctors to have to choose between their duty to serve their

---

<sup>70</sup> J.J. Lederman, "The Doctor, Abortion, and the Law: A Medicolegal Dilemma," *CMAJ*, 87 (August, 1962), p. 216.

patients and a duty to obey the law. In his view, the Criminal Code did not guarantee the lawfulness of therapeutic abortion and the *Bourne* case had no legal force in Canada. He further suggested that:

It is intolerable to suggest that the doctor, whose services are vital to the general welfare of the community, should in the course of performing these services remain technically at the mercy of the legal authorities. However, this appears to be the present state of affairs in Canada. Canadian doctors who perform therapeutic abortions either labour in the mistaken belief that these operations are legal or mislead themselves with the belief that the law will not disturb them for their acts.<sup>72</sup>

Dr. Lederman's position was echoed by other doctors. Dr. S.C. Robinson, Assistant Professor of Obstetrics and Gynecology at Dalhousie University, for instance, suggested in a 1963 article in the *Dalhousie Medical Journal* that sections 209, 237 (1) and 238 of the Criminal Code did indeed make it explicitly unlawful to perform an abortion at any point of a pregnancy. He argued, though, that in the case of therapeutic abortion, section 45 of the Criminal Code, seemed to provide protection for anyone who performed a surgical procedure, provided it was for the benefit of the person being operated on.<sup>73</sup> In essence, he suggested that doctors were protected because there were rarely any indications which necessitated the performance of the procedure.<sup>74</sup> When they did exist, it was possible to argue for the need for the procedure on medical grounds. Because there was no Canadian precedent affirming that this was the case, however, it was clear to doctors that clarification of the law was needed. The Canadian Medical Association, represented by a number of successful obstetricians and gynecologists, made this point to the

---

<sup>71</sup> *Ibid.*

<sup>72</sup> *Ibid.*, p. 220.

<sup>73</sup> Robinson, "Induced Abortion," p. 12. See also G.P.R. Tallin, "The Legal Implications of the Non-Therapeutic Practices of Doctors," *CMAJ*, 87 (August, 1962), p. 212-213.

<sup>74</sup> Robinson pointed to three separate studies of therapeutic abortion in Britain, the United States and Canada which had shown a decrease in therapeutic abortions in the late 1940s to late 1950s. In Britain the rate was 1/500 live

House of Commons in 1967 noting that the existing law was discredited when persons of their stature had to break it.

The discussions among doctors about the legality of performing therapeutic abortions indicate an interest in protecting the profession. Certainly, the protection of their disciplinary power was an integral part of the culture of medicine. But doctors were also clearly interested in protecting their patients and this is where the difficulty really arose. As Dr. Donald Smith, Chairman of the Nova Scotia Medical Society's Committee on Maternal Welfare and Lecturer in Obstetrics and Gynecology at Dalhousie University reported in *The Nova Scotia Medical Bulletin* in 1967, only those physicians or hospitals religiously opposed to abortion under any situation were against changing the law. However, he argued that while respecting such moral principles and religious codes, such minority views could not govern proposed changes to the law. "The majority of the medical profession cannot accept the doctrine that a human life which commences at conception has a right to live at the expense of the mother"<sup>75</sup> and in order to ensure that they could protect their patients' welfare without being prosecuted for performing an illegal operation, Dr. Smith argued that revision of the Criminal Code was required. This was particularly important when doctors recognized that the statistics in 1967 showed that approximately one out of every twenty Canadian women had had a criminal abortion.<sup>76</sup>

The discussions about revisions of the law raised a number of issues about abortion that had surfaced earlier. How to justify the termination of a life that had begun at conception, and determining what were true medical indicators for abortion were all prominent in these discussions. Dr. J.W. Mullner, writing to the Editor of the *Canadian Medical Association*

---

births, in New Jersey, 1/236 live births and in Winnipeg, 1/373 live births. "Induced Abortion," p. 12.

<sup>75</sup> Donald F. Smith, "Therapeutic Abortion – Should the Law be Changed?" *The Nova Scotia Medical Bulletin*, (June, 1967), p. 118.

<sup>76</sup> Editorial, "Justice of Miscarriage," *The Nova Scotia Medical Bulletin*, (June, 1967), p. 115.

*Journal* in 1967, urged the medical profession to follow the Hippocratic Oath by not supplying abortifacients to pregnant women which would include performing therapeutic abortion except when “the loss of life of the fetus is incidental and not premeditated...”<sup>77</sup> In other words, therapeutic abortion should be performed only in cases where the death of the mother was imminent if the pregnancy was not terminated. What the discussions in the medical journals of this period indicate is that morality was becoming, as it had been in the early period, a central part of the medical discourse. And, given the moral premise of such discussions, there was certainly no consensus.

While many doctors expressed their concern about the need to perform therapeutic abortions,<sup>78</sup> one doctor in particular dissented publicly from the view of the profession as it was presented in the *Canadian Medical Association Journal*. Dr. Colin P. Harrison of Vancouver wrote first to the editor of the journal in 1963 about whether abortion should be legalized.<sup>79</sup> The article began by discussing some of the reasons presented to legalize abortion. He noted that some argued that abortion should be legalized to stop the prevalence of illegal abortions. If this was a sound argument, he wondered, why not also make legal “murder...bashings or...drug addictions” since these were also crimes which were prevalent. “Prevalence of crime” he concluded “is no argument for legalization.”<sup>80</sup> He also argued that the “elimination” of an unborn child who posed a threat to the life or health of the mother was not valid since if carried to its logical conclusion, anyone should be eliminated if they threatened the life or health of anyone else. The point of Harrison’s letter was that abortion could be argued to be either a good

---

<sup>77</sup> Mullner, “Letter to the Editor – Abortion and the Law,” p. 1613.

<sup>78</sup> For instance, see Wilson, “Medical Indications for Therapeutic Abortion”; Kinch, “Are We Doing Too Many Therapeutic Abortions.”

<sup>79</sup> In the first article by Harrison his address was actually listed as Victoria, Australia. However, subsequent contributions in later years identified him as being from Vancouver. It is unclear whether Harrison was visiting Australia during his first letters or whether he was practicing there at the time. See “The Issue of Legalized Abortion,” *CMAJ*, 88 (February, 1963): 329-330.

or a bad thing when the premise should be “that each person has the right not to have his life unjustly taken from him” and this, of course, included the fetus because life begins at conception.<sup>81</sup>

A second letter to the Editor, written as an allegory, was submitted by Harrison the following year. In the story entitled “Farewell to Honour,” he told of a woman traveller and her child who were assisted through a jungle in which three ogres lived (Death, Disease and Unhappiness) by a band of knights who “belonged to a proud and noble profession and had sworn a great oath to protect all under their care.”<sup>82</sup> As one of the knights led the woman and child through the jungle they were attacked by an ogre.

But with ready courage the brave knight sprang forward and, drawing his sword, sank it to the hilt in the soft belly of the child. And innocence was sacrificed to the ogre and the ogre was appeased and the traveller and knight continued on their way. Now when the people heard of this, there were some who murmured against the treatment of the child. But the newspapers called them unprogressive and the knights said that they were impractical and the lawyers said “There should be a law.” And so a law was framed and it was called the “Law of the Jungle” and its first precept was “The young, the innocent, the dependent and the defenceless, thou shalt NOT protect.” And the knights cheered the law. But the proud tomb of Hippocrates crumbled and from its age-dried dust there welled fresh tears of shame. For the traveller was a woman and her child was unborn.<sup>83</sup>

It is clear from these two contributions from Dr. Harrison that he had very strong views about abortion, particularly in terms of the morality of the practice. Indeed, in his third contribution to

---

<sup>80</sup> *Ibid.*, p. 329.

<sup>81</sup> *Ibid.*, p. 330. Dr. S.G. Stern of Toronto responded to this initial letter by suggesting that a rational argument was not presented by Harrison. See Letter to the Editor, “The Issue of Legalized Abortion,” *CMAJ*, 88 (April, 1963), p. 899 and the response by Harrison “Response to S.G. Stern,” *CMAJ*, (April, 1963): 899-900.

<sup>82</sup> C.P. Harrison, “Farewell to Honour,” *CMAJ*, 92 (September, 1964), p. 569-570.

<sup>83</sup> *Ibid.*, p. 570. There were four letters in response to Harrison’s, none of which supported his view on abortion. See the response from Drs. L.A. Jentz and A.E. Croal of the Brantford General Hospital, “Farewell to Honour,” *CMAJ*, 91 (October, 1964), p. 824; D. Moore of North Surrey, British Columbia, “Farewell to Honour,” *CMAJ*, 91 (October, 1964), p. 824; Dr. P.H. Melville of Toronto, “Postscript to ‘Farewell to Honour,’” *CMAJ*, 91 (November, 1964), p. 1130; Dr. O.G. Lane of the Victoria Union Hospital in Prince Albert, Saskatchewan, “Defeat for ‘Dishonour?’” *CMAJ*, 91 (December, 1964), p. 137

the journal in 1966, he argued that

the fact of the matter is that there is no half-way house between complete prohibition of abortion on the one hand and complete freedom of abortion on the other, that is not a matter of imposing some moral code on the public. For moral codes just cannot be averaged by saying that many people believe that abortion is right and many believe that it is wrong, so let us make it legally half right and half wrong.<sup>84</sup>

The point, as far as Harrison was concerned, was that a change in the legislation on abortion would not help to clarify what was moral or immoral. The “moral dilemma” existed in the first place because physicians who believed that abortion was an appropriate way to rectify certain medical conditions “were forced to act outside the law because of the moral beliefs of others.”

He continued,

Others, believing that abortion is evil in itself, do not wish the society of which they are part to condone it, in effect, by legalizing it. These moral attitudes must be respected because it is upon them that civilization ultimately rests.<sup>85</sup>

Given the inability to rectify different views on morality, Harrison argued that to change the law on abortion to allow it under certain conditions and not others would simply lead doctors to ensure that women seeking abortions met those criteria.<sup>86</sup> He concluded by noting that if some abortions were categorized as legal where presently they were illegal, “the social attitude to human life will deteriorate and the physician will find himself less able to make his own personal

---

<sup>84</sup> C.P. Harrison, “On the Futility of Legalizing Abortion,” *CMAJ*, 95 (August, 1966), p. 361.

<sup>85</sup> *Ibid.*, p. 365.

<sup>86</sup> He clarified this point in a rebuttal to a letter questioning his argument. He noted, “let us suppose that the law makes it illegal to steal and then it is found that 20% of the population is stealing. If the law were changed to read ‘it is illegal to steal more than fifty dollars,’ there would be fewer people with a ‘cynical disregard for Law, and for the Rule of Law’ but society would be worse off because the law cannot afford to be a statement of what people do but must be a statement of what people should do. It must be enunciated as though every man were perfect and it must be administered according to his imperfections if it is to be both humane and effective.” C.P. Harrison, “On the Futility of Legalizing Abortion,” p. 688 in response to the letter from Dr. Peter M. Grant of St. Catherines, Ontario in the same issue. “On the Futility of Legalizing Abortion,” *CMAJ*, 95 (October, 1966), p. 879.

decisions.”<sup>87</sup> This, presumably, was his ability to refuse to terminate an unwanted pregnancy.

Letters sent in reply to Dr. Harrison’s article, all supported to some degree the liberalization of the law on abortion. As Dr. R. N. Richards of Toronto noted, “the desire for abortion is so strong that religious fear, government legislation and education have not been able to reduce the incidence of criminal abortion.” For Richards, the only solution was to “make abortion available to every woman upon request.”<sup>88</sup> Psychiatrist Dr. P.M. Grant noted that, unlike Harrison, “I retain some hope that the law can yet become a closer approximation to the goodness and wisdom of us doctors.” He went on to ask,

If we cannot define all the circumstances in which abortion is permissible, can we define some of them? Can we, with our combined medical brain power, enunciate any guiding principles as to when, if ever, abortion is justified? Can we, at the very least, recognize, as Dr. Harrison recognizes, that cases where abortion should be performed are conceivable?<sup>89</sup>

It is clear from the letters from both Harrison and his refuters that there was not consensus within the profession about whether or not changes to the legislation on abortion were needed. Despite these differing views, however, the CMA sought out an appropriate amendment to the Criminal Code to ensure protection of its members as well as for their patients.

Prior to the *Bourne* decision doctors had operated on the assumption that they could terminate a pregnancy to save the life of the mother. Over the course of the twentieth century and with the advances of medical science, the number of contraindications to pregnancy decreased as many previously contraindicative illnesses became manageable. In the interwar period doctors began to discuss other factors which might necessitate the performance of therapeutic abortions, like socio-economic pressures and mental illness. Their justification of the

---

<sup>87</sup> Harrison, “On the Futility of Legalizing Abortion,” p. 366.

<sup>88</sup> R.N. Richards, “One the Futility of Legalizing Abortion,” *CMAJ*, 95 (October, 1966), p. 830.

<sup>89</sup> P.M. Grant, “On the Futility of Legalizing Abortion,” *CMAJ*, 95 (October, 1966), p. 879.

termination of pregnancies seemed to be cemented by the *Bourne* decision which stressed that doctors had the legal ability to terminate an unwanted pregnancy to save not only the life, but also the health of the mother.

The evolving definition of health became crucial as doctors began to question their legal status after the wording of the section on abortion in the Criminal Code changed in 1955. Doctors became more focused on ensuring their legal status in performing therapeutic abortions, and their desire to be able to determine who should and should not have an abortion would become a large part of their recommendations for changes to the Criminal Code in the late 1960s. It is evident from this exploration of the shifts in doctors' discussions of therapeutic abortion that, by the 1940s and 1950s doctors became more concerned about their status as professionals in performing therapeutic abortions which led them to seek changes in the law. But, as we saw in chapter three, doctors were also interested in women's welfare. One of the easiest ways to protect women from the dangers of either illegal operations or in the case of contraindicative illnesses or factors was for doctors to be able to provide them with access first to legal and safe methods of contraception and, in exceptional circumstances, to legal abortion. The next chapter explores submissions to the Standing Committee on Health and Welfare by doctors and interest groups which ultimately decided how the law on abortion in Canada was liberalized. It is clear from the submissions that the medical profession played a key role in shaping the legislation. However, it is also clear that doctors did not all agree about how the legislation should be changed as a variety of positions on the morality of the issue emerged. At the end of the day, however, their recommendations reflected their concern, not only for their professional and legal status, but also for their patients' welfare and well-being which had become a major focus in their discussions of the postwar period.

## Chapter Five

### **“A General Consensus”: *The Role of Medical Discourse in Framing Revisions to the Legislation on Abortion***

During questioning by the Standing Committee on Health and Welfare appointed to investigate abortion in Canada,<sup>1</sup> committee member Stanley Knowles (N.D.P.) queried the members of the delegation representing the Canadian Medical Association about the performance of therapeutic abortion:

Mr. Knowles: ...My first question is this. Are you absolutely sure that the Criminal Code gives you an unquestioned right to perform an abortion when the life of the mother is at stake?

Dr. Aitken: No, not an unquestioned right. It has been so interpreted. I understand, if the life of the mother were threatened.

Mr. Knowles: But the Criminal Code itself is contradictory on this point, is it not? In other words, you really want to end your life as law breakers. You would like to get this business straightened out.

Dr. Aitken: We would, indeed. We would like this very much indeed. I think it would be safe to say that this is one of our main purposes. We do not like being law breakers.<sup>2</sup>

This testimony seems to suggest that doctors' desire to have the Criminal Code revised was

---

<sup>1</sup> The Standing Committee on Health and Welfare was newly formed in February 1966 when twenty-four members of Parliament were appointed to the committee. The Standing Committee was probably formed partly in response to growing support for amendments to the sections of the Criminal Code which dealt with birth control and abortion. Dr. Harry Harley was elected as chair and Dr. Gaston Isabelle as vice-chair of the committee during their first meeting on 17 February, 1966. During that first meeting, Stanley Knowles was also elected to the Sub-Committee on Agenda and Procedure along with Messrs Harley, Isabelle, P.B. Rynard, and A. Simard. Brenda Margaret Appleby, *Responsible Parenthood: Decriminalizing Contraception in Canada*, Toronto: University of Toronto Press, 1999, p. 208-209.

<sup>2</sup>Evidence presented to the Parliamentary Committee on Health and Welfare, October 31, 1967, p. 108.

strictly in their own interest – to protect their status and allow them to avoid being law breakers. Indeed, the Canadian Medical Association had debated the issue of their legal status in terms of abortion both in their journal and in the association's General Council meetings. As we have seen, although many doctors had performed therapeutic abortions when they believed the life of the mother was threatened, there was increasing concern in the late 1950s and early 1960s that doctors were not protected legally for doing so since the Criminal Code did not explicitly grant them the power to perform such operations.

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. These three bills, (Bills C-122, C-123 and C-136)<sup>3</sup> were referred to the Standing Committee on Health and Welfare by the House of Commons in June 1967. The Committee was to consider and report on the issue given that the three Bills proposed different sets of conditions for the legalization of abortion. Although the Standing Committee was still relatively new, the process of hearing testimony on issues being considered for revisions had happened before. The Standing Committee had first been convened on 17 February 1966 to hear testimony about four bills on contraception that had been referred from the House of Commons, and continued those meetings until 18 November 1966.<sup>4</sup> From 3 October 1967 to 5 March 1968 the Committee reconvened to hear from witnesses as they considered Bills C-122, C-123, and C-136 clause one, which dealt with proposed amendments to the Canadian Criminal Code regarding abortion.

The social and political context within which the Standing Committee (and doctors)

---

<sup>3</sup> Bill C-122 was introduced by Grace MacInnis (N.D.P). Bill C-123 (Clause one) was introduced by Ian Wahn (Liberal). Bill C-136 was introduced by H.W. Herridge (N.D.P.).

<sup>4</sup> For a discussion of the Standing Committee's consideration of contraception see Appleby, *Responsible Parenthood*.

operated framed the discussions of both abortion and contraception reform. Historians Robert Bothwell, Ian Drummond and John English note that, as Canadian baby boomers came of age and began to attend universities, they expressed their own counterculture of sex, drugs, fashion and political extremes. One study of personal attitudes and behaviour conducted at university and trade schools in three Canadian cities in the late 1960s showed “an acceptance of increased permissiveness and fewer feelings of guilt about sexual activity.”<sup>5</sup> At the same time that sexual activity (at least by some) was increasing, the birth rate was decreasing, dropping in Canada from 28.2 live births per thousand women in 1957 to 18.2 per thousand in 1967. This decline in the birth rate confirmed that contraceptives were being used (the pill was available in Canada in 1961) despite the fact that they were illegal.<sup>6</sup> This shift in values certainly suggested that many members of the Canadian public were ready for legislative change in matters relating to reproductive control. Indeed, one of the arguments in favour of legislative change for both contraception and abortion was that the laws on both of these issues were unenforceable and, therefore, not sound. Reports of back-alley abortions and claims that abortions were on the increase helped to emphasize that women were having abortions, despite the illegality of the practice.<sup>7</sup> This necessitated changes so that the law would reflect the status quo. Many doctors

---

<sup>5</sup> Robert Bothwell, Ian Drummond and John English, *Canada Since 1945: Power, Politics and Provincialism (Revised Edition)*, Toronto: University of Toronto Press, 1989, p. 310. See also Doug Owram, *Born At The Right Time: A History of the Baby Boom Generation*, Toronto: University of Toronto Press, 1996.

<sup>6</sup> J.L. Granatstein, *Canada 1957-1967: The Years of Uncertainty and Innovation*, Toronto: McClelland and Stewart, 1986, p. 7. See also Angus McLaren and Arlene Tigar McLaren, *The Bedroom and the State: The Changing Practices and Politics of Contraception and Abortion in Canada, 1880-1997 (Second Edition)*, Toronto: Oxford University Press, 1997, p. 125-127. While the pill and other contraceptives were available, it was not legal in 1961 to use them and this was emphasized in the case against Harold Fine, a Toronto pharmacist who was charged, convicted and fined for selling condoms in 1960. See Appleby, *Responsible Parenthood*, p. 3-4; McLaren and McLaren, *The Bedroom and the State*, p. 132.

<sup>7</sup> See Alphonse de Valk, *Morality and Law in Canadian Politics: The Abortion Controversy*, Montreal: Palm Publishers, 1974; Reports of the Abortion Squad of the Morality Department of Metropolitan Toronto Police indicated that there were more than 35,000 criminal abortions procured in Toronto each year. See W.T. Noonan and D.E. Cannell, “A Seven-Year Study of Maternal Deaths in Ontario,” *Ontario Medical Review*, 32 (October, 1965), p. 707. Another estimate suggested that anywhere from 50,000 to 100,000 abortions were being performed each year in Canada. *CMAJ*, 97 (1967), p. 1233. See also McLaren and McLaren, *The Bedroom and the State*, p. 136.

certainly supported changes which would allow them to legally prescribe birth control to their patients and to perform therapeutic abortions when they deemed it appropriate. Together with the medical support for revising the Criminal Code, groups advocating women's rights were beginning to emerge in this period, calling for changes to laws which affected women. Although such sentiments did not represent a strong voice in the debate over changes, there can be no question that they were present. Outside Canada legislative changes regarding both birth control and abortion were also being pursued. Both the United States and Britain changed their laws, although many historians have pointed out that despite similarities in the social attitudes toward contraception and abortion in both Britain and the United States changes in Canada were more conservative.<sup>8</sup>

Beyond a popular call for legislative change and despite the historically conservative nature of Canadian politics, some politicians felt that change was needed in Canada in the 1960s. The leadership for such amendments came primarily from the minority Liberal government and had been part of their campaign platform as they sought to overtake Prime Minister Diefenbaker. In order to do so they campaigned under a platform of human rights and tabled a plan to separate laws that dealt with moral issues from laws of the state, a plan that would come to be associated with Pierre Trudeau.<sup>9</sup> Appointed as minister of justice in 1967, Trudeau set to work reforming old laws that, in his words, "impose the concepts which belong to a sacred society on a civil or profane society."<sup>10</sup> Indeed, the suggested changes to the legislation regarding birth control and abortion contained in the Canadian Criminal Code put forth by Trudeau were really just part of a

---

<sup>8</sup> Bothwell et. al. *Canada Since 1945*, p. 310-311.

<sup>9</sup> In his portfolio as Justice Minister Trudeau focused on "constitutional negotiations with the provinces, drafting the Divorce Reform Bill, and reforming the Criminal Code." These were "representative of the Liberal legislative plan to create a legal distinction between religious morality and state laws" largely in response to increasing secularization in Quebec. Appleby, *Responsible Parenthood*, p. 15-16.

<sup>10</sup> George Radwanski, *Trudeau*, Toronto: The Macmillan Co. of Canada, Ltd., 1978, p. 96 as quoted in Appleby, *Responsible Parenthood*, p. 16.

larger omnibus bill which sought to not only legalize therapeutic abortions but to regulate sales of firearms, allow for charitable lotteries, and remove the state from the bedrooms of the nation by rejecting outdated sexual taboos with respect to homosexuality and birth control.<sup>11</sup>

While at first glance it might seem that a more liberal attitude toward sex on both the social and political fronts was the key contributing factor in legislative reform with respect to abortion, more traditional and conservative forces contributed to the reforms as well. Advocates of reform came from historically powerful and well-established social institutions such as the medical and legal professions, professions considered to be conservative, even cautious in their public stance on the issues of contraception and abortion. Some academics have been highly critical of these professional groups, especially the medical profession, suggesting that they sought changes to the legislation in their own interests.<sup>12</sup> Despite this trend in the academic literature about abortion, the first four chapters of this thesis suggest that doctors' positions on abortion shifted to fit within the social and political contexts of the day. If this is the case then we must view the CMA's position on abortion as not simply a reflection of their own desire to maintain their status as a profession (although doctors are always constrained by this to some extent), but rather as a reflection of how the medical profession's position changed over time. We know that the attitudes of Canadians about abortion were changing in the 1960s, and hence, the view of the profession on the practice also changed.

---

<sup>11</sup> McLaren and McLaren, *The Bedroom and the State*, p. 9. Historians have pointed out the new attitudes toward sex, morality, and the family in the 1960s stemmed partly from a liberalizing trend in Canadian politics characterized by the Canadian Bill of Rights (1960). See Appleby, *Responsible Parenthood*, p. 94; O'ram, *Born at the Right Time*, p. 266.

<sup>12</sup> Gail Kellough, *Aborting Law: An Exploration of the Politics of Motherhood and Medicine*, Toronto: University of Toronto Press, 1996; Janine Brodie, Shelley Gavigan and Jane Jensen, *The Politics of Abortion*, Toronto: Oxford University Press, 1992; F.L. Morton, *Pro-Choice vs. Pro-Life: Abortion and the Courts in Canada*, Norman and London: University of Oklahoma Press, 1992; Sally Sheldon, *Beyond Control: Medical Power and Abortion Law*, London: Pluto Press, 1997; Michael Thomson, *Reproducing Narrative: Gender, Reproduction and Law*, Aldershot: Ashgate Publishing, 1999.

This chapter explores the submissions and testimony of witnesses to the Standing Committee on Health and Welfare, as well as those of the three MP's who tabled bills, with a focus on members of the medical profession. The position of physicians (there were both advocates for and against changing the legislation) needs to be placed within the context of the shifts which occurred in their own discourse on abortion. Doing so demonstrates that, while the subject of abortion reform in Canada was definitely medicalized by the 1960s, doctors' position cannot be seen simply as self-serving and at odds with the growing movement to recognize women's rights. Indeed, doctors' discussions of the practice in this post-war period suggests that medical professionals were concerned about women's welfare and it can be suggested that, to some extent, this was a move on their part to recognize women's right to choose whether or not to continue a pregnancy. But it should be remembered that at the heart of doctors' discussions of the practice was their need to view abortion as a medical procedure which meant that they framed their position within their larger discussions of maternal welfare and the role of their profession. These preoccupations dominated their discussions of abortion. The three main themes present in the medical discourse on abortion, namely, the role and status of the medical profession, the moral issues surrounding the practice of abortion, and how abortion practices affected women's role, can all be seen in the testimony of medical professionals to the Standing Committee as well as in submissions by other witnesses. And the theme of women's welfare which emerged in doctors' discussions of abortion in post-war Canada was presented as a key concern of the medical profession in their testimony to the Standing Committee. While doctors, with the exception perhaps of Dr. Henry Morgentaler, did not publicly frame their discussions of abortion solely within the context of women's rights to reproductive control over their own bodies, this chapter argues that they did, whether arguing for or against changes to the legislation

on abortion, have what they perceived to be their patients' best interests in mind.

### ***Background to the Legislation from the Medical Profession's Point of View***

What was the impetus for discussions among the medical profession for changes in the Criminal Code? Certainly the 1938 *Bourne* case in England prompted doctors to accept the idea that the defence of necessity as used in the case was applicable in Canada. In chapter two the assumption by Canadian doctors that the precedent set by this case would apply in Canada was discussed. It is not surprising that Canadians would rely on English law for precedents – especially given that Canadian law is derived from English example. Just as Canada's original abortion laws were based on the British laws, so too was the movement for reform of the law in the 1960s.<sup>13</sup> In fact, British influence was still strong in Canada in the 1960s – even the *Canadian Medical Association Journal* had a monthly feature called “The London Letter” which reported medical news from Britain. It was not only doctors who recognized a close, formal connection between what happened in Britain and what happened in Canada. J.R. Weir, President of the Canadian Bar Association, noted at the annual meeting in 1966 that, “we tend to make a change in our law only after England has done so.”<sup>14</sup>

The Wolfenden Report (1957) represented the first move in Britain to separate private

---

<sup>13</sup> That Canadian law is derived from and based on British law is accepted by scholars. For instance see F.L. Morton, *Pro-Choice vs. Pro-Life*, p. 18; Robert Campbell and Leslie Pal, *The Real Worlds of Canadian Politics: Cases in Process and Policy*, Peterborough, Ontario: Broadview Press Ltd., 1989: 165-226; Constance Backhouse, “Involuntary Motherhood: Abortion, Birth Control and the Law in Nineteenth Century Canada,” *Windsor Yearbook of Access to Justice* (1983): 61-130; Anne McLellan, “Abortion Law in Canada,” in J. Douglas Butler and David F. Walbert (eds.), *Abortion, Medicine and the Law*, New York: Facts on File, 1992: 333-405; de Valk, *Morality and Law in Canadian Politics*, p. 1.

<sup>14</sup> See Presidential Address, *Canadian Bar Association Journal*, 1966, p. 341 as quoted in de Valk, *Morality and Law in Canadian Politics*, p. 1. As de Valk notes, the British North America Act preserved existing common criminal law, and the Canadian *Criminal Code*, when codified in 1892 closely resembled the British Code (1880). When the Canadian Code was further consolidated in 1906 and 1927, the 1906 consolidation preserved “...the criminal law of England insofar as this had not been altered by the (Canadian) Statute.” p. 1. See also Alan Mewett, “The Criminal Law, 1867-1967,” *The Canadian Bar Review*, (December, 1967), p. 726-740; F.L. Morton, *Pro-Choice vs. Pro-Life*, p. 18-19. In a letter to the editor of the *Canadian Medical Association Journal*, Dr. J.J. Lederman of Vancouver, British Columbia noted that, “it is true that the law of Canada is a child of the law of England and, like any child, bears in many respects the stamp of its progenitor.” Lederman did not think, though,

morality and criminality. Both homosexuality and prostitution were addressed in the report that suggested that “there must remain a realm of private morality and immorality...which is not the law’s business.”<sup>15</sup> Although the Wolfenden Report did not address abortion per se, the report is considered to represent the beginning of the debate over abortion in Britain because of its suggestion that the state should not regulate personal matters, a theme that would be adopted by Pierre Trudeau in Canada in the 1960s.<sup>16</sup> When the British Labour party returned to power in 1966, a reform bill on abortion was tabled and Britain passed the first essential “abortion on demand” bill of all the Western European nations.<sup>17</sup>

The change in the British law received a great deal of press in Canadian medical journals, especially in the “official” journal of the profession, the *Canadian Medical Association Journal*. It reported in its column, “The London Letter”, that some Canadian doctors worried about how changes to the legislation on abortion would affect the profession. For instance, in 1967 a report in the column suggested that the medical profession wondered whether revisions would mean that they would eventually be called upon to not only terminate unwanted pregnancies but also other lives as well (euthanasia). There was also concern that some “doctors” would take advantage of the new legislation to increase their income by performing abortions, thereby creating an “iniquitous situation” between doctors who charged the “usual extortionate price” and those who did not perform the procedure.<sup>18</sup> This report seems to suggest that some doctors still viewed abortion-providers in a negative light, not unlike the way they had been

---

that this meant that Canada could not disagree with British law in certain circumstances. “The Doctor, Abortion, and the Law,” *CMAJ*, 87 (October, 1962), p. 821.

<sup>15</sup> Morton, *Pro-Choice vs. Pro-Life*, p. 19.

<sup>16</sup> Trudeau’s famous quip about the state having no place in the bedrooms of the nation is the best evidence of this.

<sup>17</sup> Morton, *Pro-Choice vs. Pro-Life*, p. 19. “Abortion on demand” in the Abortion Act (1967) simply meant that women could request to have their pregnancies terminated. As Sally Sheldon notes, this did not mean that women actually had the right to choose. Rather, the Abortion Act accords clear moral authority to the doctor, in that it is he who has the final decision regarding abortion.” *Beyond Control*, p. 25.

<sup>18</sup> Editorial, “The London Letter – The Abortion Battle of Britain,” *CMAJ*, 96 (April, 1967), p. 1171.

characterized at the turn of the century when doctors worked to regulate their profession.

Despite the concerns expressed by some doctors, others who worried about the lack of clarity in the existing law believed that its amendment was necessary and would not change how the profession addressed abortion. By 1969 however, an article in the *British Medical Journal* claimed that the revision of the law had altered “the whole character of the gynaecologist’s work because he has to deal with two, three or four requests [for abortion] every session”<sup>19</sup> Not only did this change medical practice in Britain, claimed the author, but also societal attitudes toward abortion.<sup>20</sup> These conflicting reports, though, were about the status of the profession in Britain. What did they mean to Canadian doctors who were facing the prospect of *Criminal Code* amendments at home?

Canadian doctors, too, were concerned about how changing the legislation might affect them. One of the common themes in the discussions about the change in the British laws – that the change in the legislation would cause Britain to become less moral – was also expressed by Canadian doctors and others. As we have seen, Dr. Colin Harrison, writing in the *Canadian Medical Association Journal* put the moral quandary as he saw it, in allegorical terms.<sup>21</sup> Others simply suggested that doctors, with revision to the law, would face moral decisions in practice.<sup>22</sup> Conservative M.P. Walter Carter suggested during the debate of Omnibus Bill in 1969 that a government “which relaxes....curbs on drugs, makes divorce easier, permits abortion and homosexuality, is in the process of remaking our society. The question we must ask is, in whose

---

<sup>19</sup> Editorial, “The London Letter - The Abortion Capital of the World,” *CMAJ*, 100 (April, 1969), p. 733.

<sup>20</sup> *Ibid.*

<sup>21</sup> C.P. Harrison, “Farewell to Honour,” *CMAJ*, 91 (September, 1964): 569-570. See also the subsequent letters to the editor in response to this letter from L.A. Jentz and A.E. Croal of the Brantford General Hospital, *CMAJ*, 91 (October, 1964): 824; Norman S. Skinner of the Saint John General Hospital, *CMAJ*, 91 (October, 1964): 824; P.H. Melville, “Postscript to ‘Farewell to Honour,’” *CMAJ*, 91 (November, 1964): 1130; O.G. Lane of the Victoria Union Hospital in Prince Albert, Saskatchewan, “Defeat for ‘Dishonour?’” *CMAJ*, 91 (December, 1964): 1373-1374.

<sup>22</sup> A.D.K., “The By-Products of Conception,” *CMAJ*, 98 (February, 1968): 422-423.

image and likeness?<sup>23</sup>

In Canada, despite the medical profession's ongoing discussions about abortion, abortion itself did not become an explicitly discussed legal issue until the 1950s. Before that time, doctors assumed their legal ability to perform the procedure for therapeutic reasons, relying after 1938 on the *Bourne* decision. However, as medical indications for therapeutic abortions declined in the 1950s, doctors' uncertainty about their legal status increased. This does not mean, however, that doctors were advocates of abortion. Many doctors were uncomfortable with the idea that thriving abortion businesses existed,<sup>24</sup> or simply did not approve of abortion.

Many historians have credited the impetus for change in the legislation to a 1959 article by Joan Finnigan in *Chatelaine* magazine. Finnigan described the case of a fourteen year old girl who had been brutally gang raped and subsequently became pregnant. She was aborted by her caring physician who believed that termination of her pregnancy was warranted, despite the risk he faced for performing an illegal operation. Finnigan used this case (which may sound familiar because it was essentially the scenario of the 1938 *Bourne* case) to point out that in comparison with other countries, like Sweden, Denmark, Russia and Japan, Canada's abortion laws were the "stiffest...in the world." For this reason, Finnigan called for the grounds for abortion to be broadened to include rape, eugenic concerns, or threat to the mother's physical or mental health.<sup>25</sup> Alphonse de Valk has further argued that the move for change in the legislation went

---

<sup>23</sup> Morton, *Pro-Choice vs. Pro-Life*, p. 24. Although there were also discussions occurring in the United States in this period about the illegality of abortion, doctors in Canada appear to have been much more interested in what was happening in Britain. This is probably because of the close connection the profession had maintained with the happenings in the UK throughout this period of study and because Canadian doctors had relied so heavily on the British precedent from the *Bourne* decision to guide their own practices.

<sup>24</sup> See Noonan and Cannell, "A Seven-Year Study of Maternal Deaths in Ontario," 705-707. The Badgley Report investigating the effectiveness of the 1969 revision to the Criminal Code in the early 1970s reported that many "back-street abortions" were still performed. See Campbell and Pal, *The Real Worlds of Canadian Politics*, p. 170.

<sup>25</sup> See Joan Finnigan, "Should Canada change its Abortion Law?" *Chatelaine*, (August, 1959): 17; Campbell and Pal, *The Real Worlds of Canadian Politics*, p. 171; Morton, *Pro-Choice vs. Pro-Life*; Jane Jenson, "Competing Representations: The Politics of Abortion in Canada," in Caroline Andrew and Sanda Rodgers (eds.), *Women and the Canadian State*, Montreal: McGill-Queen's University Press, 1997, p. 295-296. As Jane Jenson has noted,

through two phases: a media campaign (begun by Finnigan) championed primarily by the *Toronto Globe and Mail* and then a review of the legislation by the CMA and CBA, beginning about 1963.<sup>26</sup> While there is no question that the real push toward liberalization of the law occurred in the 1960s, the discussion of the practice in Canadian medical journals had always existed, shifting to fit changing societal contexts. We know that in the early period the medical discourse on abortion had been a way for regular physicians to differentiate themselves from irregular practitioners. In the interwar period the shift had been toward a discussion of abortion in the context of the high maternal mortality rate. In the postwar period, doctors' discussions of abortion shifted to address their concerns about women's welfare. It was within this context that doctors discussed proposed changes to the Canadian law on abortion in the late 1960s.

***Beginning the Discussion: Bills C-122, C-123 (Clause 1), and C-136***

The Standing Committee, after hearing four bills on contraception<sup>27</sup> from 17 February 1966 to 18 November 18 1966, reconvened to deal with abortion reform on 3 October 1967. The first meeting of the Committee on that day heard presentations from the three Members of Parliament who had proposed the bills. Bill C-122, proposed by Grace MacInnis (N.D.P., Vancouver-Kingsway), sought to specify that there were grounds for abortion "if continuation of the pregnancy would involve serious risk to the life or grave injury to the health, either physical or mental, of the pregnant woman." It also proposed that "substantial risk of a defective child

---

Finnigan's social welfare approach to legalizing abortion was common in other Western European countries where Keynesian economics and social welfare was a stronger discourse in the postwar period (such as the legislation proposed in Britain). She suggests that in Canada, this discourse was weaker (represented by the New Democratic Party) and therefore, such ideas were much less powerful than elsewhere. She points to Bill C-136 introduced by H.W. Herridge in the mid-1960s as an example of this noting that, because it was "based on such a social discourse it received relatively little attention." Instead, she suggests that the 1969 legislation is much more representative of the dominant discourses – those of professional men and some Protestant religions. p. 296, fn 8 (p. 361).

<sup>26</sup> See de Valk, *Morality and Law in Canadian Politics*, p. 35-42. See also Campbell and Pal, *The Real Worlds of Canadian Politics*; Morton, *Pro-Choice vs. Pro-Life*, p. 20.

<sup>27</sup> Ian Wahn's bill on contraception was a two-part bill designed to deal with pregnancy termination and contraception. Only Clause two was dealt with in the Standing Committee's hearings on contraception with Clause One referred to the Standing Committee's later hearings on abortion. See Appleby, *Responsible Parenthood*, p. 17.

being born; or the pregnancy is the result of rape or incest” were grounds for abortion. Bill C-123 (Clause 1), proposed by Ian Wahn (Liberal, Toronto-St. Paul’s), “had two basic purposes; first to clarify the law, and second, to provide proper safeguards and a uniform procedure for all hospitals across the country.” The bill also sought “to declare what the existing law actually is and to make it entirely clear that doctors are entitled to perform therapeutic abortions which are necessary to preserve either the life or the health of the pregnant woman.” Finally, Bill C-136 proposed by H.W. Herridge (N.D.P., Kootenay West), was based on the British abortion law (1967).<sup>28</sup> In essence the British law allowed abortion under broad conditions and included cases where “the continuance of the pregnancy would involve risk to the life or injury to the physical or mental health of the pregnant woman or the future well-being of herself and/or the child or her other children.” Further, “in determining whether or not there is such risk of injury to health or well-being account may be taken of the patient’s total environment actual or reasonably foreseeable.” In the broadened sense of Bill C-136, rape and incest were covered in the clause. Also included as grounds was “a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.”<sup>29</sup> All three bills recommended that the decision to abort could be made either by the consent of two doctors or by a hospital committee, along with the consent of the pregnant woman and her husband (if married).<sup>30</sup> Although all three bills were similar, the Standing Committee carefully questioned the MPs who had proposed them to ensure that they understood the nuances of each. In Canada, the idea of abortion reform was revolutionary and the three bills presented to the House of

---

<sup>28</sup> It is interesting to note that both MacInnis and Herridge were members of the N.D.P., the same party to fight for and usher in medicare in Saskatchewan. This is not a coincidence. For one discussion of the establishment of medicare in Saskatchewan see C. David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance 1911-1966*, Kingston and Montreal: McGill-Queen’s University Press, 1986.

<sup>29</sup> See Bills C-122, C-123 and C-136 as published in the Standing Committee on Health and Welfare Minutes; Eleanor Pelrine, *Abortion in Canada*, Toronto: New Press, 1971, p. 30-32.

<sup>30</sup> Pelrine, *Abortion in Canada*, p. 32.

Commons on the issue were definitely treated as such.

Grace MacInnis, (N.D.P.) M.P. and sponsor of Bill C-122 was questioned first by the Standing Committee. In her opening statement, Mrs. MacInnis noted her four reasons for putting forth the bill. First, she suggested that Canada needed to do something to combat the illegal abortions occurring each year. The current situation was that it was not a matter

...between having abortion in Canada and not having abortion in Canada. The choice is between having a large number of illegal abortions taking place in this country, and having abortions made legal with these limited grounds and seeing that they are performed under conditions of proper medical competence and sanitation.<sup>31</sup>

The desire to have legislation which would prevent, or even eliminate illegal abortions, was certainly shared by many of the witnesses who would appear before the Standing Committee over the next six months. It was also an issue that the media had brought to the public's attention. Alphonse de Valk has pointed to three publications that played a central role in reporting about abortion in this period: *Chatelaine* magazine, the *United Church Observer* and the *Toronto Globe and Mail*. While all three publications published articles on the issue it was the *Globe* that became "the most formidable protagonist of the legalization of abortion among the general public."<sup>32</sup> Indeed, de Valk argues that the *Globe* was "responsible for systematically drawing the attention of the wider public to the issue."<sup>33</sup> The media attention given to abortion, together with Canadians' interest in individual human rights and the reform movements that were part of sixties culture, brought the issue which doctors had discussed for years into the public consciousness.

One of the earliest articles in the *Globe* noted in 1961 that the question of abortion was

---

<sup>31</sup> Canada, House of Commons, "Issue No. 1: Minutes of Proceedings and Evidence (Tuesday October 3, 1967)," *Standing Committee on Health and Welfare*, p. 3.

<sup>32</sup> de Valk, *Morality and Law in Canadian Politics*, p. 11.

<sup>33</sup> *Ibid.*

being raised not only in Canada but also in the United States, Britain and other European countries.<sup>34</sup> By the time the Standing Committee began meeting on the issue in 1967, Britain was beginning the final stages of approval of new legislation allowing abortion. Grace MacInnis used this connection as the second reason to support her bill. The historically close connection between Canadian and English law she argued, emphasized that the Canadian law was simply outdated. She also pointed to countries like Switzerland and even states like Colorado and California as examples of a shift toward more liberal attitudes about abortion and the translation of that shift into law.<sup>35</sup>

For MacInnis, more liberal attitudes about abortion by the Canadian public presented a third reason for changing the law. In her mind, Canada was ready for a change. She pointed to a 1965 Gallup poll which had found that 71% of Canadians wanted to see a change in abortion law as well as a CBC phone-in program, “Cross-Country Checkup,” where a number of callers also expressed the view that the law should be changed. This public support, suggested MacInnis, indicated that the current law was a “bad law” which contributed to the “backstreet abortion racket that goes on in this country.”<sup>36</sup> Indeed, back-street abortions became one of the points used by MacInnis (and others) to argue in favour of changes to the legislation because not only were women entitled to protection from harm from such a procedure, but also because the estimates of 100,000-300,000 illegal abortions in Canada each year seemed to suggest that a large proportion of women were seeking to terminate their unwanted pregnancies. Given these

---

<sup>34</sup> Editorial, “The Abortion Issue”, *Globe and Mail*, September 1, 1961, p. 6.

<sup>35</sup> In 1967 abortion was legal in Switzerland and MacInnis noted that, although the practice was still illegal in France, the number of women who were going to Switzerland to obtain abortions had caused la Commission des Affaires Culturelles, familiales et Social de l’Assemblée Nationale to recommend that both contraception and abortion on strictly limited grounds be made legal. She also noted that the state of California was “conducting vigorous campaigns” for amendment to their abortion laws, and that Colorado had already passed legislation amending the abortion laws. The Colorado legislation was amended as an appendix (“B”) to the proceedings of the Standing Committee. See *Standing Committee on Health and Welfare*, p. 4.

<sup>36</sup> *Ibid.*

numbers, the suggestion was made that that the majority of Canadians were in favour of changing the law.<sup>37</sup>

Her last argument for change to the Canadian abortion law, however, was the one that was most discussed by both the Committee and the press. She suggested that “the positive side” of a change in the abortion law would be Canada’s ability “to work toward quality population...”

We are beginning to hear about the need for improving population and certainly to have children born into a country as the result of rape or incest is not going to be too helpful when one considers the environment that they are likely to encounter. Also, I want to say that if conditions like those of thalidomide babies or congenital diseases are known ahead of time, I do not think it is a good thing for Canada to allow those beings to come into the world...I think it is time we gave parents a chance. I think that women ought to have far more control over what happens to them when monstrosities are born. I have known women who have had to put up with lifetimes of that sort of thing, and it would have been far better, both for them and for those poor little deformed creatures, to have never been brought into the world.<sup>38</sup>

While her suggestion that abortion could help to prevent unwanted pregnancies was not a new one (some doctors certainly made such arguments throughout the twentieth century, particularly those who were members of eugenics groups), it was an argument that clearly made some members of the Standing Committee uneasy. Mr. Robert Stanbury (Lib., York-Scarborough), for instance, noted that,

Mrs. MacInnis, I am with you, I think most of the way on your argument but I run into difficulty when you mix your motivations for this bill between the need to recognize the choice of individuals and what apparently is also motivation behind your bill, with the feeling that society should be protected against a low quality of child. I am frankly a bit shocked by this.<sup>39</sup>

Mr. Stanbury’s shock seems to have stemmed from MacInnis’ suggestion that population control, not only in terms of number of children born but “quality” of children, was a key reason

---

<sup>37</sup> de Valk, *Morality and Law in Canadian Politics*, p. 46.

<sup>38</sup> Standing Committee Minutes, p. 4-5.

for needing the abortion laws in Canada liberalized. It is perhaps understandable that he would react this way given the Nazi attitudes regarding population quality during the Second World War. However, MacInnis' position should not really have been that shocking to Stanbury in a time when there was much discussion about the need for population control in the world. Indeed, the advent of the pill as a form of birth control and the discussions of the Standing Committee about legalizing contraception in Canada had heard similar arguments.<sup>40</sup> As MacInnis noted, it was also a time when some women who had taken thalidomide during their pregnancies were seeking out abortions to terminate what would in all likelihood produce deformed babies. Although exposure to German Measles in the first trimester of pregnancy had long been a concern to women given that there was a chance that their pregnancies would not produce "normal" babies, the thalidomide scares of this period received more publicity with the press reporting high profile cases like the Van de Put trial in Belgium and the Finkbine case in Arizona.<sup>41</sup> Such reports seemed to indicate that some Canadians, along with others in the Western world, were beginning to question traditional views of abortion.

Alphonse de Valk has traced the press coverage of the abortion debate in Canada from its beginnings toward the end of the 1950s and his findings, particularly in terms of the coverage provided to the issue by the *Globe*, indicates that MacInnis was not far off-the-mark in her

---

<sup>39</sup> *Ibid.*, p. 6.

<sup>40</sup> Appleby, *Responsible Parenthood*, p. 66.

<sup>41</sup> Perhaps the most famous thalidomide case was that of Sherry Finkbine in August, 1962. Finkbine was an American children's show host (Romper Room) from Arizona. When she requested an abortion because of her belief that her child would be born deformed due to her having taken thalidomide, and was refused, she flew to Sweden to have the pregnancy terminated there. Similarly, the Van de Put trial in Liege, Belgium in the same year also indicated that morality was changing in Western society. In this case, which was widely reported, the parents of a deformed child due to thalidomide, together with other relatives and their family doctor, administered barbiturates in honey to the newborn. Although those involved were subsequently charged with murder, they were acquitted by an all-male jury. de Valk, *Morality and Law in Canadian Politics*, p. 6, 13. In a 1967 edition of "The London Letter" the *Canadian Medical Association Journal* suggested that while there had been an Abortion Law Reform Association in Britain since before the second World War the issue did not gain significant public interest until "the thalidomide tragedy swayed public opinion in favour of a more liberal abortion policy." *CMAJ*, 96 (April, 1967), p. 1171.

approach to the liberalization of the abortion laws. As de Valk notes, the reporting of the thalidomide crisis of the early 1960s, while short-lived, was instrumental in indicating how Canadians felt about abortion because it revealed that many people were willing to allow and accept abortion, even in cases where there was only a possibility that a baby would be born with a deformity.<sup>42</sup> The *Globe*, he suggests, was the most instrumental newspaper to present the abortion issue to the public. One of the key articles to do so appeared in response to a statement made by Judge Ken Langdon of Oakville, Ontario in December 1962. Langdon had publicly recommended that abortion be legalized for girls under the age of 16, for victims of rape, and that sterilization be provided to parents of large families. As the *Globe* reported in January 1963 in response to the news of the Judge's statement:

Pressure for reform of the laws governing abortion has been growing in recent years at many levels of Canadian society. Highly placed members of the legal, medical and university Professions have urged the extension of legal abortion. The National Council of Women presented a brief to the Royal Commission on Health Services which disclosed that illegal abortion is the commonest cause of maternal mortality in Canada. Leading clergymen of major Protestant communions and of the Jewish faith have endorsed extension of legal abortion. Members of Parliament representing all four political parties have also gone on record as favouring extension.<sup>43</sup>

As the earliest press reports indicate, the *Globe* was mounting a campaign for the liberalization of the Canadian abortion laws early in the 1960s using similar arguments to those presented by Grace MacInnis in 1967. Given MacInnis' note that one of the key reasons for suggesting changes to the legislation was that "...very large sections of the country are ready for this degree [of change in the abortion laws]"<sup>44</sup> there seems to be an indication that the press was influential

---

<sup>42</sup> de Valk, *Morality and Law in Canadian Politics*, p. 13.

<sup>43</sup> Editorial, "Two Problems to be Faced," *Globe and Mail*, January 2, 1963. This article is also quoted in de Valk, *Morality and Law in Canadian Politics*, p. 13.

<sup>44</sup> Standing Committee Minutes, p. 6.

in the tabling of the abortion bills.

Researchers do not agree, however, on who prompted the notion that the law be changed. Most academics investigating abortion in this period suggest that it was the medical profession, first and foremost, who lobbied for change to the abortion laws in order to protect their own profession and not for any other reason.<sup>45</sup> Yet, this examination of the medical profession's discussions of abortion suggests that the medical discourse in the postwar period was no different than in other periods. The medical profession placed its own views on the issue firmly within the context of the day. In the 1960s, they could not help but be influenced by calls for legalized abortion in cases where the risk of deformity was high, and by a public interest in contraception. They were also influenced by reports of women suffering from back-alley abortions which were becoming more publicized.

The problem of back-alley abortions was one that doctors were very familiar with. For decades they had been arguing that this aspect of abortion needed to be addressed and, in fact, had tried different approaches, mainly in the form of education, to prevent women from dealing with unwanted pregnancies in this way. Physicians' discussions about how to prevent women from seeking out such abortionists, however, were insular. While these discussions were accessible to members of the profession, they do not seem to have been heard by those outside. Women continued to seek out ways to terminate their unwanted pregnancies, despite the risks of doing so. This is perhaps not that surprising since being told about the dangers of abortion did not offer a solution. Press reports of significant cases like those of women seeking to terminate their pregnancies because of the risk that their child would be born deformed, helped to raise the

---

<sup>45</sup> See Brodie, Gavigan and Jenson, *The Politics of Abortion*; Kellough, *Aborting Law*. McLaren and McLaren note that, while the first public call for reform of the abortion law came from Joan Finnigan in her *Chatelaine* article, doctors and lawyers had complained about the rigidity of the law since the early 1960s. They further argue that some doctors were particularly disturbed by the deaths of women due to back-alley abortions and by the fact that

public consciousness of this issue, bringing it outside the realm of medicine, and seems to indicate that there was public support for changing the laws on both abortion and birth control. These cases also fit within the larger Planned Parenthood movement and those advocating the need for population control. That Canadians were ready for legislative change was also suggested by the other bills on abortion reform, indicating that there was some strength in that argument. For instance, in his introductory statement to the Standing Committee, Ian Wahn noted that “I feel confident that there is almost a general consensus in Canada that we can safely go this far [in revising the legislation]...”<sup>46</sup> Despite this similarity to MacInnis’ bill, Wahn’s bill was in many respects, different. The main difference was that it sought to “clarify the confusion which now exists in our Canadian law on this subject.”<sup>47</sup>

Wahn pointed out that therapeutic abortions were performed in order to safeguard the life or health of the woman involved and that, indeed, doctors performed them on a regular basis. The problem, of course, was that the existing sections of the Criminal Code dealing with abortion were rather unclear and difficult to interpret. He noted that there were a number of sections which either dealt with abortion specifically or could be interpreted as dealing with abortion. These sections made it unclear as to what the law was with respect to the practice, particularly as far as doctors were concerned. He then outlined the different sections to highlight his point. Section 209, for instance, dealt with the death of an unborn child. That section stated that anyone who caused the death of “a child that has not become a human being” is guilty of an indictable offence and subject to life imprisonment. However, subsection 2 of the same section noted that any person who, in good faith, causes the death of an unborn child in order to save the

---

they perceived the state, with the abortion law, to be meddling in medical matters which should be left to the discretion of physicians. *The Bedroom and the State*, p. 136.

<sup>46</sup> Standing Committee Minutes, p. 15.

<sup>47</sup> *Ibid.*, p. 14.

life of the mother of such child was exempt.<sup>48</sup> This, testified Wahn, suggests that “an abortion is legal if it is performed in good faith to preserve the life of the mother.” However, this was not the only section dealing with abortion. Section 237 made it an indictable offence with a penalty up to life imprisonment for anyone who used any means to procure the miscarriage of a female person whether she was pregnant or not.<sup>49</sup> This section also included a penalty of up to two years imprisonment for the pregnant woman who attempted to procure her own miscarriage. The difficulty with this section, as Wahn noted, was that it did not seem to allow for any exceptions at all. “This creates a serious difficulty of interpretation” he said “because it seems to be inconsistent with Section 209 which provides specifically that if you kill an unborn child for the purpose of preserving the life of the mother it is not a criminal offence.”<sup>50</sup> While there seemed to be a fairly large discrepancy between Sections 209 and 237, there was, perhaps an explanation. Section 45 of the Criminal Code provided protection for doctors when performing a surgical operation for the benefit of the patient.<sup>51</sup> Wahn outlined his belief about Section 45 to the Standing Committee:

Now this section was not passed with abortion in mind, I believe it was passed to protect medical practitioners who perform surgical operations with reasonable skill, perhaps in cases where the patient died or was injured and the medical practitioner required the protection

---

<sup>48</sup> Section 209 read: Every one who causes the death of a child that has not become a human being, in such a manner that, if the child were a human being he would be guilty of murder, is guilty of an indictable offence and is liable to imprisonment for life. Subsection (2) says: This section does not apply to a person who, by means that, in good faith, he considers necessary to preserve the life of the mother of a child that has not become a human being, causes the death of the child.

<sup>49</sup> Section 237 read: Every one who, with intent to procure the miscarriage of a female person, whether or not she is pregnant, uses any means for the purpose of carrying out his intention is guilty of an indictable offence and is liable to imprisonment for life. And: Every female person, who being pregnant, with intent to procure her own miscarriage, uses any means or permits any means to be used for this purpose of carrying out her intention is guilty of an indictable offence and is liable to imprisonment for two years. It should be noted that the legal terminology had always equated “miscarriage” with abortion, as had doctors in many instances.

<sup>50</sup> Standing Committee Minutes, p. 14-15.

<sup>51</sup> Section 45 of the *Criminal Code* read: Every one is protected from criminal responsibility for performing a surgical operation upon any person for the benefit of that person if (a) the operation is performed with reasonable care and skill, and (b) it is reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case.

which is provided in this section. But in terms it does seem to go far enough to indicate that someone who performs a surgical operation with reasonable skill, which is justified, having in mind the state of health of the patient, is protected from criminal responsibility. I cite these sections merely to show that there is real confusion as to what the state of the law is in Canada with regard to therapeutic abortions. The basic purpose of my bill, which as I say is a very modest purpose, is simply to clear up this confusion by stating specifically that therapeutic abortions are legal in Canada.<sup>52</sup>

It is perhaps not surprising to learn that Wahn's bill was drafted in consultation with Dr. Donald Low, the Chairman of the Abortion Committee of the Ontario Medical Association, and also not surprising that clarification of the law in terms of medical practice was the main thrust of the bill.

The bill proposed by Mr. Herridge (Bill C-136) followed a similar line of thought to Wahn's but was much more radical in its approach, calling for the law to be revised in order to allow medical practitioners to perform a therapeutic abortion, as well as encouraging revision to take into consideration social factors, for example the economic status of a mother,<sup>53</sup> when determining the impact of a pregnancy on a mother's health. While some doctors had certainly recognized that socio-economics played a role in some women's decision to terminate their pregnancies, most were not willing to argue that social factors should play a role in determining whether a termination of pregnancy was indicated. Most doctors were concerned, instead, with "medical" factors like the possibility of genetic deformities, and medical risks to the mother's health, which included psychiatric risks. Such indications seemed more appropriate for the medical profession to determine, where social factors were largely open to interpretation and were not rooted in "science." Even still, doctors wanted to be able to make the final determination about when an abortion was warranted. The idea that "humanitarian" reasons for abortion should be included in any revision to the law likely stemmed from such

---

<sup>52</sup> Standing Committee Minutes, p. 14-15.

<sup>53</sup> As we have seen, doctors had also been discussing the need to take into account social factors in determining the

recommendations in the British bill. It is interesting to note that the bills presented by Wahn and Herridge were subjected to far fewer questions than the bill proposed by MacInnis. Perhaps this was due to the fact that Mrs. MacInnis raised the issue of population control and eugenics in her bill and in her testimony to the standing committee. Herridge's bill also made suggestions along the same lines as it called for the legislation to take into account social factors, though. The main difference seems to be in the approach of the bills. Both Wahn's and Herridge's bills were presented with the main objective being clarification of the law for doctors where MacInnis' bill suggested that it should be left to "individual conscience" to decide whether an abortion was needed, even though she did note the need for two doctors to agree on the need for the procedure.<sup>54</sup> In questioning Ian Wahn about Bill C-123, Mr. Rock of the Standing Committee wondered whether Wahn had gone "far enough" in his bill or whether it was necessary to go further as Mrs. MacInnis' or Mr. Herridge's bills had gone. In his response, Wahn noted the importance of Parliament staying a course in which there was consensus among the public. "Parliament can not be too far ahead of public opinion," he noted "I think there is a general consensus that the law should be clarified to provide specifically for legalization of therapeutic abortion. Once you go past that point, I am not sure whether public opinion is ready for it, or ever will be."<sup>55</sup>

### ***The Medical Profession on Revising the Criminal Code: Status, Morality and Women***

One of the key reasons for framing changes to the legislation within the context of abortion as a medical procedure was that doctors had successfully constructed the practice in the medical discourse over the course of the twentieth century. It is not surprising, then, that it was viewed in the 1960s (and still is today), first and foremost as a medical issue. We have seen how

---

need for therapeutic abortion.

<sup>54</sup> Standing Committee Minutes, p. 3.

doctors, in their attempt to regulate their profession and secure their status as health care providers, advocated that only they had the scientific medical knowledge of the body and, therefore, could determine when and when not to terminate a pregnancy. Indeed, the medical profession had established its control over women's bodies over decades as it promoted itself as expert on health matters and, therefore, the body. With respect to abortion, doctors worked to situate themselves within society as the only experts who could determine when an abortion was needed. It is really quite extraordinary that, in less than a century, the medical profession had established the power and ability to medicalize a procedure which had, for centuries before, been regulated by women themselves. However, we know that, despite this power, some women continued to take reproductive control into their own hands by attempting to procure their own abortions, or by seeking out a provider of illegal abortions. A feminist approach to this issue would suggest that this was an attempt by women to place the procedure within their control. Certainly, we know that women were beginning to act collectively in this period to exercise power over their own bodies which included having access to legal, safe abortions. While their views were represented to the Standing Committee, their voices were not yet loud enough to be heard in the political arena in the sense that it was not the call for women's control over their own bodies that fostered the debates over changes to the *Criminal Code*.

Jane Jenson has pointed out that the medical profession, on the other hand, did have dominance as political actors and could represent abortion as a health issue and medical practice that was within the realm of doctors' control.<sup>56</sup> This is a very important point. Even in the testimony of women's groups to the Standing Committee, the representation of abortion as a medical procedure and, therefore, within the realm of the medical profession, was clearly

---

<sup>55</sup> *Ibid.*, p. 17.

<sup>56</sup> Jenson, "Competing Representations: The Politics of Abortion in Canada," p. 294.

evident. For instance, in their testimony to the Standing Committee the National Council of Women noted that the decision about whether an abortion should be performed would be left to two medical doctors. Other groups, like the Women's Liberation Group and the Canadian Law Reform Association (CALRA), while suggesting that abortion be available "on request", still noted the need for doctors to "approve" the request.<sup>57</sup> The medical discourse had established that it was doctors who had the knowledge to make the final judgement call about when a procedure was warranted.

What had changed in the discourse in this period was the extension of the medical profession's power to make such determinations from those based on medical indications (disease, threat to the mother's health) to conditions which were not based in medical science (social factors). Many members of Canadian society also believed that the procedure of abortion was a medical issue and supported the idea that doctors should be the ones who made the final decisions about abortion. It should be stressed that placing the decision to abort in the hands of doctors was the key to revising the legislation on abortion. Who actually performed the procedure was incidental to the discussions as it was assumed that once the decision to terminate was made, any practitioner could perform the operation safely. Regular physicians, as we have seen in the previous chapters, worked very hard to ensure that their disciplinary power was entrenched. In other words, they were successful in arguing that matters of health, indeed, any matter that affected the body, fell within the domain of medical science and that other forms of health care (homeopathic medicine, midwifery) were not legitimate and practiced by "quacks."<sup>58</sup>

This discourse of the medicalization of abortion, Jane Jenson suggests, meant that

---

<sup>57</sup> *Standing Committee Minutes*, p. 395-446.

<sup>58</sup> It should be remembered here that this was the discourse as constructed by the medical profession. There is evidence to suggest the popularity of alternative medicine. For a discussion of alternatives to the regular medical profession in terms of childbirth see Wendy Mitchinson, *Giving Birth in Canada, 1900-1950*, Toronto: University of

abortion was understood primarily within the discourse of medicine and that what we would today call “pro-choice” viewpoints were not represented in the discussions surrounding changes to the legislation.<sup>59</sup> Specifically, the need for access by women to legal and safe abortions was not present.<sup>60</sup> In her article, “Competing Representations: The Politics of Abortion in Canada,” Jenson argues that in the politics of representation, pro-choice (or women’s rights-based) views did not have the power to challenge existing representations of the interests of society and women in the 1960s (in particular, those of doctors), and could not, therefore, shape the issue in their own interests. She argues that “the power of other collective actors to shape the abortion issue around their own definition of interests was a major block to new representations and the actors promoting them.”<sup>61</sup> In other words, the collective voice of the medical profession (although we must be clear that they were not and are not a homogeneous group) was too strong to allow for new representations of the abortion issue.

While there is no doubt that the medical profession played a powerful role in the discussions about revision of the abortion legislation, it must be made clear that women’s voices were present. Jenson suggests that “the almost total absence of feminists’ pro-choice voices in the universe of political discourse in 1969 set the politics of abortion in Canada off down a road to 1988 via the path of medical definition in an uneasy silence about the moral dimensions of the issue, as well as about whose interests were implicated by this issue.”<sup>62</sup> But was this really the

---

Toronto Press, 2002.

<sup>59</sup> The term “pro-choice” is used to denote the movement to promote the ability of women to choose whether or not to have an abortion and suggests that women should have that control over their own bodies. “Pro-life” is the general term used to describe the movement which argues that the fetus has a right to life, and therefore, should never be aborted. It should be mentioned here that the movements we would today refer to as “pro-life” or “pro-choice” did not exist as such in Canada in the 1960s. These groups did not act collectively until the 1970s as they argued for changes to the liberalized law of 1969 suggesting that it either did not go far enough in providing access to abortion for women, or that it went too far.

<sup>60</sup> Jane Jenson, “Getting to Morgantaler: From One Representation to Another,” in Brodie, Gavigan and Jenson, *The Politics of Abortion*, Toronto: Oxford University Press, 1992, p. 19.

<sup>61</sup> *Ibid.*, p. 18.

<sup>62</sup> *Ibid.*, p. 20. See also Jenson, “Competing Representations: The Politics of Abortion in Canada,” p. 296. “1988”

case? We have seen how some doctors actually took what we today would call a feminist position regarding abortion by arguing that women's welfare needed to be considered in the revisions to the legislation. Doctors were not the only ones to provide testimony to the Standing Committee, however. In fact, many women's groups and advocates in favour of changing the legislation to protect women's welfare also testified. So, while there is some truth to Jenson's idea about representation (doctors certainly did play a major role in the revisions to the legislation), this view oversimplifies the concept of representation because it neglects to take into account the position of some doctors that women's welfare was a key issue in the revisions by assuming that the medical profession, indeed, the medicalization of abortion, is homogeneous and not feminist. Doctors in the post-war period were keenly interested in protecting their patients' welfare and, particularly in their discussions of abortion, were seeking ways in which to safeguard that well-being despite legal restrictions for doing so. Indeed, Jenson seems to suggest that doctors were simply profession-centred and, inherently, anti-feminist. She also suggests that "feminist" viewpoints were not heard. This was not the case and the need to examine the discussions about revision to the legislation in the context of the day is evident. The next section will consider these issues in light of the shifts which occurred in the medical discourse over the first half of the twentieth century.

### ***Searching for Consensus: The Profession, Women, Morality and Abortion***

The legislation enacted in 1969 did not challenge the status quo and simply clarified doctors' legal ability to perform therapeutic abortion, but the legislation and the doctors' position it reinforced were influenced by wider social and political contexts - doctors (and their discussions) did not exist in a vacuum but were influenced by a number of different interests in

---

refers to the year the Supreme Court of Canada determined that the Criminal Code sections dealing with abortion were unconstitutional because they violated women's security of the person according to the Canadian Charter of

this period. These interests were reflected in the three main themes which emerged in their testimony to the Standing Committee, both as members of professional organizations and as individual physicians. Always at the heart of the discourse was their status as a profession, but the role of women, particularly the role they played as patients in abortion practices, as well as the morality of the practice of abortion were also discussed from a variety of angles by both doctors and other witnesses to the Standing Committee.

Representatives of the Canadian Medical Association (CMA) were among the first to give testimony on the abortion issue to the Standing Committee in the fall of 1967, with a distinguished group of doctors presenting the position of the Association. Dr. Douglas Cannell was a former Professor of Obstetrics and Gynaecology and head of the department at the University of Toronto, and Chief of Obstetrics and Gynaecology Services of the Toronto General Hospital. Dr. Greg Tompkins was Associate Professor of Obstetrics and Gynaecology at Dalhousie University and Chief of Obstetrics and Gynaecology at the Halifax Infirmary, as well as serving as Chairman of the Committee on Maternal Welfare of the CMA. Dr. Donald Low was a retired Professor of Obstetrics and Gynaecology at the University of Toronto and had served on the Ontario Medical Association's Committee on Maternal Welfare, the Committee charged with investigating the problem of maternal death and abortions within the Province of Ontario for the OMA. He also acted as a consultant to Ian Wahn in drafting bill C-136. Dr. Kenneth Gray was Professor of Forensic Psychiatry at the University of Toronto and of the Clarke Institute of Psychiatry. Finally, the spokesman for the group was Dr. Donald Aitken, General Practitioner and Assistant Secretary of the Canadian Medical Association.

Dr. Aitken began his testimony to the Standing Committee by pointing out that the problem of abortion had been an interest of the CMA, and, in fact, noted that the General

Council of the CMA had discussed the issue on many occasions dating back to 1961.<sup>63</sup> “I stress that this problem has been discussed very widely and very thoroughly over that seven-year period.”<sup>64</sup> Indeed, the issue had not only been discussed in meetings of the CMA but was also the subject of a number of articles in the *Canadian Medical Association Journal* and other Canadian medical journals in the 1960s.<sup>65</sup> While widely discussed among many medical practitioners in this period, there was clearly no consensus on the issue.<sup>66</sup> As Dr. Aitken noted, the delegation to the Standing Committee was not present to press a particular point of view. “We are here” he noted, “to express the view of the CMA, and I would say that although we all have personal opinions we would like to try to stay within the bounds of this resolution because we are representing the 20,000 Canadian doctors who are members of the CMA.”<sup>67</sup> Of course, the medical profession was testifying to present a particular point of view – one that was to serve as reinforcement of the belief that abortion was a medical procedure and, therefore, an issue that doctors should deal with and make decisions regarding. It is clear from the testimony of the delegation to the Standing Committee that the CMA was aware of the difficulty of creating legislation, given that there was not consensus among members of the profession much less

---

<sup>63</sup> British Columbia doctors had first raised the issue of therapeutic abortion in 1961, but it was Ontario doctors who took the lead in the medical association itself by authorizing a special committee for the study of sterilization and therapeutic abortions in May, 1963. The committee was chaired by Dr. D.M. Low and he was joined by Dr. D.E. Cannell who represented the Maternal Welfare Committee, Dr. K.G. Gray, and Dr. M.G. Tompkins of Halifax. Low and Tompkins were also the CMA representatives. The committee’s study aimed to make “recommendations either from changes in the (Ontario) Public Hospitals Act or for new legislation.” de Valk, *Morality and Law in Canadian Politics*, p. 16-17. See also “Transactions of Council – May 10, 11, 1963,” *Ontario Medical Review*, July, 1963, p. 418; “Transactions of Council – May 25, 26, 1964,” *Ontario Medical Review*, August, 1964, p. 606

<sup>64</sup> Standing Committee Minutes, No. 4, p. 97.

<sup>65</sup> Examples of doctors recommending changes to the law can be found in J.J. Lederman, “The Doctor, Abortion and the Law: A Medicolegal Dilemma,” *CMAJ*, 87 (August, 1962): 216-222; C.W. Carpenter and F.E. Bryans, “Maternal Mortality in British Columbia: A Study of 145 Deaths from 1955 to 1962,” *CMAJ*, 92 (January, 1965): 160-170; Maternal Mortality Report No. 19, “Abortion,” *Ontario Medical Review*, 31 (April, 1964): 288-290; Editorial, “Justice of Miscarriage,” *Nova Scotia Medical Bulletin*, (June, 1967): 115-116; Donald F. Smith, “Therapeutic Abortion – Should the Law Be Changed?” *Nova Scotia Medical Bulletin*, (June, 1967): 118-120.

<sup>66</sup> For a discussion of a number of dissenting views which were published in the journals during this period see chapter four.

<sup>66</sup> A.D.K., “The By-Products of Conception,” *CMAJ*, 98 (February, 1968): 422-423.

<sup>67</sup> Standing Committee Minutes, p. 98.

among the majority of Canadians. A reading of the discussions of the Committee on Maternal Welfare, the group elected by the CMA to carry out discussions about what the association should recommend to the Minister of Justice in terms of revisions to the legislation indicate the difficulty in determining what those recommendations should be.<sup>68</sup> Dr. Aitken testified that, in actual fact, the CMA was not unanimous in their acceptance of the resolution. However, “we have come up with what we feel is a consensus of the medical profession on this point, but we are not pretending that this is the unanimous decision of all doctors.”<sup>69</sup> The consensus was their Resolution No. 17, presented at the CMA Meeting in Quebec on June 9<sup>th</sup> and 10<sup>th</sup>, 1967. The resolution read as follows:

*Re: Change of Criminal Code re Therapeutic Abortion*

THAT the Canadian Medical Association recommend to the Minister of Justice that the Criminal Code of Canada be amended so as to provide that an operation for the termination of pregnancy shall be lawful:

- (a) If continuation of pregnancy will endanger the life or health of the pregnant female or there is substantial risk that the child may be born with a grave mental or physical disability, and the operation is performed by a duly qualified medical practitioner, in a hospital accredited by the Canadian Council on Hospital Accreditation after approval by a Therapeutic Abortion Committee of such hospital, or
- (b) Where there are reasonable grounds to believe that a sexual offence has been committed from which pregnancy has resulted.<sup>70</sup>

Although the CMA’s resolution did not represent a unanimous position, it did represent a call by the Association for a clarification of the law to reflect the status quo, reinforcing that doctors should make decisions regarding whether or not abortions should be provided to women. As we have seen, doctors were already performing therapeutic abortions when they believed it

---

<sup>68</sup> For instance see CMA, “Report of the Maternal Welfare Committee,” (1964). Brenda Margaret Appleby also discusses this in *Responsible Parenthood*, p. 32-33.

<sup>69</sup> Standing Committee Minutes, p. 98.

<sup>70</sup> See Resolution No. 17 as entered in the Minutes of the Standing Committee on Health and Welfare, p. 98-99.

threatened the life or health of the woman involved. Given that medical indications had nearly been eliminated by advances in medical science by the 1960s, it is clear that “medical” decisions about abortion were very subjective and often inequitable – women who could either afford to travel to a doctor to obtain a procedure and/or who had access to a hospital that would provide them (some non-Catholic hospitals had established their own therapeutic abortion committees) really determined the frequency of the practice. What it would appear the CMA was looking for was simply confirmation that those members of their profession who engaged in abortion practices were protected legally, but not actual change in the law which would help to guard against some of the inequities that existed with regard to the practice.

While at first glance it may appear that the CMA’s resolution and input into the proceedings was simply self-centered, given that they did not argue for a change in the legislation to ensure equal access by all women to the procedure, this was not the case – at least it does not represent the big picture where doctors were concerned. As we saw in chapter four, doctors were keenly interested in their patients’ welfare in this period, particularly when it came to abortion. Indeed, Dr. Aitken noted that the best interest of their patients was of paramount importance to doctors. As he suggested, doctors in general did not enjoy performing abortions. In his words, “it is not our idea of a pleasant way to spend an afternoon. It is done because, with the best motives in the world, they [doctors] feel this is the best thing to do for a particular patient.”<sup>71</sup>

Despite the fact that many doctors had noted in the *Canadian Medical Association Journal* that there were few, if any, real medical indications for abortion (conditions which would threaten the life or health of the mother) it is clear that doctors still wanted to make the final judgement call on this issue. Perhaps this is not surprising given that doctors were the ones

who had to perform, as Dr. Aitken termed them, such unpleasant procedures. They were also the ones who had to deal with women who presented with complications after having undergone an illegal procedure. In his testimony, Dr. Low emphasized, for instance, that more should be done to publicize the danger of illegal abortion and to get witnesses to testify against abortionists. These practitioners operated outside traditional medicine and its views and it is clear that medical professionals were eager to stop such practices.<sup>72</sup> Even in the case of traditional medical professionals it is clear that doctors believed that it was impossible for the state to regulate their profession with abortion legislation. As Dr. J.C. Whyte, Head of the Department of Obstetrics and Gynecology at Ottawa Civic Hospital, noted in his testimony to the Committee as a member of the delegation of representatives of the Canadian Welfare Council, laws restricting or trying to put “checks” in place to regulate doctors are useless. “A far far better way to deal with these cases is to have responsible committees who review them afterwards and say: ‘Joe, you did not do it right; your privileges are taken away.’ Otherwise, there are a hundred ways you can get around it; it means nothing.”<sup>73</sup> This idea was supported by one of Dr. Whyte’s colleagues, Dr. Grygier, Director of the Centre of Criminology at the University of Ottawa and also representing the Canadian Welfare Council. He noted that the most appropriate way to deal with abortion at the present time (he testified in front of the Committee in 1968), was to deal with it as a medical problem.

The theme of abortion as a medical problem is one which had been present in the medical journals for some time and which became even more evident during the hearings of the Standing Committee. That the CMA and other doctors presented their position on the issue within a framework of medical ethics (similar to a religious or moral framework) denotes the importance

---

<sup>71</sup> *Ibid.*, p. 98.

<sup>72</sup> Standing Committee Minutes, p. 103.

of the way the medical profession operated. Indeed, it suggests that the medical profession “thinks” differently than the rest of society and that they operate within their own disciplinary culture with their thoughts/actions framed within the culture and discourse of medicine. Not all medical delegations presented their testimony to the Standing Committee in the same way, however. The testimony of the Catholic Physicians Guild of Manitoba, for instance, promoted the view that physicians had a duty to uphold the sanctity of life and that the same should be upheld in law. While the delegates conceded that it was impossible to legislate morality, they suggested that “laws are required to outline the broad aspects of the country’s morality...”<sup>74</sup>

While it is important to recognize that the CMA’s position on abortion was not embraced by all doctors – the view of the medical profession was not a homogenous one – it is clear that their approach to the abortion issue was shared by other groups. Many other delegations to the Standing Committee accepted and enforced the CMA’s framing of their position, demonstrating that the profession’s medicalization of abortion had been accepted by others in Canadian society. The Canadian Bar Association, for instance, noted the importance of the medical profession in determining whether an abortion was necessary. And while their position on the need for a termination board, a board comprised of lawyers as well as doctors, differed from that of the medical profession, they did reinforce the point that doctors should exclusively have the power to make decisions on medical matters. The CBA believed that legal experts were only required in cases of rape. They noted that, in order to determine the need for a therapeutic abortion in the case of sexual assault, a determination of whether an offence had occurred first needed to be

---

<sup>73</sup> *Ibid.*, p. 696.

<sup>74</sup> “In a country such as ours there are people of many different backgrounds and religious beliefs. In a discussion on the subject of therapeutic abortion the opinions are as varied and as numerous as the people entering into that discussion. In a subject with so little unanimity surely there is no indication for embarking on a radical new course. We do not intend to be dictatorial but we do wish to express our concern for, and interest in, the mores of our country.” Testimony of Dr. Paul V. Adams representing The Catholic Physicians Guild of Manitoba, Standing Committee Minutes, p. 221-222.

established. This was essentially a legal, as opposed to a medical matter and required, they argued, the expertise of the legal profession. The concept of a termination board was really the only difference between the position of the CBA and that of the CMA.<sup>75</sup>

Even those advocates of more than simply affirming what was already occurring, recognized the importance of safe access to abortion provided by the medical profession. For instance, Mrs. Lore Perron, President of the Association for the Modernization of the Canadian Abortion Law (AMCAL), an organization established to promote the need for revision to the legislation, noted that, while her Association's desire was for women to have the right to choose abortion, they agreed that a woman's decision should be made together with her doctor, and, in all likelihood, in consultation with another physician. "The question of whether or not an abortion should be performed must be a medical one. No doctor or hospital should have the right to put religion or any other considerations before the life of the mother. We know of both doctors and hospitals where this has happened."<sup>76</sup> Her argument continued along this vein as she noted the importance of equal access by women to abortion. "...For the women who can afford an illegal abortion," she noted, "there are more openings to obtain one: they can pay high prices to a qualified medical practitioner or make a trip to Japan, perhaps. It is the lower income group who mainly resort to the back-alley abortionist or the do-it-yourself method."<sup>77</sup> This in itself is an interesting position – a call for the recognition of socio-economic conditions – not in terms of risk to the mother's welfare after childbirth, but the risk to her if she attempted an illegal abortion. Indeed, this was an issue that the profession had struggled with as they looked for

---

<sup>75</sup> For a discussion about the difference between a therapeutic abortion committee and a termination board, see Standing Committee Minutes, p. 49.

<sup>76</sup> Standing Committee Minutes, p. 118.

<sup>77</sup> *Ibid.* It should be noted, however, that even women with the financial means to secure an abortion in another country were still often at a disadvantage in terms of accessing an abortion during its illegality. In *No Choice*, one woman recalled her abortion experience as she was sent by her family physician to a back-alley abortionist where she was subjected to both physical and mental humiliation after which she paid to have an abortion in New York

ways to prevent women from arriving for treatment in septic conditions because they had attempted an illegal operation.

The risk to women from back-alley abortionists was one which was presented to the Standing Committee by a number of different groups. A study by the morality squad of the Toronto Police had pointed to a large number of back-alley abortions in the late 1950s and early 1960s and this finding was noted by a number of different groups.<sup>78</sup> In the case of both doctors and women's groups like AMCAL, the risk to women from these illegal procedures was reason enough to change the legislation.<sup>79</sup> Indeed, a number of articles in the *Canadian Medical Association Journal* noted the dangers of pursuing an illegal operation and wondered how women could be better educated about the risks of abortion. For doctors, though, their concern must also have been for their profession. As we have seen, doctors worried about having to treat women who arrived at hospitals with varying degrees of septic poisoning. Doctors were aware that maternal deaths, even if from illegal abortions, reflected negatively on their ability to effectively treat their patients and many argued that along with education, they needed to be able to provide birth control information to their patients. Effective contraceptive practices would, at least, reduce the numbers of requests for abortion as it would work toward preventing unplanned pregnancies.

This issue of access was also raised by other groups testifying to the Standing Committee. The Canadian Bar Association, like the CMA, had been debating the issue of abortion within their profession for a number of years. Indeed, they had been holding joint meetings with members of the CMA since 1965 in order to present a united front about changes

---

City.

<sup>78</sup> For instance see Noonan and Cannell, "A Seven-Year Study of Maternal Deaths in Ontario," p. 707.

<sup>79</sup> Even though groups like AMCAL advocated that doctors be involved in making the final determination about whether an abortion was indicated, they clearly hoped that the revision to the Criminal Code would go much further

to the legislation.<sup>80</sup> While questioning the CBA about their call for the establishment of termination boards, the main point that the CBA and CMA could not agree upon, members of the Standing Committee asked whether all women in all areas would be able to find a termination board. In his questioning of Mr. Cooper of the CBA, Mr. Ballard wondered about the issues that might arise in a situation where a woman seeking an abortion was from a remote rural area. “I am wondering about the problems,” he noted,

that might be met by a person from a town like Hay River, Alberta, which is away up in the north country – you would have to fly out from this town – or some place in Northern Ontario where there is only one doctor, probably no lawyer and certainly never a Bachelor of Social Work. You are saying to the people who live in the smaller communities that they have to make a trip to the city in order to go through this procedure.<sup>81</sup>

Mr. Cooper’s response was that in other medical matters trips for treatment might be required of the patient and, therefore, he did not seem to think that having “urban abortions” was problematic. Yet in abortion, the making of a timely decision is crucial in terms of risk to the mother. Most doctors did not advocate performing the procedure due to increased risk to the mother beyond twelve weeks of pregnancy, or past the first trimester.<sup>82</sup> Therefore, for many women, the need to travel to an urban centre might prove very problematic because securing travel arrangements might diminish their window of opportunity for having an abortion.

Advocates of women’s rights like AMCAL, the National Council of Women, and the Women’s Liberation Group, and even some of the MPs who were members of the Standing Committee did

---

than just legislating the ability of doctors to define a therapeutic abortion.

<sup>80</sup> The Maternal Welfare Committee of the CMA reported in 1965 that there had been a great deal of discussion about therapeutic and criminal abortion. This led the Committee to recommend that they meet with the CBA before they draft their recommendations for legislative revisions. The issue of course was whether doctors were legally entitled to perform therapeutic abortions at all under the existing sections of the Criminal Code. CMA, “Report of the Maternal Welfare Committee, (1965).

<sup>81</sup> Standing Committee Minutes, p. 44.

<sup>82</sup> After the first trimester, in most cases, rather than being able to perform a D&C or other method of abortion, doctors had to actually induce labour to terminate a pregnancy which could be both dangerous to the mother’s life

make the connection that this could be an extreme disadvantage to women who did not have access (either because of a geographical location, or financial means) to secure a procedure performed by a qualified medical practitioner. Not only that, termination boards (or even therapeutic abortion committees) in these circumstances would not eliminate the need for illegal operations. The argument against termination boards or therapeutic abortion committees was that, faced with the desire to terminate an unwanted pregnancy, some women might choose to attempt to secure the procedure by illegal means rather than take their chances waiting through the bureaucratic process that was proposed by both the CBA and CMA. The bottom line, of course, was that this approach to solving the problem of illegal abortions was discriminatory.<sup>83</sup>

The position that women had the right to determine whether to terminate their own pregnancies was not one which was prominent in the majority of presentations to the Standing Committee, but is one that needs to be examined in greater detail. What is particularly interesting about such representations, especially those coming from women themselves, is how they were framed within their own personal experiences with abortion, either their own, or the experiences of friends or family members. For instance, as part of her opening statement to the Committee, Lore Perron brought to the attention of the members some of the correspondence she had received from women who supported AMCAL's position on abortion reform. She noted that the Association had a number of case histories on file which detailed women's experiences with abortion. One of the case histories she presented is particularly telling and bears repeating here. This history is of Mrs. X who arrived in the operating room for an emergency caesarean section.

She was in strong labour but, on internal examination, the doctor could not detect a cervix, let alone any dilation of the cervix. After the healthy, normal baby was delivered, we followed through with the hysterectomy. Once the uterus

---

and her mental health.

<sup>83</sup> Standing Committee Minutes, p. 47.

was extracted and examined it was discovered that the cervix had been burned off and that nothing but scar tissue remained. Although there was no opening left into the uterus the doctor knew that there must have been one at one time because this woman had two other children and they had been delivered normally. It was discovered after she recovered from surgery that she had tried to abort herself with an acid solution but she was not successful in losing the baby, and the only thing she did was burn off the cervix.<sup>84</sup>

This story was certainly not an isolated one. The medical journals, as we have seen, also reported such cases to their colleagues as an indication of the prevalence of the problem.

Doctors, next to women, were on the front lines of this issue. It also indicates that the situation of women who were faced with an unwanted pregnancy in Canada in the 1960s was really not that much different than the experience of women faced with the same situation at the turn of the century. Despite advances in medical science and better access to health care, women were still determined to control their own reproduction, regardless of the risk to their own lives.

Doctors were keenly aware that women sought ways to regulate their own bodies in cases of unwanted pregnancy – they saw the results on a regular basis in hospital emergency rooms across the country. While most members of the medical profession were not willing to entertain the idea of women deciding for themselves whether they needed an abortion (despite the fact that women did it all the time, albeit not legally), they were willing to provide some safeguards to women against needing an abortion in the first place by providing access to birth control.

Certainly this issue was discussed at greater length in the Standing Committee's examination of the four bills presented on contraception. But the issue came up a number of times in the abortion testimony as a way of preventing the need for abortion in the first place, and, as we have seen, was an issue in doctors' discussions of maternal welfare in this period. Throughout the minutes of the proceedings of the Standing Committee, witnesses identified a need to combat the

“social evil of illegal termination”<sup>85</sup> or abortion of pregnancies. The obvious way to guard against this was the ability of women to access safe and reliable means of birth control. The CMA had discussed this issue in the 1950s and 1960s and by 1965 the Maternal Welfare Committee had recommended that there was a need for the establishment in Canada of family planning clinics, that contraceptives should be made available to welfare recipients, and that the *Criminal Code* needed to be amended with respect to contraception.<sup>86</sup> These recommendations, however, were largely meant to suggest that it was necessary to amend the legislation to reflect the status quo since many doctors had been providing birth control to their patients for some time.<sup>87</sup> Together with birth control advice and prescriptions,<sup>88</sup> doctors felt that widespread education programs would be helpful in guarding against the problems associated with illegal abortions.<sup>89</sup> These recommendations were not new, however. As we have seen, doctors had been advocating the need for such programs throughout the postwar period.

Doctors’ desire to have the criminal law on abortion clarified, as evidenced in the CMA’s brief to the Standing Committee, has been the focus of most examinations of abortion history. For instance, Brodie, Gavigan and Jenson point out that the goal of the state reformers in proposing changes to the legislation was to save the state from the threat to its legitimacy that the

---

<sup>84</sup> *Ibid.*, p. 119.

<sup>85</sup> *Ibid.*, p. 36.

<sup>86</sup> Appleby, *Responsible Parenthood*, p. 32.

<sup>87</sup> For instance, see Editorial, “Birth Control,” *CMAJ*, 57 (November, 1947): 489-490; S.C. Robinson, “Induced Abortion,” *Dalhousie Medical Journal*, 16 (Spring, 1963): 11-13; C. Douglas Ringrose, “Current Concepts in Conception Control,” *CMAJ*, 89 (August, 1963): 246-248; Editorial, “Physicians and Contraception,” *CMAJ*, 91 (October, 1964): 820-821.

<sup>88</sup> A number of articles detailing the latest advances in birth control technology also appeared in the 1960s. For instance see Laboratory Report, “‘The Pill’ and the Laboratory,” *Manitoba Medical Review*, (August-September 1966): 478-479; Morris P. Wearing, “The Use of Norethindrone (2 Mg.) with Mestranol (0.1 Mg.) in Fertility Control: A Preliminary Report,” *CMAJ*, 89 (August, 1963): 239-241; J.H. Dickinson and G.G. Smith, “A New and Practical Oral Contraceptive Agent: Norethindrone with Mestranol,” *CMAJ*, 89 (August, 1963): 242-245; Editorial, “Oral Contraceptives,” *CMAJ*, 89 (August, 1963): 270-271.

<sup>89</sup> A series of articles appeared on the establishment of family planning clinics in this period in the *Canadian Public Health Journal*. For instance see, E. Aenid Dunton, “A Family Planning Clinic in a County Health Unit,” *Canadian Public Health Journal*, 58 (1967): 181-185; C.J.G. MacKenzie, G.P. Evans and J.G. Peck, “The Vancouver Family

laws on birth control and abortion posed, given the inability of the state to uphold such laws.<sup>90</sup> Certainly this was a concern for many of the groups testifying before the Standing Committee, including the Canadian Bar Association. The CBA also argued that the law needed to be changed to clarify when and how abortions should be performed. Given that these two groups were the most prominent in the debate about this issue and given that the changes in the law in 1969 essentially incorporated their recommendations, it is not difficult to see why the CMA has been “blamed” for promoting what has been perceived as self-serving legislation, enacted in the interest of (and only in the interest of) physicians, neglecting women’s needs, whose bodies are subjected to illegal procedures.

It is true that women’s bodies and their subjection to back-alley procedures was not really the focus Standing Committee in 1967-68, at least in terms of briefs submitted to them. However, an examination of the medical discourse does show that the medical profession was indeed concerned for their female patients and that, although there was a definite desire for changes in the legislation to protect their profession, there was also a clear desire to protect women from the dangers associated with illegal abortion. They believed that placing the decision of abortion firmly within their professional control would do so. Doctors were concerned for their female patients – it is almost as if there is an implicit assumption that if they do not protect themselves, they cannot protect their patients – an interesting and paternal, yet understandable position. This opinion clearly stemmed from their discussions about women’s welfare in the postwar period and the societal context made it much easier for doctors to argue for changes to the legislation because the loosening social mores surrounding sexuality, together with easier access to birth control, provided for a clearer separation between the two. In other

---

Planning Clinic: A Case Study,” *Canadian Public Health Journal*, 58 (1967): 53-60.

<sup>90</sup> Brodie, Gavigan, and Jenson, *The Politics of Abortion*, p. 20.

words, their arguments for changes to the legislation were more than just a response to the 1955 legal change and to their own desire to regulate their profession. They were part of the evolution of the medical discourse on abortion which, by the 1960s, focused strongly on the need to protect women's welfare. This means that despite the fact that women's views were clearly under-represented in the submissions to the Standing Committee, including those by the medical profession, they were there.

Does the under-representation of women's rights mean that doctors were not interested in them? Or is this simply a case where a women's rights-based discourse was not yet part of the mainstream social discourse? This is surely the case. There was not substantial power in rights-based arguments simply because they had only just emerged. That doctors were discussing the need to be able to provide therapeutic abortions for reasons other than if the life of the mother was truly threatened seems to me to suggest that a shift was occurring in how they viewed women and their need to control their own bodies. On the other hand, doctors had been discussing abortion and their role in the procedure for almost a century, using abortion as a means to regulate their own profession. Gail Kellough suggests that the new law (1969) legitimized doctors' position as "moral gatekeeper and simply formalized a process that provided women with unequal access to health care. The informal system had been limited to meeting the needs of middle-class women rather than women generally, and the new law simply institutionalized this discrepancy. Rather than eliminating the class bias, the changes in legislation codified existing qualities and did little to expand the parameters of reproductive choice for women generally."<sup>91</sup> Further, she suggests that there is ample evidence to suggest that doctors did not simply enforce the new law on abortion, but that they actively created it

---

<sup>91</sup> Kellough, *Aborting Law*, p. 78.

according to their own professional values.<sup>92</sup> Kellough's position is one which is derived from a desire to find answers to why women in Canada did not have equal access to abortion in this period – a critical perspective aimed at finding the oppressors of women – rather than from the perspective of trying to understand why that oppression existed in the first place. We need to examine the different discourses on abortion to understand more fully why the discussions and representations of the medical profession held such weight in the first place. To suggest that they created the legislation according to their own personal values is not really a revelation. Of course they did! Doctors, just as other actors, frame their discussions within the context of their own experiences, their own cultures, just as advocates of women's right to choose abortion would later frame their discourse within the context of their experiences as women struggling to access abortion. And we should not forget the role of the state legislators in this process. By framing the legislation within the medical discourse, legislators could avoid dealing with emerging human rights issues as well as the ethical questions surrounding the practice which were downplayed by all of the submissions to the Standing Committee. After 1969, it would become less and less easy to do so.

The history of abortion in Canada is a complex one – one with many layers and many discourses – shifting over time to reflect changing social and political and, in this case, medical contexts. A review of the testimony to the Standing Committee reveals the complexity of those layers and how they were all intertwined and bound together by the idea that abortion was a medical procedure. Without a doubt, doctors were highly successful in establishing their disciplinary power over the course of the twentieth century and this is why they are always part of any of the discourses on abortion. However, to suggest that they did not have their patients'

---

<sup>92</sup> She notes that "the basic professional values of the medical establishment [were] values that involved 'its status as a free, autonomous, self-governing profession.'" *Ibid.*, p. 77.

best interests in mind when they made their submissions, both for and against abortion, does not fit with their discourse on abortion as it had emerged and shifted over time. It also does not fit the nature of their profession – one which is focussed on improving the health of their patients.

## *Conclusion*

The central role that the medical profession played in shaping the dominant discourse on abortion in Canada has been at the heart of the historiography on abortion. This thesis points out that, indeed, the profession was highly influential in shaping not only the medical discourse on abortion but other discourses as well including those of the legal profession and even feminist groups like the Association for the Modernization of the Canadian Abortion Law (AMCAL). However, my examination of the medical discourse over time reveals shifts in how the profession viewed the practice of abortion and alterations in the discourse in different periods reflecting changing medical, social and legal contexts. These shifts show that the discussions of abortion that are found in Canadian medical journals helped to support the official position of the medical profession, albeit an elite position which was certainly not shared by all Canadian doctors. It also shows that the discourse changed over time as the profession sought ways to positively influence the welfare of their female patients.

In the early period, the focus for regular doctors was on the regulation of their profession. Abortion was one issue that they used to differentiate themselves from irregular doctors with whom they were competing for patients. Within the discourse on abortion which they helped to construct were three important themes. First, of course, was the emphasis on the professionalization of medicine. Regular physicians argued that it was only irregulars who performed abortions and this formed part of their rationale for eliminating irregulars from the practice of medicine through restricting access to medical schools and calling on the state to

regulate professional practice and qualifications. Within this aspect of the discourse the new focus on medical science played an important role because regulars used evidence that life began at conception to both support their condemnation of abortion and of those who performed the procedure. Science also allowed the regulars to make moral distinctions between those who performed (as well as those women who had the procedure performed on them) and those who did not perform abortions. Since abortion began to be viewed as the termination of another life (given that life began at conception) regular doctors argued that it was murder. Even when there was evidence that regulars had performed the procedure, the profession blamed it on poor regulars' need for money who had to compete with alternative medicine for patients.

Women patients who sought out abortions in this period were also condemned by the regular medical profession. These women, suggested the regulars, were attempting to shirk their responsibility to be mothers, to build a strong and healthy nation. While the prescriptions for true womanhood are most often identified as representative of late-nineteenth century Canada, such prescriptions continued into the early twentieth century. Despite the demonstration by women during the Great War as they undertook many non-traditional occupations in support of the war effort that the biological essentialism of the nineteenth century was questionable, the idea that women were made to be mothers continued to dominate Canadian women's existence.

In the interwar period a renewed emphasis on Canadian mothering by the middle-class followed the recognition that many lives had been lost during the war along with the perception that the "quality" of the population was declining. The "right" kind of mothers needed to be cultivated in order to raise a strong and healthy nation. In this sense, the emphasis of the medical discourse on the importance of regulating motherhood remained. Also consistent with the

discourse of the early period was the emphasis by the medical profession on their status.

Although regular doctors had established themselves as the health care providers for the nation, they were still concerned with maintaining their status. The issue of a high maternal mortality rate in this period brought into doubt their scientific ability to protect mothers in childbirth and this was problematic for the profession, particularly since doctors began to recognize a connection between the maternal death rate and abortion rates. Given this connection the medical profession sought to better classify maternal deaths to ensure that deaths from abortion were not counted in the overall death statistics. They enlisted the help of the state to help regulate the classification of maternal deaths and to promote education programs for women through the newly established federal department of health and in public health programs. What was also evident in the discourse on abortion of the interwar period was the shift in the discourse as doctors began to question why women would seek out illegal abortions in the first place. They also began to change how they defined health in response to the *Bourne* case which suggested that therapeutic abortions could be performed to protect a mother's life or health.

The third shift in the medical discourse on abortion occurred after 1940 when doctors began to seriously investigate the reasons women sought illegal abortions. The recognition of the need for some women to access abortion was a big leap even from their acknowledgement in the interwar period that abortion was a significant reality in many women's lives. It also signified that doctors were seeking ways to reconcile the medical discourse on abortion with the ever-present prescriptions for women to be mothers. What the shift indicates was doctors' understanding that, in order for women to be good mothers, they had to be able to choose that vocation, rather than be relegated to it because of their biology. They recognized that for some

women, childbirth was not a positive experience and that in some cases births needed to be limited. This new shift to a focus on women's welfare was extremely significant and it became part of their recommendations for changes to the legislation on abortion which eventually took place in the 1960s.

This examination of the shifts in the medical discourse over time is certainly not meant to be definitive but it is significant to the study of the history of abortion in Canada. It calls into question the feminist historiography which suggests that doctors acted solely in their own interests and the interests of their profession in promoting changes to the legislation on abortion in 1969. While there is no question that the Canadian medical profession, represented primarily in the views of medical faculty and specialists found in their professional journals throughout the periods studied here, always had their professional interests in mind when they discussed abortion, there is also no question that doctors were concerned with their patients welfare, albeit in a way that was defined by the profession. I would even go so far as to suggest that, in their own way, that concern was even evident in the early period when doctors condemned the practice in a paternalistic attempt to protect women from what they viewed to be the evils of abortion. It should be remembered that physicians throughout the period of study (and perhaps still) have believed "that women's bodies were socially deterministic and flawed."<sup>1</sup> However, this view was not constructed solely in support of the medical profession but in relation to the social constructs of the time in which doctors were discussing abortion. Thus, it is not possible to separate the medical discourse on abortion from social and political constructs. I have

---

<sup>1</sup> Wendy Mitchinson, "Agency, Diversity and Constraints: Women and Their Physicians, Canada, 1850-1950," in Susan Sherwin (ed.), *The Politics of Women's Health: Exploring Agency and Autonomy*, Philadelphia: Temple University Press, 1998, p. 124.

attempted to point out where the medical profession's views overlapped and fit with the socio-cultural experiences of women and how the medical discourse was constrained by those same constructs. In short, it is unfair of us to expect that the medical profession could have promoted access to abortion in periods when such access would have gone against what was viewed as proper for women. Doctors had to operate within the culture in which they lived. This does not mean, however, that all doctors operated in the same way. Catholic physicians' public position on abortion was certainly shaped by the religious doctrine in which they believed and they therefore, denounced the practice as being contradictory to their views on the need to protect innocent human life. In the case of abortion, the innocent life was that of the fetus. For these doctors, abortion was immoral no matter what the circumstances.

This examination of the discourse, however, demonstrates that doctors (even some Catholic doctors) did look for ways to provide access to abortion even in the period of its illegality and this is particularly evident in the post-war period when members of the profession relied more heavily than ever before on the *Bourne* decision's definition of health to provide therapeutic abortions. Indeed their testimony to the Standing Committee on Health and Welfare suggests that doctors were truly concerned with their patient's welfare and were seeking ways to promote their welfare while operating within the legal parameters set out by Canadian law.

This thesis, I hope, is the beginning of further investigations into the role of the medical profession in shaping abortion practices and policies. I have only been able here to touch briefly on the way the medical discourse helped to shape other discourses on abortion, particularly those that emerged in the 1960s. To do this, however, it is necessary to better understand the discourse and to see that it did change over time. This thesis demonstrates, I believe, the success of the

medical profession in regulating its views on abortion, negating positions that were not those of the elites. Even today it would seem that what we know (as the general public) about health and health care practices is shaped by the medical discourse – we do not typically come into contact with doctors who act totally outside or in opposition to what the profession deems to be appropriate. Perhaps this is why Henry Morgentaler has been so controversial – for his willingness to publicly oppose the “official” discourse on abortion. In future studies it will be particularly interesting to examine in more detail the relationship between those positions in opposition to the medical discourse such as those of Henry Morgentaler, the National Council of Women and the Association for the Modernization of the Canadian Abortion Law who argued for greater access to abortion, and the various Right to Life organizations and the Catholic Church who argued for stricter legal controls on the practice of abortion in Canada. While not examined in detail here, there is evidence to suggest that such discourses rely heavily on the medical science of conception and, indeed, on the medical discourse and it will be interesting to see where the intersections between the medical discourse and other competing discourses lie. That, however, is for the next project.

## ***Bibliography***

### ***Unpublished Sources – Primary***

#### *Canada – Department of Justice*

RG 13 Volume 2972, File 185300-237-1 (Vol. 7).

RG 13 Volume 2972, File 185300-237-1 (Pt. 7.2)

RG 13 1997-98/416 v. 31, File 21600-39

RG 13 Volume 31, File 21600-39

#### *Canada – Department of Health and Welfare*

RG 29, Volume 55, File 6752-2-16 (pt. 1)

RG 29, Volume 55, File 6756-2-16

RG 29 1996-97/698 v. 52, File 6756-2-1

#### *Canada – Planned Parenthood*

MG 28 I 350, Volume 1, File 1-11.

MG 28 I 350, Volume 1, File 1-12.

MG 28 I 350, Volume 2, File 2-6.

MG 28 I 350, Volume 2, File 2-7.

MG 28 I 350, Volume 2, File 2-15.

MG 28 I 350, Volume 2, File 2-21.

MG 28 I 350, Volume 2, File 2-22.

MG 28 I 350, Volume 3, File 3-8.

MG 28 I 350, Volume 3, File 3-9.

MG 28 I 350, Volume 3, File 3-14.

MG 28 I 350, Volume 3, File 3-23.

MG 28 I 350, Volume 3, File 3-31.  
MG 28 I 350, Volume 3, File 3-32.  
MG 28 I 350, Volume 3, File 3-35.  
MG 28 I 350, Volume 3, File 3-36.  
MG 28 I 350, Volume 4, File 4-1.  
MG 28 I 350, Volume 5, File 5-9.  
MG 28 I463, Volume 11, File 11-11.

***Published Sources – Primary***

“Abortion,” *The Canada Lancet*, 15 (January, 1883): 137-139.

“Abortion,” *Western Catholic Reporter*, (February 24, 1966): 3-4.

“Abortion Dangers,” *MD of Canada*, 2, 10 (October, 1961): 27.

“Abortion in Sweden,” *CMAJ*, 93 (October, 1965): 986.

“Abortionists,” *The Canada Lancet*, 21 (1889): 217-218.

“Abortion Lawful or Unlawful,” *CMAJ*, 26 (March, 1932): 364-365.

Adair, Fred L. (ed.), *Obstetrics and Gynecology, Volume 1*, Philadelphia: Lea & Febiger, 1940.

A.D.K., “Doctor’s Dilemma,” *CMAJ*, 101 (August, 1969): 176.

A.D.K., “Instant Abortion,” *CMAJ*, 99 (October, 1968): 822.

A.D.K., “The By-Products of Conception,” *CMAJ*, 98 (February, 1968): 422-423.

Andrews, Alfred A., “On Abortion,” *Canada Lancet*, 7 (1875): 289-291.

Around the Hospitals, “Grace Hospital: The Medical Indications of Abortion,” *The Manitoba Medical Review*, 33 (May, 1953): 253.

Association News, “Abortion in Sweden,” *CMAJ*, 93 (October, 1965): 986.

- Atlee, H.B., "Some Life-Saving Procedures in Obstetrics," *CMAJ*, 49 (November, 1943): 378-382.
- Atlee, H.B., "Some Thoughts on Abortion," *The Nova Scotia Medical Bulletin*, 26 (1947): 39-43.
- Atlee, H.B., "The Way We Treat 'em," *The Nova Scotia Medical Bulletin*, 35 (1956): 395-399.
- "A Victim of Society," *The Globe and Mail* (Friday, November 26, 1965): 5.
- A.W.M., "Bill C-195," *Criminal Law Quarterly*, 10 (1967-68): 382-89.
- Ayd, Frank J. Jr., "Physicians and Contraception," *CMAJ*, 92 (June, 1965): 1321.
- Bain, Ian, "The Development of Family Planning in Canada," *Canadian Journal of Public Health*, 55 (1964): 334-340.
- Baldy, J.M. (ed.), *An American Text-book of Gynecology, Medical and Surgical, For Practitioners and Students*, Philadelphia: W.B. Saunders Company, 1896.
- Barnes, P.H., "Rheumatic Heart Disease in Pregnancy: A Review," *The Manitoba Medical Review*, 39 (November, 1959): 683-687.
- Bean, I.W., "Unity in the Medical Profession," *Alberta Medical Bulletin*, 25 (May, 1960): 60-62.
- Beith, Esther, "Prenatal Nursing Supervision," *Canadian Public Health Journal*, 28, 12 (December, 1937): 591-595.
- Berard, Michel-J., "Threatened and Habitual Abortions," *Laval Medical*, 36 (May, 1965): 478-479.
- Berkeley, Comyns, "Diseases of the Vagina," in Thomas Watts Eden and Cuthbert Lockyer (eds.), *The New System of Gynaecology, Volume I*, Toronto: The Macmillan Company of Canada Ltd., 1917: 51-80.
- Bethune, William, "Inversion of the Uterus," *CMAJ*, 29, 6 (December, 1933): 631-634.
- "Biology and Ethics," *CMAJ*, 99 (November, 1968): 1013.
- Birt, Arthur, "More Odds and Ends," *Nova Scotia Medical Bulletin*, 16, 5 (May, 1938): 374.
- Blackader, A.D., "Maternal Welfare," *CMAJ*, 24, 4 (April, 1931): 560.
- Blackader, A.D., "Thoughts on Maternal Mortality," *CMAJ*, 20 (June, 1929): 656-658.
- Blair, Murray, "A Conservative Treatment of Incomplete Abortion," *CMAJ*, 25, 5 (November, 1931): 576-582.

Blair, Murray, "The Role of Haemorrhage in Mortality Rates in Pregnancy and Childbirth," *CMAJ*, 52 (February, 1945): 166-169.

"B.M.A. in Travail," *CMAJ*, 99 (September, 1968): 628.

Bourne, F. Munroe, Samuel O. Freedman and Guy E. Joron, "Intoxication by Aminopterin Used as an Abortifacient," *CMAJ*, 76 (March, 1957): 473-475.

Bowers, W.C., "Justifiable Artificial Abortion and Induced Premature Labor," *The Canada Lancet*, 32 (1899): 113.

Brend, William A., *A Handbook of Medical Jurisprudence and Toxicology*, London: Griffin, 1941.

Brews, R. Alan, "General Diseases in Relation to Midwifery," *The Canada Lancet and Practitioner*, 80, 4 (April, 1933): 111-116.

Brock, R. Rees, "Medical Privilege: Legal Aspects," *Manitoba Medical Review*, 47 (October, 1967): 463-469.

Burgess, H.C., "Treatment of Abortion," *CMAJ*, 14 (August, 1924): 701-703.

Campbell, Archibald Donald and Mabel A. Shannon, *Gynaecology for Nurses*, Philadelphia: F.A. Davis Company, 1946.

Campbell, D. Grant, "Pregnancy and Heart Disease," *CMAJ*, 13, 4 (April, 1923): 244-249.

Canada, House of Commons, "Issues No. 1-24," *Standing Committee on Health and Welfare*, Second Session, 27<sup>th</sup> Parliament, Ottawa, 1967-1968.

Canadian Bar Association, *The 1965 Yearbook of The Canadian Bar Association and the Minutes of Proceedings of its Forty-Seventh Annual Meeting*, Ottawa: National Printers, 1965.

Canadian Bar Association, *The 1966 Yearbook of The Canadian Bar Association and the Minutes of Proceedings of its Forty-Eighth Annual Meeting*, Ottawa: National Printers, 1966.

Canadian Medical Association, "Minutes of National Conference, Committee on Maternal Welfare," *Annual Report*, 1961: 36-42.

Canadian Medical Association, "Report of the Committee on Ethics," *Annual Report*, 1955: 37-41.

Canadian Medical Association, "Report of the Committee on Ethics," *Annual Report*, 1954: 26-29.

Canadian Medical Association, "Report of the Committee on Ethics," *Annual Report*, 1957: 43-44.

Canadian Medical Association, "Report of the Committee on Ethics," *Annual Report*, 1958: 37-38.

Canadian Medical Association, "Report of the Committee on Maternal Welfare," *Annual Report*, 1939: 19.

Canadian Medical Association, "Report of the Committee on Maternal Welfare," *Annual Report*, 1940: 24.

Canadian Medical Association, "Report of the Committee on Maternal Welfare," *Annual Report*, 1941: 22-23.

Canadian Medical Association, "Report of the Committee on Maternal Welfare," *Annual Report*, 1943: 19-21.

Canadian Medical Association, "Report of the Committee on Maternal Welfare," *Annual Report*, 1944: 26-27.

Canadian Medical Association, "Report of the Committee on Maternal Welfare," *Annual Report*, 1945: 22-23.

Canadian Medical Association, "Report of the Committee on Maternal Welfare," *Annual Report*, 1946: 24.

Canadian Medical Association, "Report of the Committee on Maternal Welfare," *Annual Report*, 1957: 49-50.

Canadian Medical Association, "Report of the Committee on Maternal Welfare," *Annual Report*, 1959: 21-23.

Canadian Medical Association, "Report of the Committee on Maternal Welfare," *Annual Report*, 1960: 24-26.

Canadian Medical Association, "Report of the Committee on Maternal Welfare," *Annual Report*, 1962: 41-43.

Canadian Medical Association, "Report of the Committee on Maternal Welfare," *Annual Report*, 1963: 56-57.

Canadian Medical Association, "Report of the Committee on Maternal Welfare," *Annual Report*, 1964: 53-54.

Canadian Medical Association, "Report of the Committee on Maternal Welfare," *Annual Report*, 1965: 77-79.

Canadian Medical Association, "Report of the Committee on Maternal Welfare," *Annual Report*, 1966: 62-64.

Canadian Medical Association, "Report of the Committee on Maternal Welfare," *Annual Report*, 1967: 68-70.

Canadian Medical Association, "Report of the Committee on Public Health," *Annual Report*, 1944: 30-31.

Canadian Medical Association, "Report of the Committee on Public Health," *Annual Report*, 1947: 27-28.

Canadian Medical Association, "Report of the Committee on Public Health," *Annual Report*, 1955: 24-26.

Canadian Medical Association, "Report of the Committee on Public Health," *Annual Report*, 1956: 28-30.

Canadian Medical Association, *Code of Ethics*, The Canadian Medical Association: 1956.

Canadian Medical Association, *Code of Ethics*, The Canadian Medical Association: 1963.

Canadian Public Health Association, "Twenty-Ninth Annual Meeting, Winnipeg, September 19-21, 1939," *Canadian Public Health Journal*, 31 (1940): 339-340.

Cannon, O.A., "Septic Abortion," *CMAJ*, 12, 3 (March, 1922): 163-168.

Cappon, Daniel, "Psychiatric Indications for the Termination of Pregnancy - Comments," *CMAJ*, 79 (August, 1958): 234-236.

Carpenter, C.W. and F.E. Bryans, "Maternal Mortality in British Columbia: A Study of 145 Deaths from 1955 to 1962," *CMAJ*, 92 (January, 1965): 160-170.

Cathell, D.W., *The Physician Himself and Things that Concern His Reputation and Success*, Philadelphia: The F.A. Davis Company Publishers, 1898.

Chapman, Henry C., *A Manual of Medical Jurisprudence and Toxicology (Second Edition)*, Philadelphia: W.B. Saunders, 1896.

Cherry, Thomas H., *Surgical and Medical Gynecologic Technic*, Philadelphia: F.A. Davis Company, 1929.

Chipman, W.W., "Some Conclusions After a Symposium in Obstetrics," *CMAJ*, 14 (August, 1924): 704-705.

"Chromosomes and Abortions," *MD of Canada*, 6 (July, 1965): 25-26.

Clarke, Patricia, "Abortion: The Back Door to Birth Control," *The United Church Observer*, (November, 1966): 8.

Clayman, A. David, Barry J. Williams and L. Wogan, "Reaction of Unmarried Girls to Pregnancy," *CMAJ*, 101 (September, 1969): 328-334.

Coady, B.K., "Case Reports," *Dalhousie Medical Journal*, 4, 1 (February, 1939): 43-44.

Copeland, Gordon Grote, "Obstetrical Fundamentals and Maternal Mortality or The Four Horsemen of Death and Damage to Motherhood Sepsis, Toxaemia, Haemorrhage and Shock," *Canadian Journal of Medicine and Surgery*, 75, 2 (February, 1934): 38-48.

Cornish, Vaughan, "The Geographical Aspect of Eugenics," *Public Health Journal*, 16 (July, 1925): 317-319.

Cornwall, W.D., "Eugenics vs. Euthenics as a Method for Race Betterment," *CMAJ*, 29, 4 (October, 1933).

Corston, James McD., "Bleeding During Pregnancy," *The Nova Scotia Medical Bulletin*, 35 (1956): 381-385.

Corston, James McD., "Preventative Medicine in Obstetrics," *The Nova Scotia Medical Bulletin*, 32 (1953): 21-25.

Cosbie, W.G., "The Effect of Better Obstetrics on Maternal Mortality," *Bulletin of the Academy of Medicine of Toronto*, 20 (July, 1947): 209-214.

Cosbie, W.G., "Maternal Mortality," *The Canadian Medical Association Journal*, 43 (July, 1940): 38-44.

Cosbie, W.G., "Syphilis in Relation to Abortion, Stillbirths and Infant Mortality," *American Journal of Obstetrics and Gynecology*, (1922): 42-44.

Cosbie, W.G., "The Obstetrical Causes and Prevention of Stillbirth and Early Infant Mortality," *CMAJ*, 13, 11 (November, 1923): 877-880.

Couture, Ernest, "Maternal Hygiene in Wartime," *Canadian Public Health Journal*, 35 (May, 1944): 175-180.

"Criminal Abortion," *The Canada Lancet*, 4, 1 (December, 1871): 185-186.

“Criminal Abortion – Foetus Cut Up in Utero,” *The Canada Lancet*, 13 (August, 1881): 366.

Crossen, Harry Sturgeon and Robert James Crossen, *Diseases of Women (Seventh Edition)*, St. Louis: The C.V. Mosby Company, 1930.

Cryderman, Ethel, “Significant Facts,” *The Public Health Journal*, 19, 4 (April, 1928): 191-192.

Cunningham, A.J., “Physicians and Contraception,” *CMAJ*, 92 (January, 1965): 87.

Curtis, Arthur Hale and John William Huffman, *A Textbook of Gynecology*, Philadelphia: W.B. Saunders Company, 1951.

Dafoe, W.A., “The Types and Treatment of Abortion,” *CMAJ*, 22 (June, 1930): 793-797.

Davis, M.M., “Early Ambulation Following Abortion,” *CMAJ*, 66 (April, 1952): 317-320.

DeLee, Joseph B., *The Principles and Practice of Obstetrics*, Philadelphia: W.B. Saunders Company, 1913.

De Veber, L.L., “Abortion and the Law,” *CMAJ*, 99 (July, 1968): 81-82.

Dickinson, J.H. and G.G. Smith, “A New and Practical Oral Contraceptive Agent: Norethindrone with Mestranol,” *CMAJ*, 89 (August, 1963): 242-245.

“Doctors and Politics,” *Saskatchewan Medical Quarterly*, 22 (September, 1958): 59-60.

Dodds, Donald J., “Physicians and Contraception,” *CMAJ*, 91 (November, 1964): 1080.

Dower, Gordon E., “Response to Roman Catholic Views on Abortion,” *BC Medical Journal*, 8 (1966): 237-239.

Draper, Frank Winthrop, *A Text-book of Legal Medicine*, Philadelphia: W.B. Saunders & Company, 1905.

Dudley, E.C., *The Principles and Practice of Gynecology for Students and Practitioners (Fifth Edition)*, Philadelphia: Lea & Febiger, 1908.

Duncan, J.H., “Can Doctors Halt Declining Rate of Births?” *Canadian Doctor*, 6, 8 (August, 1940): 20-23.

Duncan, J.H., “Maternal Mortality in Country Practice,” *CMAJ*, 38, 6 (June, 1938): 550-552.

Dunton, E. Aenid, “A Family Planning Clinic in a County Health Unit,” *Canadian Public Health Journal*, 58 (1967): 181-185.

Editorial, “Abortion,” *The Canada Lancet*, (January, 1883): 137-139.

Editorial, "Abortionists," *The Canada Lancet*, 21 (March, 1889): 217-218.

Editorial, "Abortion on Social Grounds," *CMAJ*, 96 (February, 1967): 429.

Editorial, "Birth Control," *Social Welfare*, 5 (September, 1923): 243-244.

Editorial, "Birth Control," *CMAJ*, 57 (November, 1947): 489-490.

Editorial, "Control of World Population," *CMAJ*, 94 (March, 1966): 503-504.

Editorial, "Criminal Abortion," *The Canada Lancet*, (December, 1871): 185-187.

Editorial, "Criminal Abortion – Foetus Cut Up in Utero," *The Canada Lancet*, (August, 1881): 366.

Editorial, "Current Problems in Obstetrics," *CMAJ*, 99 (September, 1968): 507-508.

Editorial, "Does It Pay? No!," *The Canada Lancet*, 42 (1908-09): 648-649.

Editorial, "Foeticide," *The Canada Lancet*, 10 (November, 1877): 93.

Editorial, "Habitual Abortion as a Psychosomatic Complaint," *CMAJ*, 97 (September, 1967): 547.

Editorial, "Infantile Mortality and Sterility," *CMAJ*, 13, 9 (September, 1923): 677-678.

Editorial, "Justifiable Artificial Abortion and Induced Premature Labor," *The Canada Lancet*, (1889): 113.

Editorial, "Maternal and Infant Mortality in Canada," *CMAJ*, 54 (May, 1946): 493-494.

Editorial, "Maternal Mortality and the Practice of Obstetrics," *CMAJ*, 20, 2 (February, 1929): 180-181.

Editorial, "Maternal Mortality Studies," *CMAJ*, 93 (August, 1965): 275-276.

Editorial, "National Birth Rate," *CMAJ*, 51 (October, 1944): 368.

Editorial, "On Birth Control," *CMAJ*, 16 (October, 1926): 704-705.

Editorial, "Oral Contraceptives," *CMAJ*, 89 (August, 1963): 270-271.

Editorial, "Physicians and Contraception," *CMAJ*, 91 (October, 1964): 820-821.

Editorial, "Population and Family Planning in Public Health," *Canadian Journal of Public Health*, 59 (1968): 278-280.

Editorial, "Puerperal Mortality: Success or Failure?" *Canadian Public Health Journal*, 25, 12 (December, 1934): 599-600.

Editorial, "Signs of Decadence," *Canadian Journal of Medicine and Surgery*, 54, 6 (December, 1923): 181-184.

Editorial, "Signs of Improvement in Maternal Mortality," *Canadian Public Health Journal*, 31 (July, 1940): 339-340.

Editorial, "The Induction of Abortion as a Therapeutic Measure," *The Canada Lancet*, (July, 1881): 342-343.

Editorial, "The Population Bomb," *CMAJ*, 86 (June, 1962): 1074-1075.

Editorial, "The Problem of Maternal Mortality," *CMAJ*, 20, 10 (October, 1929): 432.

Editorial, "The Problem of Recurrent Abortion," *CMAJ*, 80 (May, 1959): 832.

Editorial, "Therapeutic Abortion," *CMAJ*, 98 (March, 1968): 512-513.

Editorial, "The Rubella Syndrome of Congenital Malformations," *The Canadian Medical Association Journal*, 87 (September, 1962): 571.

Editorial, "Therapeutic Abortion," *CMAJ*, 98 (March, 1968): 512-513.

Editorial, "Treatment of Abortion," *The Canada Lancet*, (December, 1880): 118.

Editorial, "When a doctor is accused of criminal abortion," *Dominion Medical Monthly*, 32 (1909): 121.

Eibel, Philip, "Abortion and the Law," *CMAJ*, 98 (May, 1968): 1017.

Emory, Florence H. M., *Public Health Nursing in Canada*, Toronto: Macmillan Company, 1953.

"Eugenics and the Family," *Canadian Public Health Journal*, 31 (1940): 201-202.

Fairbairn, J.S., *Gynaecology with Obstetrics - A Text-Book for Students and Practitioners*, London: Oxford University Press, 1924.

Ferguson, Mary C., "Mental Hygiene and Prenatal Care," *Canadian Public Health Journal*, 25 (July, 1934): 349-351.

Ferguson, Robert, "A Plea for Better Obstetrics," *CMAJ*, 10, 10 (October, 1920): 901-904.

- Fisher, T.L., "The Medico-Legal Situation in Canada," *The Manitoba Medical Bulletin*, 44, 3 (March, 1964): 145-147.
- Fisher, T.L., "The Medico-Legal Situation in Canada," *The Nova Scotia Medical Bulletin*, 43 (1964): 347-350.
- Fleming, A. Grant, "Study of Infant Deaths in Toronto During the Summer of 1921," *Public Health Journal*, 13 (May, 1922): 199-203.
- "Foeticide," *The Canada Lancet*, 10 (November, 1877): 93.
- Frederick, E.V., "Bichloride of Mercury Poisoning by Vaginal Application," *CMAJ*, 10, 8 (August, 1920): 751.
- French, Herbert B., "The Low Birth-Rate of British Columbia – Some Causes and a Remedy," *Public Health Journal*, 18 (June, 1927): 262-266.
- Friesen, Rhinehart F., "Abortions," *The Manitoba Medical Review*, 39 (October, 1959): 597-599.
- Friesen, Rhinehart F., "Progress in Obstetrics and Gynecology, 1969," *The Manitoba Medical Review*, 40 (December, 1960): 781-784.
- Friesen, Rhinehart F., "Recent Advances in Obstetrics and Gynaecology," *The Manitoba Medical Review*, 45 (April, 1965): 225-227.
- Friesen, Rhinehart, "The Use and Abuse of Blood in Abortions," *CMAJ*, 80 (May, 1959): 802-805.
- Galabin, Alfred Lewis and George Blacker, *The Practice of Midwifery*, London: J & A Churchill, 1910.
- Garrett, R.W., *Textbook of Medical and Surgical Gynecology*, Kingston, 1897.
- Garrigues, Henry J., *A Text-Book of Diseases of Women*, Philadelphia: W.B. Saunders, 1894.
- Garrigues, Henry J., *Gynecology, Medical and Surgical - Outlines for Students and Practitioners*, Philadelphia: J.B. Lippincott Company, 1905.
- Goodall, J.R., "Maternal Mortality," *CMAJ*, 20 (October, 1929): 447-450.
- Goodall, James R., "Puerperal Infections: An Extramural Lecture," *CMAJ*, 22 (May, 1930): 694-697.
- Goodall, Ray, "A Case for Induced Abortion," *United Church Observer*, 1963.

- Goodell, William, *Lessons in Gynecology (Third Edition)*, Philadelphia: F.A. Davis, 1890.
- Goodwin, James C., "Diagnosis in Gynecology," *Canadian Journal of Medicine and Surgery*, (January, 1936): 6-20.
- Gowron, A.T., "Septic Abortion and Lung Abscess Treated with Penicillin," *Manitoba Medical Review*, 28 (January, 1945): 14-15.
- Grant, K.M., "Heart Disease in Pregnancy," *The Nova Scotia Medical Bulletin*, 38 (1959): 189-193.
- Grant, P.M., "On the Futility of Legalizing Abortion," *CMAJ*, 95 (October, 1966), p. 879.
- Gray, Kenneth G., "Has the Law of Abortion Been Changed?" *Ontario Medical Review*, 25 (1958): 515.
- Gray, K.G., "Psychiatric Indications for Therapeutic Abortion," *Ontario Medical Review*, 25 (1958): 1097-1098.
- Greene, J., "Septic Abortion," *Manitoba Medical Review*, (June-July, 1961): 366-368.
- "Group to fight illegal abortions," *Canadian Churchman*, 95 (April, 1968): 1, 13.
- Guest, Edna, "Problems of Girlhood and Motherhood," *Public Health Journal*, 13 (May, 1922): 193-198.
- Guttmacher, Alan F., "The Problem of Therapeutic Abortion," *Modern Medicine of Canada*, 10 (February, 1955): 71-72.
- "Habitual Aborters," *MD of Canada*, 6 (June, 1965): 36-37/
- "Habitual Abortion," *Modern Medicine of Canada*, 6 (December, 1951): 37.
- Hamilton, Ruby M., "The National Council of Women and Maternal Mortality," *Canadian Public Health Journal*, 20 (March, 1929): 161.
- Hanley, F.W., "Patients and Doctors," *Alberta Medical Bulletin*, 27 (November, 1962): 202-205.
- Harper, Paul T., *Clinical Obstetrics*, Philadelphia: F.A. Davis Company, 1930.
- Harrison, Colin P., "Abortion and the Law," *CMAJ*, 98 (May, 1968): 971.
- Harrison, C.P., "Farewell to Honour," *CMAJ*, 91 (September, 1964): 569-570.
- Harrison, C.P., "On the Futility of Legalizing Abortion," *CMAJ*, 95 (August, 1966): 360-366.

- Harrison, C.P., "The Doctor and the Patient Under Legalized Abortion," *CMAJ*, 97 (July, 1967): 249-251.
- Harrison, C.P., "The Issue of Legalized Abortion," *CMAJ*, 88 (February, 1963): 329-330.
- Harrison, C.P., "The Pragmatism of the Law and the Profession of Medicine," *BC Medical Journal*, 11 (November, 1969): 354, 385.
- Harrison, C.P., "Response to Peter M. Grant," *CMAJ*, 95 (September, 1966): 688.
- Harrison, C.P., "Response to R.N. Richards," *CMAJ* 95 (October, 1966): 830-831.
- Harrison, C.P., "Response to S.G. Stern," *CMAJ*, (April, 1963): 899-900.
- Hart, David Berry, *Guide to Midwifery*, London: Rebman Limited, 1912.
- Hattie, W.H., "How to Reduce Maternal Mortality," *CMAJ*, 25 (September, 1931): 359-360.
- Haultain, W.F.T. et. al., "Ante-Natal Care," *CMAJ*, 24, 4 (April, 1931): 618.
- Hay, Rankin K., "Medical Privilege: A Doctor's Point of View," *Manitoba Medical Review*, 47 (October, 1967): 459-462.
- Hendry, W.B., "Maternal Mortality," *CMAJ*, 13, 4 (April, 1923): 252-254.
- Hendry, W.B., "The Problem of Haemorrhage in Obstetrical Practice," *CMAJ*, 30, 6 (June, 1934).
- Henry, George W., "Mental Hygiene During Pregnancy," *Manitoba Medical Review*, 18, 8 (August, 1938): 148-150.
- Hill, H.W., "Prenatal Negligence and Loss of Populations," *CMAJ*, 11, 9 (September, 1921): 615-619.
- Hill, H.W., "Report of the Public Health Committee on Reduction of Infant Mortality in London," *Public Health Journal*, 14 (December, 1923): 542-556.
- Hiltz, J.E., "Pregnancy Complicating Pulmonary Tuberculosis," *The Nova Scotia Medical Bulletin*, 22 (1943): 143-145.
- Hirst, Barton Cooke, *A Text-Book of Obstetrics*, Philadelphia: W.B. Saunders Company, 1912.
- Holman, Edwin J., "Sterilization, Insemination, and Abortion," *Modern Medicine of Canada*, 10 (April, 1955): 76.

- Horner, R.H., "The Treatment of Abortion," *Alberta Medical Bulletin*, 14 (April, 1949): 27-29.
- Houston, Clarence J., "A Practising Doctor's View of the Philosophy of Doctor-Hospital-Government Relationships," *Alberta Medical Bulletin*, 27 (November, 1962): 206-210.
- Hurd, W.B., "The Decline in the Canadian Birth Rate," *Canadian Journal of Economics and Political Science*, 3 (1937): 40-57.
- I.D.M., "Justice of Miscarriage," *The Nova Scotia Medical Bulletin*, June, 1967: 115-116.
- I.D.M., "Medical-Legal Inquiries: Therapeutic Abortion and Sterilization," *The Nova Scotia Medical Bulletin*, June, 1967: 116-117.
- "Inadequate Prenatal Care and Toxemia of Pregnancy," *CMAJ*, 95 (August, 1966): 410-412.
- "Intra-Amniotic Induction," *MD of Canada*, 7, 2 (February, 1966): 33-34.
- Irving, Frederick C., *A Textbook of Obstetrics - For Students and Practitioners*, New York: The Macmillan Company, 1936.
- Jackson, F.W., R.D. Defries and A.H. Sellers, "A Five-Year Survey of Maternal Mortality in Manitoba, 1928-1932," *Canadian Public Health Journal*, 25, 3 (March, 1934): 103-119.
- Jackson, F.W., N.R. Rawson and E. Couture, "Maternal Mortality in Manitoba, 1933-1937 (Second Five-Year Period)," *Canadian Public Health Journal*, 31, 7 (July, 1940): 307-321.
- Jentz, L.A. and A.E. Croal, "Farewell to Honour," *CMAJ*, 91 (October, 1964): 824.
- Johnston, William Victor, *Before the Age of Miracles: Memoirs of a Country Doctor*, Toronto: Fitzhenry and Whiteside Limited, 1972.
- Jost, A.C., "The Conservation of Child Life," *Public Health Journal*, 11, 11 (November, 1920): 503-512.
- Jost, A.C., "The Falling Birth Rate," *Public Health Journal*, 19 (June, 1928): 270-271.
- Jowett, Cecilia, *No Thought for Tomorrow: The Story of a Northern Nurse*, Toronto: Ryerson Press, 1954.
- Kawula, L., "The Evolution of Maternal Mortality Study in Saskatchewan," *Saskatchewan Medical Quarterly*, 22 (September, 1958): 62-68.
- Kerslake, D., and D. Casey, "New Abortion Technique," *MD of Canada*, 8, 10 (October, 1967): 33.

- Kinch, Robert A.H., "Are We Doing Too Many Therapeutic Abortions?" *Ontario Medical Review*, 26, 8 (August, 1959): 729-732, 771.
- Kobrinsky, S., "Hemorrhage in Pregnancy," *The Manitoba Medical Review*, 26 (August, 1946): 458-460.
- Kobrinsky, S., "Pernicious Vomiting of Pregnancy with Autopsy Findings," *CMAJ*, 19 (November, 1928): 574-575.
- Kolischer, G., "The Prevention of Conception – A Criticism of Some Methods," *Dominion Medical Monthly*, 19 (1902): 116-118.
- Kredientser, B., "The Unmarried Mother and Her Doctor", *Alberta Medical Bulletin*, 28 (May, 1963): 114-116.
- Laboratory Report, "'The Pill' and the Laboratory," *Manitoba Medical Review*, (August-September, 1966): 478-479.
- Lader, Lawrence, *Abortion*, New York: The Bobbs-Merrill Company, Inc., 1966.
- Lailey, W.W., "The Progress of Maternal Welfare in the United States and Canada," *The Public Health Journal*, 18 (June, 1927): 251-254.
- Lane, O.G., "Defeat for 'Dishonour'?" *CMAJ*, 91 (December, 1964): 1373-1374.
- Lane, R.M., "Meeting of the Council on Community Health Care, September 18 & 19, 1969," *CMAJ*, 101 (November, 1969): 21-27.
- Lane, R.M., "Tuberculosis and Pregnancy," *The Canadian Medical Association Journal*, 77 (July, 1957): 28-31.
- "Late Abortion Effects," *MD of Canada*, 8 (September, 1967):42.
- Lederman, J.J., "The Doctor, Abortion, and the Law: A Medicolegal Dilemma," *CMAJ*, 87 (August, 1962): 216-222.
- Lederman, J.J., "The Doctor, Abortion, and the Law - Response to Walter Simpson," *CMAJ*, 87 (October, 1962): 821-822.
- "Liberal Abortion," *CMAJ*, 98 (March, 1968): 467.
- Lindsay, C. Crawford and C.V. Ward, "Potassium Permanganate as an Abortifacient," *CMAJ*, 71 (November, 1954): 465-467.
- Lyons, Ben H., "The Heart in Pregnancy," *The Manitoba Medical Review*, 27 (September, 1947): 511-514.

- MacDonald, D.F., "Missed Ectopic," *Nova Scotia Medical Bulletin*, 16 (April, 1937):
- MacKenzie, C.J.G., G.P. Evans and J.G. Peck, "The Vancouver Family Planning Clinic: A Case Study," *Canadian Journal of Public Health*, 58 (1967): 53-60.
- MacKenzie, C.J.G., "The Vancouver Family Planning Clinic: A Comparison of Two Years' Experience," *Canadian Journal of Public Health*, 59 (July, 1968): 257-265.
- MacMurchy, Helen, "Classification of Maternal Deaths," *Canadian Public Health Journal*, 22, 8 (August, 1931): 412-419.
- MacMurchy, Helen, "Maternal Mortality," *Social Welfare*, 6 (1923): 28-30.
- MacMurchy, Helen, "Neo-Natal Mortality," *The Public Health Journal*, 17 (September, 1926): 442-447.
- MacMurchy, Helen, "On Maternal Mortality in Canada," *Public Health Journal*, 16 (September, 1925): 410-416.
- MacMurchy, Helen, "Report of the Committee on Maternal Welfare," *Nova Scotia Medical Bulletin*, 11 (April, 1932): 461-462.
- MacMurchy, Helen, "The Relation Between Maternal Mortality and Infant Mortality," *Public Health Journal*, 16, 8 (August, 1925): 379-382.
- "Management of Missed Abortion," *Modern Medicine of Canada*, 11 (May, 1956): 89.
- Manning, E.C., "Concerns for the Professions," *Alberta Medical Bulletin*, 29 (November, 1964): 161-164.
- "Maternal Mortality in Canada," *Canadian Nurse*, 42, 5 (May, 1936): 213-215.
- "Maternal Mortality in Canada," *Canadian Public Health Journal*, 31 (May, 1940): 252.
- Maternal Mortality Report No. 1, "O.M.A. Maternal Welfare Committee," *Ontario Medical Review*, 27 (September, 1960): 916-917, 923, 959.
- Maternal Mortality Report No. 7, "Septic Abortions – 'They Die Smiling,'" *Ontario Medical Review*, 29 (January, 1962): 42-43.
- Maternal Mortality Report No. 19, "Abortion," *Ontario Medical Review*, 31 (April, 1964): 288-290.
- Maternal Mortality Report No. 21, "Patient Preventable?" *Ontario Medical Review*, 31 (June, 1964): 422.

Maternal Mortality Report No. 32, "Welchi Septicaemia," *Ontario Medical Review*, 35 (October, 1968): 517, 533.

Maxwell, Ian, "Legislation Regarding Abortion," *The Nova Scotia Medical Bulletin*, (June, 1968): 126-127.

Maxwell, Ian, "Legislation Regarding Abortion," *The Nova Scotia Medical Bulletin*, (August, 1968): 153-158.

McCord, W.J., "Grace Hospital: The Medical Indications of Abortion," *Manitoba Medical Review*, 33 (May, 1953): 253.

McFadden, J.W., "Law and Morality," *Public Health Journal*, 13 (March, 1922): 97-105.

McGillivray, J.W., "Instant Abortion," *CMAJ*, 99 (November, 1968): 1058.

McIlwraith, Kennedy C., "How to Reduce Maternal Mortality in the Province," *Canadian Public Health Journal*, 22, 7 (July, 1931): 347-350.

McIlwraith, K.C., "Obstetrics and the State," *CMAJ*, 10, 4 (April, 1920): 305-313.

McInnis, A.C., "Review of Maternal Deaths – 1961," *Manitoba Medical Review*, (May, 1962): 286-288.

McLeod, Presley A., "Maternal Mortality from the Viewpoint of the Obstetrician," *The Canadian Medical Association Journal*, 42 (January, 1940): 53-56.

Medical Committee of the Sanatorium Board, "Tuberculosis Complicated with Pregnancy," 21, 3 (March, 1941): 45-47.

"Medical Ethics," *Alberta Medical Bulletin*, 29 (November, 1964): 183-184.

"Medical Views on Abortion," *CMAJ*, 94 (May, 1966): 1189-1190.

"Medicine and Social Reconstruction," *Alberta Medical Bulletin*, 20 (November, 1955): 28-29.

Meeting of the Council of Community Health Care, "Therapeutic Abortion," *CMAJ*, 101 (November, 1969): 21-27.

Melville, P.H., "Postscript to 'Farewell to Honour,'" *CMAJ*, 91 (November, 1964): 1130.

"Missed Abortion, Rupture of the Uterus and Retroperitoneal Hemorrhage," *CMAJ*, 93 (October, 1965): 758-759.

Mitchell, James R., "Maternal Welfare – A Challenge," *Manitoba Medical Review*, 44, 8 (October, 1964): 461-465.

Mitchell, Ross, "Hysterotomy and Sterilization," *CMAJ*, 26 (May, 1932): 629-630.

Mitchell, Ross, "Maternal Deaths in Manitoba," *CMAJ*, 45 (August, 1941): 160-161.

Mitchell, Ross, B., "New Thoughts on the Prevention of Maternal Deaths," *Manitoba Medical Review*, 15, 12 (December, 1935): 3-4.

Mitchell, Ross, "The Prevention of Maternal Mortality in Manitoba," *CMAJ*, 19 (September, 1928): 292-296.

Mitchell, Ross, "Thoughts on the Toxaemias of Pregnancy," *Manitoba Medical Review*, 21 (October, 1941): 187-189.

Montgomery, E.W., "Maternal Mortality," *Manitoba Medical Review*, 99 (November, 1929): 1-8.

Montgomery, L.G., "Abstract of 'The Question of Therapeutic Abortion in Addison's Disease,'" *CMAJ*, 28, 1 (January, 1933): 107.

Mookerjee, Basab K., Ralph Bilefsky, Alan G. Kendall and John B. Dossetor, "Generalized Shwartzman due to Gram-Negative Septicemia after Abortion: Recovery after Bilateral Cortical Necrosis," *CMAJ*, 98 (March, 1968): 578-583.

Moore, D., "Farewell to Honour," *CMAJ*, 91 (October, 1964): 824.

Morgantaler, Henry, "Unwanted Pregnancy: Abortion and the Medical Profession," *McGill Medical Journal*, 39 (Spring, 1970): 8-9, 31-41.

Mullner, J.W., "Abortion and the Law," *CMAJ*, 97 (December, 1967): 1613.

Murphy, Hilda, "Nursing Care in Pre-Eclamptic Toxaemia and Pernicious Vomiting," *Canadian Nurse*, 23, 1 (January, 1927): 14-15.

Napheys, George, *The Physical Life of Woman - Advice to the Maiden, Wife and Mother*, Toronto: The Hunter-Rose Company Limited, 1869.

Nathanson, Joseph N., "Prophylaxis in Obstetrics with Special Reference to the Value and Importance of Pre-Natal Care," *CMAJ*, 14, 6 (June, 1924).

Nathanson, Joseph N., "The Duty of the State to the Unmarried Mother and Her Child," *Public Health Journal*, 13 (January, 1922): 30-33.

Nebinger, Andrew, *Criminal Abortion: Its Extent and Prevention*, Philadelphia: Collins, Printer, 1870.

"New Abortion Technique," *MD of Canada*, 8, 10 (October, 1967): 33.

"New Law on Breath Test and Therapeutic Abortion," *Ontario Medical Review*, 36 (November, 1969): 509-512.

Niswander, K.R. and A. Patterson, "Late Abortion Effects," *MD of Canada*, 8, 9 (September, 1967): 42.

Noonan, W.T., and D.E. Cannell, "A Seven-Year Study of Maternal Deaths in Ontario," *Ontario Medical Review*, 32 (1965): 705-707.

Ober, William B., "We Should Legalize Abortion," *Saturday Evening Post* (October 8, 1966): 14-15.

Ontario Medical Association, "Report on Transactions of Council Meeting, May 7, 8, 9, 1961," *Ontario Medical Review*, 28 (1961): 94.

Ontario Medical Association, "Report on Transactions of Council Meeting, May 10, 11, 1963," *Ontario Medical Review*, 30 (1963): 82.

Osborne, D.F., "Attempted Abortion with Retention of an Intrauterine Foreign Body," *CMAJ*, 90 (February, 1964): 494-495.

Osborne, H., "Some Aspects of Women," *Alberta Medical Bulletin*, 21 (November, 1956): 23-25.

Parker, Graham E., "Bill C-150: Abortion Reform," *Criminal Law Quarterly*, 11 (1968-69): 267-274.

Paul, Gerald W., "Abortion is Wrong," *United Church Observer*, 25 (March 15, 1963): 16-17.

Paul, W.M., "Death from Induced Abortion," *Ontario Medical Review*, 25 (1958): 809-810, 851.

Percival, E., "The Induction of Abortion – Its Indications," *CMAJ*, 16 (October, 1926): 1275-1276.

Percival, Eleanor, "Therapeutic Abortion in Pulmonary Tuberculosis," *CMAJ* 26 (April, 1932): 500.

Perkin, Gordon W., "Physicians and Contraception," *CMAJ*, 92 (March, 1965): 631-632.

Perkin, Gordon W., "Physicians and Contraception," *CMAJ*, 92 (June, 1965): 1321.

- Phair, J.T., "Health Propaganda," *The Public Health Journal*, 13, 4 (April, 1922): 145-148.
- Phair, J.T., "Maternal Mortality – A General Survey," *Canadian Public Health Journal*, 23 (April, 1932): 179-182.
- Phair, J.T., "Why Maternal Deaths," *Canadian Public Health Journal*, 25, 3 (March, 1934): 141-142.
- Phair, J.T. and A.H. Sellers, "A Study of Maternal Deaths in the Province of Ontario," *Canadian Public Health Journal*, 25, 12 (December, 1934): 563-579.
- Pierce, R.V., *The Peoples Common Sense Medical Adviser in Plain English or Medicine Simplified, Seventeenth Edition*, Buffalo, New York: World's Dispensary Printing Office and Bindery, 1888.
- Plumptre, Adelaide, M., "A Mother's Duty to the State," *Public Health Journal*, 18, 4 (April, 1927): 178-181.
- "Poor Morals, Family Life Seen in Unwed Mothers," *MD of Canada*, 8 (April, 1967): 55-56.
- Power, Mary E., "Public Health Education: An Exhibit Depicting Our Maternal and Infant Deaths," *Canadian Public Health Journal*, 21, 5 (May, 1930): 251-252.
- Pratten, F.H., "Pulmonary Complications in Pregnancy," *CMAJ*, 24, 3 (March, 1931): 391-396.
- "Pregnancy and the Tuberculous Woman," *The Canada Lancet*, 53 (July, 1920): 33-34.
- "Preventing Abortions," *MD of Canada*, 6 (August, 1965): 23-24.
- Prichard, Annah L., "Maternity," *Public Health Journal*, 14 (July, 1923): 322-324.
- Primrose, Thomas, "Report of the Committee on Maternal Welfare," *CMAJ*, 85 (September, 1961): 550.
- Proceedings of the Ontario Medical Association, "Pregnancy and the Tuberculous Woman," *The Canada Lancet*, 53, 11 (July, 1920).
- "Pseudo-Abortifacient," *MD of Canada*, 3 (February, 1962): 25.
- Ptolemy, Connie Gray, "Family Planning Interpretation – The Nurse's Role," *Canadian Public Health Journal*, 60 (1969): 402-408.
- Puddicombe, John, "The Importance of Prenatal Care," *Child and Family Welfare*, 10, 2 (1934): 10-13.

- Randall, Clyde L., and Paul K. Birtch, "Spontaneous Abortion – Diagnosis and Treatment," *CMAJ*, 66 (February, 1952): 132-137.
- Rawson, Noel R., "Maternal Deaths in Manitoba," *Canadian Public Health Journal*, 32 (1941): 55-69.
- Reece, John J., *Text-Book of Medical Jurisprudence and Toxicology (Eighth Edition)*, Philadelphia: P. Blakiston's Son & Co., 1912.
- Reed, Charles A.L. (ed.), *A Text-Book of Gynecology*, New York: D. Appleton and Company, 1901.
- "Report of the Maternal Welfare Committee," *BC Medical Journal*, 8 (1966): 377-379.
- Review, "Therapeutic Abortion in Pulmonary Tuberculosis," *CMAJ*, 26, 4 (April, 1932): 500.
- Review article, "The Health of Women," *CMAJ*, 35, 5 (November, 1936).
- Rice, F.E. and E.E. Bissett, "Report on Maternal Mortality," *Public Health Journal*, 19, 12 (December, 1928): 577-579.
- Richards, R.N., "On the Futility of Legalizing Abortion," *CMAJ*, 95 (October, 1966): 830.
- Ringrose, C.A. Douglas, "Current Concepts in Conception Control," *CMAJ*, 89 (August, 1963): 246-248.
- Ringrose, C.A. Douglas, "Conception Control," *CMAJ*, 89 (December, 1963): 1199.
- Ringrose, C.A.D., "Physicians and Family Planning," *CMAJ*, 92 (January, 1965): 88.
- Roberts, Rev. James R., "Roman Catholic Thoughts on the Problems of Abortion," *BC Medical Journal*, 8 (1966): 57-64.
- Robinson, Charles R., "Endometrial Ossification Following a Recent Abortion," *CMAJ*, 1317-1318.
- Robinson, S.C., "Induced Abortion," *Dalhousie Medical Journal*, 16, 1 (Spring, 1963): 11-13.
- Robinson, S.C., "The Use and Abuse of Blood Transfusion in Obstetrics," *The Nova Scotia Medical Bulletin*, 38 (1959): 201-203.
- Robson, T.B. and A.G. Gornall, "Pregnanediol Assays and the Abortion Problem," *CMAJ*, 72 (June, 1955): 830-834.
- Ryberg, Percy E., *Health, Sex and Birth Control*, Toronto: The Anchor Press, 1942.

- Scarlet, E.P., "A Doctor's Notebook," *Alberta Medical Bulletin*, 31 (May, 1966): 50-55.
- Scarlet, E.P., "Medicine as a Profession," *Alberta Medical Bulletin*, 26 (August, 1961): 78-82.
- Scarlet, E.P., "Men for All Seasons: Some Observations on Medicine and Society," *Alberta Medical Bulletin*, 28 (February, 1963): 15-24.
- Schaefer, George, R. Gordon Douglas and Irving H. Dreishpoon, "Tuberculosis in Pregnancy," *Modern Medicine of Canada*, 8 (1953): 75-76.
- "Septic Abortion: Diagnosis and Therapy," *Modern Medicine of Canada*, 11 (July, 1956): 80-81.
- Shepherd, R.W., "The Population Bomb," *CMAJ*, 87 (December, 1962): 1204-1205.
- Shute, Evan V., "Should Spontaneous Abortion be Prevented?" *CMAJ*, 82 (January, 1960): 72-76.
- Simard, Rene et Paul-Emile Fortin, "Avortement Par Incontinence du Col Uterin," *Laval Medical*. 34 (1963): 1067-1069.
- Simpson, Walter, "Letter to the Editor - The Doctor, Abortion, and the Law," *CMAJ*, 87 (October, 1962): 821.
- Skinner, Norman S., "Abstract of 'Vaginal Bleeding from Potassium Permanganate,'" *CMAJ*, 53 (September, 1945): 298.
- Smith, A. Laphorn, "Is the Present Method of Educating Girls Consistent with their Physiological Development? And is it for the Welfare of the Race?" *Dominion Medical Monthly*, 23 (1904): 320-327.
- Smith, Donald F., "Therapeutic Abortion - Should the Law Be Changed?" *The Nova Scotia Medical Bulletin*, (June, 1967): 118-120.
- Smith, Kenneth D., and Harris S. Wineberg, "A Survey of Therapeutic Abortion Committees," *Criminal Law Quarterly*, 12 (1969-70): 279-306.
- Soden, Ruth Ann, "Is Abortion Always Wrong?" *The United Church Observer* (October, 15, 1968): 16-19.
- Stander, Henricus J., *Williams Obstetrics: A Textbook for the Use of Students and Practitioner (Eighth Edition)*, New York: Appleton-Century Company, 1941.
- "Statement of the Catholic Bishops of Canada on Abortion," *The Nova Scotia Medical Bulletin*, (October, 1968): 185-187.

Stern, S.G., "Letter to the Editor - The Issue of Legalized Abortion," *CMAJ*, 88 (April, 1963): 899.

Stevens, William J., "Recent Advances in Obstetrics," *Canadian Nurse*, 27, 6 (June, 1922): 285-289.

Stewart, D.B., "Abortions: A Review of 326 Cases from the Public Gynecology Wards of the Winnipeg General Hospital," *Manitoba Medical Review*, (November, 1941): 211-212.

Storer, Horatio R., "The Abetment of Criminal Abortion by Medical Men," *Canada Medical Journal*, 3 (1867): 225-234.

Tallin, G.P.R., "The Legal Implications of the Non-Therapeutic Practices of Doctors," *CMAJ*, 87, 5 (August, 1962): 207-215.

Taussig, Frederick J., *Abortion Spontaneous and Induced: Medical and Social Aspects*, St. Louis: C.V. Mosby Company, 1936.

Taussig, Frederick J., *The Prevention and Treatment of Abortion*, St. Louis: C.V. Mosby Company, 1910.

Taylor, A.C., "The Clinical Types of Abortion and Their Treatment," *University of Toronto Medical Journal*, 3, 6 (April, 1926): 245-251.

Taylor, M.S., "The Public Health Nurse – Her Work in Relation to Maternal Mortality," *Canadian Public Health Journal*, 21, 7 (July, 1930): 349-351.

"The Abortion Battle of Britain," *CMAJ*, 96 (April, 1967): 1171-1172.

"The Abortion Capital of the World," *CMAJ*, 100 (April, 1969): 733.

"The Death of an Unfortunate Young Woman," *Saturday Night*, 37 (December 3, 1921): 1.

"The Induction of Abortion as a Therapeutic Measure," *The Canada Lancet*, 13 (July, 1881): 342-343.

"Therapeutic Abortion," *CMAJ*, 94 (February, 1966): 402-403.

Thomas, T. Gaillard, *A Practical Treatise on the Diseases of Women, Sixth Edition*, Philadelphia: Lea Brothers & Co., 1891.

Thomson, A.E. and R.J. Nixon, "Intravascular Haemolysis and Acute Renal Failure Following Postabortal Sepsis due to *Clostridium Welchii*," *CMAJ*, 80 (May, 1959): 450-452.

"Threatened Abortion," *Modern Medicine of Canada*, 6 (November, 1951): 46.

"Threatened Abortion," *Modern Medicine of Canada*, 9 (July, 1954): 65.

Tietze, Christopher, Kohl Schuyler, Stanley Best and Johan Eliot, "Teaching of Fertility Regulation in Medical Schools: A Survey in the United States and Canada, 1964," *CMAJ*, 94 (April, 1966): 717-722.

Tompkins, M.G., "Maternal Mortality Study," *The Nova Scotia Medical Bulletin*, 37 (1958): 69-71.

Topics of Current Interest, "A Clinical Study of Abortion," *CMAJ*, 35 (December, 1936): 691-692.

Topics of Current Interest, "Therapeutic Abortion and the Law," *CMAJ*, 39, 4 (October, 1938): 401-402.

"Toronto Authorizes Distribution of Birth Control Information," *MD of Canada*, 6, 5 (May, 1965): 50.

"Treatment of Abortion," *The Canada Lancet*, 13 (December, 1880): 118.

Trench, Violet, "The Home - The First Factory of the Nation," *Public Health Journal*, 16, 11 (November, 1925): 524-529.

Tupper, Carl, "Missed Abortion," *The Nova Scotia Medical Bulletin*, 40 (1961): 178-180.

Tupper, Carl and R.J. Weil, "The Problem of Spontaneous Abortion," *The Nova Scotia Medical Bulletin*, 35 (1956): 212-213.

Tyrer, Alfred Henry, *Sex, Marriage and Birth Control (Tenth Edition)*, Toronto: Marriage Welfare Bureau, 1943.

Vant, J. Ross and Ronald H. Horner, "Maternal Mortality in Alberta, 1935-1958," *Alberta Medical Bulletin*, 25 (May, 1960): 49-53.

Vant, J. Ross, "Report of the Committee on Maternal Mortality," *Alberta Medical Bulletin*, 3, 4 (October, 1938): 15-16.

Vant, J. Ross, "The Contribution Made by Maternal Mortality Study Committees," *CMAJ*, 82 (June, 1960): 1303-1308.

Van Wyck, H.B., "Maternal Mortality," *Canadian Public Health Journal*, 23, 12 (December, 1932): 562-566.

Van Wyck, H.B., "Recent Advances in Obstetrics of Interest to the General Practitioner," *CMAJ*, 62 (February, 1950): 109-119.

- Vernon, C.W., "The Church and Social Hygiene," *Public Health Journal*, 15 (August, 1924): 348-351.
- Vital Statistics, "The Recent Improvement in Maternal Mortality in Canada," *Canadian Public Health Journal*, 31, 1 (January, 1940): 37-39.
- Waring, Elmer S., "The Toxaemias of Pregnancy," *The Canada Lancet*, 53, 12 (August, 1920): 555-562.
- Waring, Gerald, "Report from Ottawa," *CMAJ*, 96 (January, 1967): 164.
- Waring, Gerald, "Report from Ottawa," *CMAJ*, 97 (November, 1967): 1233.
- Waring, Gerald, "Report from Ottawa," *CMAJ*, 98 (January, 1968): 126.
- Waring, Gerald, "Report from Ottawa," *CMAJ*, 98 (February, 1968): 419.
- Waring, Gerald, "Report from Ottawa," *CMAJ*, 99 (August, 1968): 380.
- Waring, Gerald, "Report from Ottawa," *CMAJ*, 100 (May, 1969): 870.
- Waring, Gerald, "Report from Ottawa," *CMAJ*, 101 (July, 1969): 114.
- Washburn, H.H., "The Administration and Operation of the Norfolk County Family Planning Clinic," *Canadian Journal of Public Health*, 58 (1967): 277-279.
- Wasman, H.S., "Psychological Factors Involved in Normal Pregnancy," *University of Toronto Medical Journal*, 25, 2 (November, 1947): 51-60.
- Wearing, Morris P., "The Use of Norethindrone (2 Mg.) with Mestranol (0.1 Mg.) in Fertility Control: A Preliminary Report," *CMAJ*, 89 (August, 1963): 239-241.
- Webb, Jean F., "Observations on Maternal and Infant Health in Canada," *Canadian Journal of Public Health*, 45 (January, 1954): 1-6.
- Webster, J. Clarence, *A Textbook of Obstetrics*, Philadelphia: W.B. Saunders Company, 1903.
- Weil, R.J. and Lucille Stewart, "Possible Correlation Between Hormone Levels and Emotional Status in the Pregnant Woman," *The Nova Scotia Medical Bulletin*, 35 (1956): 429.
- Weingold, A.B., Seigal, S. and M.L. Stone, "Intra-Amniotic Induction," *MD of Canada*, 7, 2 (February, 1966): 33-34.
- Welply, W.R., "Medical Privilege: Discussion," *Manitoba Medical Review*, 47 (October, 1967): 470-471.

"When a doctor is accused of criminal abortion," *Dominion Medical Monthly*, 32 (1909): 121-122.

Whitehouse, H. Beckwith, "Methods of Examination," in Thomas Watts Eden and Cuthbert Lockyer (eds.), *The New System of Gynaecology, Volume I*, Toronto: The Macmillan Company of Canada Ltd., 1917: 119-90.

Whyte, J.C., "The Rubella Syndrome of Congenital Malformations," *CMAJ*, 87 (September, 1962): 571.

Williams, Glanville, *The Sanctity of Life and the Criminal Law*, New York: Alfred A. Knopf, 1957.

Wilson, D. Laurence, "Medical Indications for Therapeutic Abortion," *Ontario Medical Review*, 26, 8 (August, 1959): 733-736, 766.

Wilson, Karl M., "The Problem of Maternal Mortality," *CMAJ*, 34, 5 (May, 1936): 518-525.

Wodehouse, R.E., "Maternal Deaths," *CMAJ*, 34 (May, 1936): 525-527.

"Women and Children First!" *Canadian Doctor*, 6, 10 (October, 1940): 13-21.

Wright, Adam H., *A Textbook of Obstetrics*, New York: D. Appleton and Company, 1908.

Wyllie, J., "Sex Differences in the Mortalities of Childhood and Adult Life," *Canadian Public Health Journal*, 24, 11 (November, 1933): 530-542.

Yadav, D.R., "The Mushroom Crowd," *CMAJ*, 92 (January, 1965): 88.

Young, H.E. and J.T. Phair, "Maternal Mortality in Canada," *Public Health Journal*, 19, 3 (March, 1928): 135-136.

Young, Scott, "Death Before Birth," *Maclean's*, 60 (April 1, 1947): 7-8, 61-62.

Zarfes, D.E., "Psychiatric Indications for the Termination of Pregnancy," *CMAJ*, 79 (August, 1958): 230-234.

### ***Published Sources - Secondary***

Annau, Catherine, "Eager Eugenicists: A Reappraisal of the Birth Control Society of Hamilton," *Histoire Sociale/Social History*, 27, 53 (May, 1994): 111-134.

Appleby, Brenda Margaret, *Responsible Parenthood: Decriminalizing Contraception in Canada*, Toronto: University of Toronto Press, 1999.

Arnup, Katherine, André Lévesque and Ruth Roach Pierson (eds.), *Delivering Motherhood: Maternal Ideologies and Practices in the 19<sup>th</sup> and 20<sup>th</sup> Centuries*, London: Routledge, 1990.

Arnup, Katherine, *Education for Motherhood: Advice for Mothers in Twentieth Century Canada*, Toronto: University of Toronto Press, 1994.

Backhouse, Constance, "Involuntary Motherhood: Abortion, Birth Control and the Law in Nineteenth Century Canada," *Windsor Yearbook of Access to Justice*, (1983): 61-130.

Backhouse, Constance, "Physicians, Abortions, and the Law in Early Twentieth-Century Ontario," *Canadian Bulletin of Medical History*, 10 (1993): 229-249.

Backhouse, Constance, "Prosecution of Abortions under Canadian Law, 1900-1950," in Jim Phillips et. al. (eds.) *Essays in the History of Canadian Law, Volume 5*, Toronto: University of Toronto Press, 1994: 252-292.

Baehre, Rainer, "The Medical Profession in Upper Canada Reconsidered: Politics, Medical Reform, and Law in a Colonial Society," *Canadian Bulletin of Medical History*, 12 (1995): 101-124.

Berg, Jan Hendrik van den, *Medical Power and Medical Ethics*, New York: W.W. Norton & Company, 1978.

Berlant, J.L., *Profession and Monopoly: A Study of Medicine in the United States and Great Britain*, Berkeley, University of California Press, 1975.

Bleier, Ruth, *Science and Gender: A Critique of Biology and Its Theories on Women*, New York: Pergamon Press, 1984.

Blishen, Bernard, *Doctors in Canada: The Changing World of Medical Practice*, Toronto: University of Toronto Press, 1991.

Bliss, Michael, "Pure Books on Avoided Subjects: Pre-Freudian Sexual Ideas in Canada," Canadian Historical Association, *Historical Papers*, (1970): 89-108.

Borst, Charlotte G., *Catching Babies: The Professionalization of Childbirth, 1870-1920*, Cambridge: Harvard University Press, 1995.

Brodie, Janet Farrell, *Contraception and Abortion in 19<sup>th</sup> Century America*, Ithaca: Cornell University Press, 1994.

Brodie, Janine, Shelley A.M. Gavigan and Jane Jenson, *The Politics of Abortion*, Toronto: Oxford University Press, 1992.

Brookes, Barbara, *Abortion in England 1900-1967*, Kent: Croom Helm Ltd., 1988.

Butler, Judith, *Gender Trouble: Feminism and the Subversion of Identity*, New York: Routledge, 1990.

Bynum, W.F., *Science and the Practice of Medicine in the Nineteenth Century*, Cambridge: Cambridge University Press, 1994.

Campbell, Robert and Leslie Pal, "Courts, Politics and Morality: Canada's Abortion Saga," in *The Real Worlds of Canadian Politics: Cases in Process and Policy*, Peterborough, Ontario: Broadview Press Ltd., 1989: 165-226.

Cannold, Leslie, *The Abortion Myth: Feminism, Morality, and the Hard Choices Women Make*, Hanover: University Press of New England, 2000.

Chandler, Marthe A., Elizabeth Adell Cook, Ted G. Jelen and Clyde Wilcox, "Abortion in the United States and Canada: A Comparative Study of Public Opinion," in Ted G. Jelen and Marthe A. Chandler (eds.), *Abortion Politics in the United States and Canada: Studies in Public Opinion*, Westport, Connecticut: Praeger, 1994.

Childbirth by Choice Trust (eds.), *No Choice: Canadian Women Tell Their Stories of Illegal Abortion*, Toronto: Childbirth by Choice Trust, 1998.

Collins, Anne, *The Big Evasion: Abortion, The Issue the Won't Go Away*, Toronto: Lester & Orpen Dennys Limited, 1985.

Collins, Larry D., "The Politics of Abortion: Trends in Canadian Fertility Policy," *Atlantis*, 7, 2 (Spring, 1982): 2-20.

Comacchio, Cynthia R., *Nations are Built of Babies: Saving Ontario's Mothers and Children, 1900-1940*, Montreal: McGill-Queen's University Press, 1993.

Cook, R.J. and B.M. Dickens, *Abortion Laws in Commonwealth Countries*, Geneva: World Health Organization, 1979.

Critchlow, Donald T., *Intended Consequences: Birth Control, Abortion, and the Federal Government in Modern America*, New York: Oxford University Press, 1999.

Cuneo, Michael W., *Catholics Against the Church: Anti-Abortion Protest in Toronto, 1969-1985*, Toronto: University of Toronto Press, 1989.

Dally, Ann, *Women Under the Knife: A History of Surgery*, London: Hutchinson Radius, 1991.

Davis, Natalie Zemon, *Fiction in the Archives: Pardon Tales and Their Tellers in Sixteenth Century France*, Stanford: Stanford University Press, 1987.

Dean, Carolyn J., "The Productive Hypothesis: Foucault, Gender, and the History of Sexuality," *History and Theory*, 33, 3 (1994).

de Valk, Alphonse, *Morality and Law in Canadian Politics: The Abortion Controversy*, Dorval: Palm Publishers, 1974.

Dodd, Diane, "The Canadian Birth Control Movement on Trial, 1936-1937," *Histoire Sociale/Social History*, 16, 32 (November, 1983): 411-428.

Dodd, Diane and Deborah Gorham (eds.), *Caring and Curing: Historical Perspectives on Women and Healing in Canada*, Ottawa: University of Ottawa Press, 1994.

Dubinsky, Karen, *Improper Advances: Rape and Heterosexual Conflict in Ontario, 1880-1929*, Chicago: University of Chicago Press, 1993.

Duffy, Paul J., *The Politics of Abortion*, Homebush, Australia: Society of St. Paul, 1971.

Dunstan, G.R. and E.A. Shinebourne, *Doctors' Decisions: Ethical Conflicts in Medical Practice*, Oxford: Oxford University Press, 1989.

Foucault, Michel, "Body/Power," in Colin Gordon (ed.), *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*, New York: Pantheon Books, 1980:

Foucault, Michel, "The Discourse on Language," in *The Archaeology of Knowledge*, trans. A.M. Sheridan Smith, New York: Pantheon Books, 1972: 215-238.

Foucault, Michel, *The History of Sexuality, Volume One*, New York: Penguin Books, 1979.

Friedson, Eliot, *Profession of Medicine: A Study in the Sociology of Applied Knowledge*, New York: Harper and Row, 1970.

Friedson, Eliot, *Professional Dominance: The Social Structure of Medical Care*, New York: Atherton Press, 1970.

Gagnon, F., R. Lemieux and H. de Saint-Victor, "Diagnostic Difficile D'Un état Infectieux Consécutif A Un Avortement Provoqué," *Laval Médical*, (October, 1947): 873-882.

Gavigan, Shelley, "On 'bringing on the menses': The Criminal Liability of Women and the Therapeutic Exception in Canadian Abortion Law," *Canadian Journal of Women and the Law*, (1986):

Gavigan, Shelley, "The Criminal Sanction as it Relates to Human Reproduction: The Genesis of Statutory Prohibition of Abortion," *Journal of Legal History*, 5 (1984): 20-43.

Gentles, Ian (ed.), *A Time to Choose Life: Women, Abortion and Human Rights*, Toronto: Stoddart, 1990.

Gordon, Colin (ed.), *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*, New York: Pantheon Books, 1980.

Gordon, Linda, *Heroes of Their Own Lives: The Politics and History of Family Violence, Boston, 1880-1960*, New York: Viking, 1988.

Gordon, Linda, *Woman's Body, Woman's Right: Birth Control in America*: New York: Penguin Books, 1990.

Gossage, Peter, "Absorbing Junior: The Use of Patent Medicines as Abortifacients in Nineteenth Century Montreal," *The Register*, 3, 1 (March, 1982): 1-13.

Granatstein, J.L., *Canada 1957-1967: The Years of Uncertainty and Innovation*, Toronto: McClelland and Stewart, 1986.

Gutting, Gary (ed.), *The Cambridge Companion to Foucault*, Cambridge: Cambridge University Press, 1994.

Hodgson, Jane E. (ed.), *Abortion and Sterilization: Medical and Social Aspects*, London: Academic Press Inc. Ltd., 1981.

Hodgson, Jane E., "The Twentieth-Century Gender Battle: Difficulties in Perception," in Rickie Solinger (ed.), *Abortion Wars: A Half Century of Struggle, 1950-2000*, Berkeley, University of California Press, 1998: 290-306.

Holmes, et.al., *Birth Control and Controlling Birth: Women-Centered Perspectives*, Clifton, New Jersey: Humana Press, 1980.

Holmes, Helen Bequaert and Laura M. Purdy (eds.), *Feminist Perspectives in Medical Ethics*, Bloomington: Indiana University Press, 1992.

Hubbard, Ruth, *The Politics of Women's Biology*, New Jersey: Rutgers University Press, 1990.

Hunt, Robert and John Arras (eds.), *Ethical Issues in Modern Medicine*, Palo Alto, California: Mayfield Publishing Company, 1977.

Hunter, Kathryn Montgomery, *Doctor's Stories: The Narrative Structure of Medical Knowledge*, Princeton: Princeton University Press, 1991.

Iacovetta, Franca and Wendy Mitchinson (eds.), *On the Case: Explorations in Social History*, Toronto: University of Toronto Press, 1998.

Imber, Jonathan B., *Abortion and the Private Practice of Medicine*, New Haven: Yale University Press, 1986.

Jacobus, Mary, Evelyn Fox Keller and Sally Shuttleworth (eds.), *Body/Politics: Women and the Discoveries of Science*, New York: Routledge, 1990.

Jenson, Jane, "Getting to Morgantaler: From One Representation to Another," in Janine Brodie, Shelley A.M. Gavigan and Jane Jenson, *The Politics of Abortion*, Toronto: Oxford University Press, 1992:

Jordanova, Ludmilla, *Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries*, Madison: University of Wisconsin Press, 1989.

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

Keown, J., *Abortion, Doctors and the Law*, Cambridge: Cambridge University Press, 1988.

Kinnear, Julia L., "The Professionalization of Canadian Nursing, 1924-32: Views in the *CN* and *CMAJ*," *Canadian Bulletin of Medical History*, 11 (1994): 153-174.

Klausen, Susanne, "Doctors and Dying Declarations: The Role of the State in Abortion Regulation in British Columbia," *Canadian Bulletin of Medical History*, 13, 1 (1996): 53-82.

Korinek, Valerie J., *Roughing It in the Suburbs: Reading Chatelaine Magazine in the Fifties and Sixties*, Toronto: University of Toronto Press, 2000.

Kuhse, Helga, *The Sanctity-of-Life Doctrine in Medicine: A Critique*, Oxford: Clarendon Press, 1987.

Laqueur, Thomas, *Making Sex: Body and Gender from the Greeks to Freud*, Cambridge: Harvard University Press, 1990.

Larson, Maglia, *The Rise of Professionalism: A Sociological Analysis*, Berkeley: University of California Press, 1977.

Leavitt, Judith Walzer, *Brought to Bed: Childbearing in America, 1750 to 1950*, New York: Oxford University Press, 1986.

Lvesque, Andrée, *Making and Breaking the Rules : Women in Quebec, 1919-1939* (trans. Yvonne Klein), Toronto: McClelland and Stewart, 1994.

Light, Tracy Penny, "Foucault's Discourse Analysis: Its Application in Western Historiography and its Promise for Abortion History," unpublished paper, University of Waterloo, 1999.

Lindstrom, Varpu, *Defiant Sisters: A Social History of Finnish Immigrant Women in Canada*, Toronto: Multicultural History Society of Ontario, 1988.

Loudon, Irvine, *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality, 1800-1950*, Oxford: Clarendon Press, 1992.

Lowe, Marian and Ruth Hubbard (eds.), *Woman's Nature: Rationalizations of Inequality*, New York: Pergamon Press, 1983.

Luker, Kristin, *Abortion and the Politics of Motherhood*, Los Angeles: University of California Press, 1984.

MacDermot, H.E., *100 Years of Medicine in Canada, 1867-1967*, Toronto: McClelland and Stewart, 1967.

Martin, Emily, "The Egg and the Sperm: How Science has Constructed a Romance Based on Stereotypical Male-Female Roles," *Signs*, 16, 3 (1991): 485-501.

McConnell, Moira and Lorenne Clark, "Abortion Law in Canada: A Matter of National Concern," *Dalhousie Law Journal*, 14 (May, 1991): 81-89.

McCulloch, Michael, "'Dr. Tumblety, the Indian Herb Doctor': Politics, Professionalism, and Abortion in Mid-Nineteenth-Century Montreal," *Canadian Bulletin of Medical History*, 10 (1993): 49-66.

McLaren, Angus, "Birth Control and Abortion in Canada, 1870-1920." *Canadian Historical Review*, 59 (1978): 319-340.

McLaren, Angus, "Illegal Operations: Women, Doctors and Abortion, 1886-1939," *Journal of Social History*, 26, 4 (1993): 797-816.

McLaren, Angus, *Our Own Master Race: Eugenics in Canada, 1885-1945*, Toronto: McClelland and Stewart, 1990.

McLaren, Angus and Arlene Tigar McLaren, "Discoveries and Dissimulations: The Impact of Abortion Deaths on Maternal Mortality in British Columbia," *BC Studies*, 64-67 (1984-85): 3-26.

McLaren, Angus and Arlene Tigar McLaren, *The Bedroom and the State: The Changing Practices of Contraception and Abortion in Canada, 1880-1997*, Toronto: Oxford University Press, 1997.

McLellan, Anne A., "Abortion Law in Canada," in J. Douglas Butler and David F. Walbert (eds.), *Abortion, Medicine, and the Law*, New York: Facts on File, 1992: 333-405.

Merkin, Donald, *Pregnancy as a Disease: The Pill in Society*, Port Washington, New York: Kennikat Press, 1976.

Miles, Angela R. and Geraldine Finn (eds.), *Feminism in Canada: From Pressure to Politics*, Montreal: Black Rose Books, 1982.

Mitchinson, Wendy, "Agency, Diversity, and Constraints: Women and Their Physicians, Canada, 1850-1950," in Susan Sherwin (ed.), *The Politics of Women's Health: Exploring Agency and Autonomy*, Philadelphia: Temple University Press, 1998: 122-149.

Mitchinson, Wendy, "Causes of Disease in Women: The Case of Late 19<sup>th</sup> Century English Canada" in Charles G. Roland (ed.), *Health, Disease and Medicine: Essays in Canadian History*, Toronto: Clarke Irwin for the Hannah Institute for the History of Medicine, 1984: 381-395

Mitchinson, Wendy, *Giving Birth in Canada, 1900-1950*, Toronto: University of Toronto Press, 2002.

Mitchinson, Wendy, "Problematic Bodies and Agency: Women Patients in Canada, 1900-1950," in Franca Iacovetta and Wendy Mitchinson (eds.), *On the Case: Explorations in Social History*, Toronto: University of Toronto Press, 1998: 266-288.

Mitchinson, Wendy, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*, Toronto: University of Toronto Press, 1991.

Mitchinson, Wendy, "The Sometimes Uncertain World of Canadian Obstetrics, 1900-1950," *Canadian Bulletin of Medical History*, 17 (2000): 193-207.

Mitham, Peter J., "For 'the Honor and Dignity of the Profession': Organized Medicine in Colonial New Brunswick, 1793-1860," *Canadian Bulletin of Medical History*, 13 (1996): 83-108.

Mohr, James, *Abortion in America: The Origins and Evolution of National Policy, 1800-1900*, New York: Oxford University Press, 1978.

Morgan, Kathryn Pauly, "Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalization," in Susan Sherwin (ed.), *The Politics of Women's Health: Exploring Agency and Autonomy*, Philadelphia: Temple University Press, 1998: 83-121.

Morgantaler, Henry, *Abortion and Contraception*, Toronto: General Publishing, 1982.

Morowitz, Harold J. and James S. Trefil, *The Facts of Life: Science and the Abortion Controversy*, New York: Oxford University Press, 1992.

Morton, F.L. *Pro-Choice vs. Pro-Life: Abortion and the Courts in Canada*, Norman and London: University of Oklahoma Press, 1992.

Naylor, C. David, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966*, Kingston and Montreal: McGill-Queen's University Press, 1986.

Nowell-Smith, Harriet, "Nineteenth-Century Narrative Case Histories: An Inquiry into Stylistics and History," *Canadian Bulletin of Medical History*, 12 (1995): 45-67.

Oppenheimer, Jo, "Childbirth in Ontario: The Transition from Home to Hospital in the Early Twentieth Century," *Ontario History*, 75, 1 (March, 1983): 36-60.

Oxorn, Harry, *Harold Benge Atlee M.D.: A Biography*, Hartsport, Nova Scotia: Lancelot Press, 1983.

Palmer, Michael, *Moral Problems in Medicine: A Practical Coursebook*, Toronto: University of Toronto Press, 1999.

Pascoe, Rebecca, "Woman Troubles: Abortion and Contraception in Canada, 1950-80," unpublished MA Thesis, University of Waterloo, 2002.

Pelrine, Eleanor, *Abortion in Canada*, Toronto: New Press, 1971.

Penny, Tracy, "'Getting Rid of My Trouble:' A Social History of Abortion in Ontario, 1880-1929," unpublished MA Thesis, Laurentian University, 1995.

Petchesky, Rosalind Pollack, *Abortion and Woman's Choice: The State, Sexuality, and Reproductive Freedom*, New York: Longman Inc., 1984.

Prentice, Alison, Bourne, Paula, Brant, Gail Cuthbert, Light, Beth, Mitchinson, Wendy, Black, Naomi, *Canadian Women: A History*, Toronto: Harcourt Brace, 1988.

Reagan, Leslie, "'About to Meet Her Maker:' Women, Doctors, Dying Declarations, and the State's Investigation of Abortion, Chicago, 1867-1940," *Journal of American History*, 77 (March, 1991): 1240-1264.

Reagan, Leslie, *When Abortion Was A Crime: Woman, Medicine, and Law in the United States, 1867-1973*, Los Angeles: University of California Press, 1997.

Reid-Ipsos, "So Whom Do We Trust? Reader's Digest Trust Survey Finds that Pharmacists, Doctors and Airline Pilots Top the List as Canada's Most Trusted Professions," January 22, 2003.

Rosenberg, Charles E., "The Therapeutic Revolution: Medicine, Meaning, and Social Change in Nineteenth Century America," in Morris J. Vogel and Charles E. Rosenberg (eds.), *The Therapeutic Revolution: Essays in the Social History of American Medicine*, Pennsylvania: University of Pennsylvania Press, 1979: 3-26.

Rothstein, William G., *American Physicians in the Nineteenth Century: From Sects to Science*, Baltimore: The Johns Hopkins University Press, 1972.

Rouse, Joseph, "Power/Knowledge," in Gary Gutting (ed.), *The Cambridge Companion to Foucault*, Cambridge: Cambridge University Press, 1994.

Ryan, Joseph G., "The Chapel and the Operating Room: The Struggle of Roman Catholic Clergy, Physicians, and Believers with the Dilemmas of Obstetric Surgery, 1800-1900," *Bulletin of the History of Medicine*, 76 (2002): 461-494.

Schlesinger, Benjamin, *Family Planning in Canada: A Source Book*, Toronto: University of Toronto Press, 1974.

Scott, Joan Wallach, *Gender and the Politics of History*, New York: Columbia University Press, 1988.

Scott, Joan Wallach, *Only Paradoxes to Offer: French Feminists and the Rights of Man*, Cambridge: Harvard University Press, 1996.

Scott, Joan Wallach., "The Evidence of Experience," in Henry Abelove, Michele Aina Barale and David M. Halperin (eds.), *The Gay and Lesbian Studies Reader*, New York: Routledge, 1993.

Sheeran, Patrick J., *Women, Society, The State, and Abortion: A Structuralist Analysis*, New York: Praeger Publishers, 1987.

Sheldon, Sally, *Beyond Control: Medical Power and Abortion Law*, London: Pluto Press, 1997.

Sheldon, Sally, "'Who is the Mother to Make the Judgement?': The Constructions of Woman in English Abortion Law," *Feminist Legal Studies*, 1, 1(1993): 3-22.

Sherwin, Susan (ed.), *The Politics of Women's Health: Exploring Agency and Autonomy*, Philadelphia: Temple University Press, 1998

Shorter, Edward, *Bedside Manners: The Troubled History of Doctors and Patients*, New York: Simon and Schuster, 1985.

Shortt, S.E.D., "Physicians, Science, and Status: Issues in The Professionalization of Anglo-American Medicine in the Nineteenth Century," *Medical History*, 27 (1983): 51-68.

Smith, Graeme and Gloria Galloway, "Few Fear Spread of Contagion," *The Globe and Mail*, Saturday May 31, 2003, p. A8.

Solinger, Rickie, "Abortion Politics and History," in Rickie Solinger (ed.), *Abortion Wars: A Half Century of Struggle, 1950-2000*, Berkeley, University of California Press, 1998: 1-14.

Solinger, Rickie (ed.), *Abortion Wars: A Half Century of Struggle, 1950-2000*, Berkeley, University of California Press, 1998.

Solinger, Rickie, "Pregnancy and Power Before *Roe v. Wade*, 1950-1970," in Solinger, Rickie (ed.), *Abortion Wars: A Half Century of Struggle, 1950-2000*, Berkeley, University of California Press, 1998: 15-32.

Starr, Paul, *The Social Transformation of American Medicine*, New York: Basic Books, 1982.

Stortz, Gerald and Murray Eaton, "Pro Bono Publico: The 1936 Eastview Birth Control Trial," *Atlantis*, 8 (1983): 51-60.

Strange, Carolyn and Tina Loo, *Making Good: Law and Moral Regulation in Canada, 1867-1939*, Toronto: University of Toronto Press, 1997.

Strange, Carolyn, *Toronto's Girl Problem: The Perils and Pleasures of the City, 1880-1930*, Toronto: University of Toronto Press, 1995.

Strong-Boag, Veronica, "Canada's Wage-Earning Wives and the Construction of the Middle Class, 1945-60," *Journal of Canadian Studies*, 29, 3 (Autumn, 1994): 5-25.

Strong-Boag, Veronica, *The New Day Recalled: The Lives of Girls and Women in English Canada, 1919-1939*, Toronto: Copp Clark Pitman Ltd., 1993.

Thomas, Clayton L. (ed.), *Taber's Cyclopedic Medical Dictionary, 16<sup>th</sup> Edition*, Philadelphia: F.A. Davis Company, 1985.

Thomson, Michael, *Reproducing Narrative: Gender, Reproduction and Law*, Aldershot: Ashgate Publishing, 1999.

Thomson, Michael, "Woman, Medicine and Abortion in the Nineteenth Century," *Feminist Legal Studies*, 3, 2 (1995): 159-183.

Turner, Bryan S., *Medical Power and Social Knowledge Second Edition*, London: Sage Publications, 1995.

Valverde, Mariana, *The Age of Light, Soap and Water*, Toronto: McClelland and Stewart, 1991.

Vogel, Morris J. and Charles E. Rosenberg, (eds.), *The Therapeutic Revolution: Essays in the Social History of American Medicine*, Pennsylvania: University of Pennsylvania Press, 1979.

Warner, John Harley, *The Therapeutic Perspective: Medical Practice, Knowledge, and Identity in America, 1820-1885*, Cambridge: Harvard University Press, 1986.

Witz, A., *Professions and Patriarchy*, London: Routledge and Kegan Paul, 1992.

Zeller, Suzanne, *Land of Promise, Promised Land: The Culture of Victorian Science in Canada*, Canadian Historical Association, Historical Booklet No. 56, 1996.