

ABORTION NURSING IN CANADA: 1960s to 1990s

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ABSTRACT

In this dissertation I investigate, interpret, and make visible the heretofore under-examined histories of Registered Nurses and their roles in developing Canadian abortion services. Often neglected in the dominant narratives of abortion, women's health, and nursing history, this examination of the hands-on work of abortion clinic nurses is significant. It reveals that nurses were key actors in the complex development of abortion services and of abortion nursing. It demonstrates that nurses created and negotiated their abortion work in the face of multiple intersecting social and professional contexts, including the state's shifting regulation of abortion, under-developed clinical facilities and practices, inter- and intra-disciplinary collaborations and tensions, and broader cultural attitudes toward abortion and its provision (both supportive and resistant). Through their work, I suggest, abortion clinic nurses supported the decriminalization of abortion, the development and provision of socially and medically safe practices, pro-choice political activism, the management of anti-abortion activism, and the overall development of abortion nursing. These findings arose from my examination of nurses' work in establishing, developing, and defending freestanding (i.e., out-of-hospital) abortion clinics in Montreal, Winnipeg, Toronto, Ottawa, and Vancouver from the mid-1960s to 1999. The analysis was conducted through the methodological lens of oral history supported by the tools of social and cultural historical inquiry and science and technology studies. It was informed by an overarching critical feminist perspective. I conducted eight semi-structured oral history interviews with retired and practicing Registered Nurses who worked in the field of abortion, and I supplemented those interviews with archival sources and documents. Overall, this analysis demonstrates that nurses made these contributions by creating and undertaking new abortion work, confronting and managing multiple challenges, and continuing to push forward owing to a fundamental

professional commitment to helping women have safe abortions through the promotion of women's bodily safety and emotional wellbeing. This dissertation thus increases and nuances collective understanding of important aspects of the previously unexplored histories of nurses and their roles in developing Canadian abortion services in the latter half of the twentieth century.

LAY SUMMARY

In this research, I explored Canadian nurses' abortion work from the 1960s to the 1990s. I interviewed eight Registered Nurses who worked in abortion services within that timeframe and examined archival documents (e.g., newspaper reports) to unearth the ways that nurses participated in the operation of freestanding abortion clinics. These clinics comprised specialty facilities that had developed outside of hospitals. I looked at nurses' illegal and legal work in those clinics before and after the federal abortion law was struck down in 1988. I found that nurses made significant contributions to establishing and developing freestanding clinics amid many challenges, such as restrictive legislation, under-developed facilities and practices, new professional relationships, and an anti-abortion (or pro-life) movement that resisted their work. In this challenging environment, however, I found that nurses remained committed to their work in the clinics owing to an ultimate aim of helping women have safe abortions.

PREFACE

This dissertation is an original unpublished intellectual product of the author, C. Haney. Ethical approval for oral history fieldwork was granted by the University of British Columbia Behavioural Research Ethics Board (ID: H15-02129).

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LIST OF ABBREVIATIONS

AHSA Alberta Health Services Archives

AIS Abortion Information Service (of Vancouver)

CARAL The Canadian Association for the Repeal of the Abortion Law (1974-1988)
Canadian Abortion Rights Action League (after 1988)

CoVA City of Vancouver Archives

CNA Canadian Nurses Association

EBC Elizabeth Bagshaw Clinic (Also known as “Bagshaw”)

EHC Everywoman’s Health Centre (Also known as “Everywoman’s”)

LAC Library and Archives Canada

NAF National Abortion Federation

OHIP Ontario Health Insurance Plan

RCSW Royal Commission on the Status of Women

STS Science and Technology Studies

TAC Therapeutic Abortion Committee

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To my friends and family. I am finished now. Thank you for helping me get here. Finally, I wish to recognize Jeanette B, Sharon B, Lisa E, Jackie F, Christena M, Lisa R, Rene W, and Joan W. for their enormous contributions both to this research project and to the development of abortion nursing in Canada. Thank you for sharing your, stories, time, knowledge, and skill.

For the nurses who worked to make the world a safer place for women.

INTRODUCTION

While sharing her memories of her long and varied career in Canadian abortion services, Joan W, a retired Registered Nurse, made a powerful statement about nurses' engagement in abortion work from the 1960s onward. She reflected:

[As a nurse] you knew what was medically required. You knew the plight of the patient and their conditions. You knew what the doctors expected. And you understood the politics of the issue. Well, come on, that's nursing!¹

This statement emerged from Joan's oral history account of her nearly forty years of abortion-related nursing work in hospitals, birth control clinics, and freestanding abortion clinics in Ontario. Her comment is remarkable for the way that it reflects recognition, experience, and understanding of three critical elements that nurses brought together in their abortion work, namely, the clinical aspects of abortion, some of the social circumstances facing women who sought and obtained abortions, and the broader political landscapes that affected abortion provision and nursing practice. Notably, Joan conceptualized this wide-ranging and long-lasting engagement with the complexity of abortion provision as nursing itself, asserting unequivocally, "Well, come on, that's nursing!"

¹ Joan W [JW] 1495. Interview by author, February 2016. As part of the research, I conducted oral history interviews with eight practicing or retired Registered Nurses. Detailed information about each of these nurses is provided in the Appendix. Ethical approval for the oral history component of this study was obtained from the UBC Behavioural Ethics Review Board.

Though Joan W's narrative points toward a rich and intriguing area of inquiry, the history of abortion nursing in Canada is neither fully acknowledged nor well understood.² Both as hands-on practitioners and non-clinical actors, nurses and their attendant abortion work have been relatively overlooked by scholars of abortion, nursing, and women's health history. In terms of abortion history, for example, nurses have been embedded within narratives that focus on abortion politics and legislation,³ physicians' experiences,⁴ pro-choice and anti-abortion

² There are but a few nursing-focused analyses related to abortion history. Karissa Haugeberg examined the *American Journal of Nursing* for nurses' responses to the legalization of abortion in the USA, doing so through a women's labour history lens (*see* Haugeberg, "Nursing"). Jayne Elliott and her colleagues briefly pointed to some abortion-related activities of the profession's leadership in their examination of the first one hundred years of operation of the Canadian Nurses' Association [CNA] (*see* Elliott et al., "CNA"). I contributed an analysis of the abortion-related discourses that were published within the professional journal, *Canadian Nurse*, between 1950 and 2000 (*see* Haney, "Nursing Identity"; Haney, "Towards Legitimate Nursing"). Finally, I conducted a similar analysis in the USA context (*see* Haney, "Professional Abortion").

³ Ackerman and Stettner, "Public Not Ready"; Backhouse, "Involuntary Motherhood"; Beahen, "Abortion and Infanticide"; Brodie, "Choice"; Brodie et al., "Politics"; Gavigan, "Criminal Sanction"; Gavigan, "Bringing on the Menses"; Johnstone, "After Morgentaler"; McLaren and Tigar McLaren, "The Bedroom"; Stettner et al., "Abortion"; "Tatalovich, "Politics".

⁴ Backhouse, "Celebrated Trial"; Backhouse, "Physicians"; Dunphy, "Morgentaler"; Jenson, "Getting to Morgentaler"; Klausen, "Doctors"; Light, "Shifting Interests"; McLaren, "Illegal Operations".

activism,⁵ and women's experiences as patients or would-be patients.⁶ In nursing history, the 'issue' of abortion has gone similarly overlooked in favour of analyses of the profession's broader development and its shifting status in health care and society. Abortion has not been positioned within core nursing history topics such as nursing's early roots,⁷ the development of nurses' training and education,⁸ secularization,⁹ the (re)organization of labour-as-such,¹⁰ and the lives and work of nursing leaders.¹¹ Nurses' hands-on abortion work has similarly gone overlooked in favour of historical investigations focused on other specialized practice fields such

⁵ Ackerman, "A Region at Odds"; Ackerman, "Defence of Reason"; Ackerman, "Not in the Atlantic"; Ackerman, "Dark Secret"; Cuneo, "Catholics"; Lochwin, "Blinded"; McDonnell, "Not Easy Choice"; Morton "Pro-Choice vs. Pro-Life"; Palmer, "Choices"; Rebick, "Ten Thousand"; Saurette and Gordon, "Arguing Abortion"; Saurette and Gordon, "Changing Voice"; Sethna and Hewitt, "Clandestine Operations"; Stachiew, "Manitoba"; Stettner, "We Are Forced"; Tomson, "Winning Choice"; Wasserlein, "An Arrow"; Weir, "Left Popular".

⁶ Childbirth by Choice Trust, "No Choice"; Palmer, "Lonely"; Sethna et al., "Choice Interrupted"; Stettner, "Unwanted".

⁷ Bates, et al., "All Frontiers"; Gibbon and Mathewson, "Three Centuries".

⁸ Baumgart and Kirkwood, "Social Reform"; Duncan et al., "100 Years"; Paul and Ross-Kerr, "Origins"; Pringle et al., "Building the Future".

⁹ McPherson, "Bedside Matters"; Violette, "Healing the Body". For the USA context, *see* Melosh, "Physician's Hand"; Reverby, "Ordered to Care".

¹⁰ McPherson, "Bedside Matters"; Ross-Kerr, "Emergence of Unions"; Scaia, "Working Professionalism".

¹¹ Nelson and Rafferty, "Notes on Nightingale"; Street, "Watch-Fires".

as public health,¹² critical care,¹³ psychiatry,¹⁴ and the rise of the nurse practitioner and licensed practical nurse,¹⁵ for example.¹⁶ Finally, in women's reproductive health history, the continuation of pregnancy (arguably more so than its interruption) and the roles of non-nurse practitioners such as physicians, midwives, and Indigenous healers, in addition to the conditions of women-as-patients, have taken centre stage.¹⁷ Conspicuously, within the general body of 'women's health' literature, nurses and their abortion work are missing from pervasive analyses of the medicalization of women's health and abortion and the rise of the women's self-help health movement (in Canada) beginning in the late 1960s.¹⁸ Scholarly inattention to nurses'

¹² Boschma et al., "Nobody Asked Me"; Green, "Through the Years"; McKay, "Public Health".

¹³ Vanderspank, "Social Construction"; Vanderspank-Wright et al., "Development of ICU".

¹⁴ Boschma, "Deinstitutionalization Reconsidered"; Boschma, "Electroconvulsive Therapy".

¹⁵ Fairman, "The Roots" (for Nurse Practitioners in the USA); Twohig, "Great Transformation"; Twohig, "We Shall Arrive".

¹⁶ Nurses' practice history is a relatively new field of study for historians of nursing. It offers myriad topics and avenues of inquiry, *see* D'Antonio, "Introduction"; Hallett and Fealy, "Introduction". Other major topics of practice history include military nursing (*see* Quiney, "Small Army"; Toman, "Officer") and missionary nursing (*see* Grypma, "Healing Henan").

¹⁷ Arnup, et al., "Delivering Motherhood"; Burnett, "Taking Medicine"; Burnett, "Different Histories"; Jasen, "Race, Culture"; Mitchinson, "Giving Birth"; Rutherford, "Caregiving"; Strong-Boag and McPherson, "Confinement".

¹⁸ Boscoe et al., "Women's Health"; Deibert-Turner, "Golden Speculum"; Dodd and Gorham, "Caring and Curing"; Mitchinson, "Nature of Bodies"; Mitchinson, "Medical Treatment"; Morrow, "Our Bodies"; Sethna, "Birth Control Handbook".

abortion work and those women who performed it in these contexts renders them invisible in a number of important histories, contributing to some wide-ranging gaps in understandings of abortion, nursing, and women's health history. It is primarily to these areas and gaps that I attend in this dissertation.

The purpose of this study, then, is to investigate, interpret, and make visible the histories of nurses and their roles in developing Canadian abortion services. This dissertation demonstrates that nurses comprised a unique group of women who have long been present for and intimately involved in the provision of abortion services to women in Canada. Yet their work has gone neglected as a worthy subject of study, perhaps owing in part to the stigmatization of abortion, its practitioners, and the women who seek it, which has been identified in contemporary literature.¹⁹ Focusing on the establishment and development of freestanding abortion clinics between the mid-1960s to the 1990s and the attendant shift of abortion nurses away from hospitals, which had been the primary site of practice for most nurses, I argue that nurses at the new clinics created and negotiated abortion work in the face of multiple intersecting social and professional contexts, including the state's shifting regulation of abortion, under-developed clinical facilities and practices, inter- and intra-disciplinary collaborations and tensions, and broader cultural attitudes toward abortion and its provision (both supportive and resistant)—each of which, this dissertation illustrates, influenced and were influenced by nurses and their work.

¹⁹ Bolton, "Women's Work"; Chiappetta-Swanson, "Dignity". For more on 'worthy subjects,' in nursing history, *see* Grypma "Critical Issues". For perceived shameful subjects, *see* McPherson, "Bedside Matters": 2.

Drawing from the words and documented experiences of nurses who provided direct care to women seeking, having, and recovering from abortions, I further suggest that in negotiating and enacting their work, nurses made unique and critical contributions to the development of modern abortion services and to the practice field of abortion nursing specifically. Overall, I argue that these nurses contributed to the successful establishment, defence, and ongoing operation of freestanding abortion clinics. I suggest that in so doing, abortion clinic nurses supported the decriminalization of abortion, the development and provision of socially and medically safe practices, abortion-supportive (i.e., pro-choice) activism, the management of anti-abortion activism, and the overall development of abortion nursing (both in terms of practice development and identity construction). Significantly, my analysis shows that nurses made these contributions by creating and undertaking new abortion work, confronting and managing multiple challenges, and continuing to push forward largely owing to a fundamental professional commitment to helping women have safe abortions by supporting safe procedures and the promotion of women's bodily and emotional safety. This dissertation thus brings to light and offers an interpretation of multiple important aspects of the previously unexplored histories of nurses and their roles in developing Canadian abortion services in the latter half of the twentieth century.

Research Questions

I posed a number of research questions to guide this study. In general, I aimed to gain an understanding of the nature of nurses' hands-on abortion work, the ways that nurses perceived it, and the ways that broader social contexts shaped or were shaped by nurses and their work. To that end, I asked descriptive questions such as what abortion-related work have nurses performed in and around freestanding clinics? What tasks did they take on? Where, when, and with whom

did they perform that work? And, in what ways and in what circumstances did their practices develop or change, and why? Going further, I posed deeper questions about the ways that nurses perceived their work, asking, what did nurses believe about abortion, nursing, and abortion nursing in particular? How did they conceptualize the connections between them? What meanings did nurses subsequently bring to or make of nurses' abortion work, and how did those perspectives affect nursing practice? Exploring these questions through oral histories and supplementary archival documents (sources which I will detail in a later section of this introduction), led me to the closer understanding of nurses' historical abortion work presented in this dissertation.

Freestanding Abortion Clinics and Vacuum Aspiration Abortion

Given that Canadian abortion history and nurses' work in it are vast areas of inquiry, I narrowed the scope of this investigation primarily to the site of freestanding abortion clinics. I did so not only because the establishment and continued operation of these clinics were key events and processes in Canadian abortion history but also because nurses and their work continually proved integral to clinic development throughout my investigation. Though the details of their development are more fully discussed throughout this dissertation, I now provide a general overview of freestanding abortion clinics and the primary abortion procedure offered there. I do so in order to generate a common understanding of in-clinic functioning and the abortion procedure itself, which may be unfamiliar to readers given the general secrecy surrounding the hands-on elements of abortion provision. This description thus provides a picture of the material context in which nurses' abortion work was developed and enacted. Thereafter, I detail the broader historical development of freestanding abortion clinics and discuss the ways that they

have been understood as historically significant by other scholars. Within that review, I also point to the ways that nursing has been concurrently conceptualized and understood in order to highlight areas where this research lends insight into the ways that abortion nursing was related to and embedded in the context of the profession at large.²⁰

General Operation

In terms of ‘freestanding abortion clinics,’ I investigate specialized out-of-hospital facilities from which trained practitioners provided surgical abortion services via the vacuum aspiration method, primarily at women’s request.²¹ The first clinic was opened illegally by physician Henry Morgentaler and nurse Joanne Cornax in Montreal in approximately 1970.²² The second and

²⁰ The following overview is a composite picture amalgamated from oral history interviews and archival sources.

²¹ This conceptualization of the freestanding abortion clinic precludes physicians’ offices, hospital day surgery departments, or other facilities that provided abortions. For more on abortion provision from physicians’ offices, *see* the work of Vancouver physicians William McCallum and Robert Makaroff. For McCallum, *see* Ross, “Friendly Abortionist.” For Makaroff, *see* “Doctor made \$300,000 in a year”. For hospital day surgery clinics, readers may wish to consult the records from Calgary’s General and Foothills Hospitals Therapeutic Abortion Committee [TAC] meetings housed in the Alberta Health Services Archives [AHSA] in Calgary.

²² Dunphy, “Morgentaler”. Note that Morgentaler has come to dominate the public and to a lesser extent the scholarly narrative of Canadian abortion history as its main protagonist and initiator of freestanding abortion clinics. However, in 1966, Toronto physician Leslie Frank Smoling opened an out-of-hospital abortion clinic (i.e., before Morgentaler). I do not study

third of these freestanding abortion clinics were opened by Morgentaler and his colleagues (also illegally) in 1983 in Toronto and Winnipeg. In Chapter One, I place the development of abortion nursing in its historical and legal context by examining the operation and defense of these three clinics. After abortion's decriminalization in 1988, additional freestanding clinics were opened across Canada, both by Morgentaler and his colleagues and by other groups independently of Morgentaler.²³ All of these freestanding abortion clinics were physically and operationally independent from hospitals, neither classified as 'small hospitals' nor funded or operated as outpatient hospital branches (hence the moniker *freestanding*). Rather, freestanding abortion clinics were established in a variety of community spaces such as converted houses, multi-purpose professional medical buildings, and renovated commercial spaces that were not formally

Smoling's clinic, however, given that Smoling did not provide the vacuum aspiration procedure and because that clinic was only shortly in operation from February to May of 1966. For his work there, Smoling was charged with fifteen counts of procuring abortions. He sold the clinic, escaped bail, and moved to Australia. His Canadian charges were stayed in 1978 and he returned to Canada in 1982. In the mid-1980s, he began working with Henry Morgentaler in Toronto. There is very little information about Smoling's clinic in the primary and secondary sources I consulted. For more on Smoling, *see* Dunphy, "Morgentaler"; English and Blatchford, "Doc skipped rap"; Scrivener and Walker, "Expect charges".

²³ For a chronological account of abortion clinics and general abortion-related events in Canada and the USA beginning in the 1800s, *see* Abortion Rights Coalition of Canada, "Abortion History". The Abortion Rights Coalition of Canada is a pro-choice alliance dedicated to fostering abortion access.

affiliated with hospitals.²⁴ In terms of funding, physicians sometimes received remuneration for the procedure through public medical insurance. However, to fully fund clinic operation and to pay nurses' wages, staff relied on private billing practices and other public fundraising efforts.²⁵

From these freestanding clinics, nurses, with physicians, credentialled- and lay-counsellors, and administrative staff, aimed to increase women's access to abortion and reproductive health care by offering a full complement of clinically safe and respectful services. These included pregnancy testing, the surgical vacuum aspiration abortion procedure (which I outline in the next section), pre- and post-operative preparation and monitoring, contraception education and prescriptions, and counselling. Typically, freestanding abortion clinics operated during regular business hours (between 0800 and 1600, for example) but not overnight. Some clinics offered after-hours emergency telephone services, which were managed by on-call nurses or physicians. Daily staffing included at least one physician (who performed the internal surgical aspect of

²⁴ For examples, the Morgentaler clinic in Toronto opened next to a feminist bookstore in the University district. Vancouver's Everywoman's Health Clinic [EHC, also known as Everywoman's] first operated out of a single-use stand-alone building in East Vancouver. Vancouver's Elizabeth Bagshaw Clinic [EBC, also known as Bagshaw] initially opened inside a multi-story, multi-use medical building in an affluent Vancouver neighbourhood. The Winnipeg Morgentaler clinic seemingly began in a converted house.

²⁵ In 1983, the Montreal Morgentaler Clinic charged women between zero to two hundred and fifty Canadian dollars depending on their ability to pay out of pocket. *See* Beirne, "Rough and Risky." The history of abortion funding is complex, and a full review of it goes beyond the scope of this study.

procedure, that is, the part that took place within women's bodies) and two to four nurses (who provided nursing care before, during, and after the procedure, which included both bodily care and psychological support or counseling). Other daily staff members commonly included one or two counsellors (who interviewed and, similar to nurses, also counselled women) and one or two receptionists (who fielded phone calls, booked appointments, and registered women on the day of surgery). In Chapter Two, I place the development of abortion nursing in its clinical context by exploring nurses' negotiation of this in-clinic work more fully.

Physically speaking, freestanding abortion clinics generally comprised a reception and communal waiting area, one or more private office-like counselling rooms, one or more procedure (or operating) rooms, and a communal post-operative recovery area. There was additional space for storing, preparing, cleaning, and sterilizing medical supplies and equipment. Finally, there were administration offices and rest areas for staff. Many clinics also featured unique physical security measures, such as locked antechambers and bulletproof barriers in the reception or waiting room areas for example, which also affected the clinics' physical presentation and functioning. Many of these measures were instituted by clinic staff in response to anti-abortionist activism. I discuss the development of abortion nursing within this cultural context of (in)tolerance to abortion provision in Chapter Three. Depending on their physical and emotional needs, women spent between two to five hours inside the clinic.²⁶

²⁶ See "Message from Dr. Morgentaler".

Clinic Patients

Given the historical sources available, the shifting legal status of abortion clinics, and the private nature of them, it is difficult to fully account for the women who attended freestanding abortion clinics.²⁷ Some public records assured readers that these women were “from various social and economic backgrounds.”²⁸ Other reports indicate that women who sought abortions in general were of variable ages, were married and unmarried, and had many or few or no children.²⁹ Despite these apparent diversities, reports indicated that access to abortion was inequitable for Canadians, and that many girls and women faced intersecting and sometimes insurmountable barriers in their efforts to obtain abortions. Common barriers included geographic location, poverty or otherwise restricted finances (of particular relevance given the costs associated with travel to the clinic, time away from work, and the procedure itself), poor family or social support, dubious support from women’s regular health care providers, and decreased ability to access information about freestanding abortion clinics.³⁰ Many of these circumstances have been shown to coincide with other factors such as women’s level of education, ethnicity, and age, for example.³¹ Broader cultural and governmental intolerance to abortion provision were also prominent factors in limiting women’s access to abortion clinics, particularly in the maritime provinces.³² Notably, women experienced these challenges before and following the

²⁷ Freestanding abortion clinics were illegal until 1988.

²⁸ “Morgentaler nurse was silent supporter”.

²⁹ Badgley et al., “Operation”; McLaren and Tigar McLaren, “Bedroom and the State”.

³⁰ Sethna et al., “Choice Interrupted”.

³¹ *Ibid.*

³² Ackerman, “Abortion Politics”.

decriminalization of freestanding abortion clinics and services in 1988. Moreover, these inequities were also embedded in the legal in-hospital system of abortion provision as well as outside of it.³³ Significantly, many of these inequities continue to exist.³⁴

Women who were able to obtain abortions at freestanding clinics typically were between six and twenty weeks pregnant.³⁵ Again, owing to inaccessible source material, it is difficult to dependably describe these women's reasons for aborting. Reports of women who have sought abortions in general, however, have cited a range of contributing factors such as failed birth control, fetal anomaly, maternal illness, and the inability to provide for or care for a child for a variety of social and economic reasons.³⁶ The majority of women who attended freestanding abortion clinics and received a vacuum aspiration abortion were between six and fourteen to

³³ Badgley et al., "Operation"; Pelrine, "Abortion in Canada".

³⁴ Eggertson, "Abortion Services"; Erdman, "Back Alleys".

³⁵ For reference, full term pregnancies average approximately forty weeks of gestation.

Throughout the 1960s and 1970s, the age of viability was generally understood to hover around twenty-seven to twenty-eight weeks. Owing to advances in fetal and neonatal medicine, the age of viability is currently understood to hover around approximately twenty-two to twenty-four weeks. For more on the history of neonatology, *see* Lussky et al., "History of Neonatal (parts 1 and 2)." For current practices related to viability, *see* Weiner and Zaichkin, "Neonatal Resuscitation".

³⁶ Badgley et al., "Operation"; Childbirth by Choice Trust, "No Choice"; McLaren and Tigar McLaren, "Bedroom and the State"; Stettner, "Unwanted".

sixteen weeks pregnant.³⁷ I examined the details of this particular procedure and provide an analysis of nurses' involvement in its development and provision in Chapter Two of this dissertation. For additional introductory context of this potentially unfamiliar and often private medical procedure, I next provide a brief overview of the internal surgical aspect of that method.³⁸

Vacuum Aspiration Abortion

Most generally, a vacuum aspiration abortion empties the uterus using suction.³⁹ In a freestanding abortion clinic, the patient reclined on her back on a gynecological operating chair

³⁷ Abortions beyond fourteen to sixteen weeks typically required additional measures as a result of advancing fetal development. These measures could include increased cervical dilation facilitated through the use of indwelling vaginal laminaria tents, for example, or the disarticulation of the fetus and its manual evacuation beyond suction removal only. I discuss the implications of gestational age limits for abortion clinic nurses in Chapter Two. For a clinical overview of surgical abortion methods beyond vacuum aspiration, *see* Hodgson, "Abortion".

³⁸ Oral history participants provided valuable descriptions of the vacuum aspiration procedure. Other sources consulted include Morgentaler, "Report"; Selig and Schulman, "Techniques"; and Hodgson, "Abortion". Hodgson's volume provides very clear photographs of the equipment and the procedure.

³⁹ This procedure has also been termed the vacuum curettage, suction curettage, vacuum extraction, and vacuum suction curettage method. For consistency, I follow the nomenclature of Hodgson, who explains that "'vacuum aspiration' best describes the underlying principle (of the

or table with her knees apart. Her legs were bent towards her chest and held in place by stirrups or straps. She rested her pelvis at the edge of the table with the operating physician seated between her legs. A nurse or other support person stood at her side. To begin the abortion, the physician inserted a non-weighted speculum into the vagina and opened its walls, thus allowing for visualization of and access to the cervix. A metal clamp was then applied to hold the cervix in place and local anesthetic was injected into it. The cervix was then opened via the insertion of increasingly larger metal or plastic dilators to a width that would allow for the passage of surgical abortion instruments (including a curved or flexible suction cannula [a hollow tube], a rigid suction cannula, and a metal spoon-shaped curette) and fetal and uterine material (e.g., amniotic fluid and placental tissue).

Once the cervix was appropriately dilated, the flexible suction cannula, which was connected to a vacuum aspiration machine and its (transparent) collection cannister by way of a long tube, was passed into the uterine cavity. The aspiration machine was turned on and the physician directed the cannula around the uterus in order to capture and evacuate its contents. Those tissues were then deposited into the canister. Next the physician inserted a metal curette, which was used to scrape the uterine walls to loosen and guide away clinging material. Following that, a second suction cannula could be introduced to capture any other tissue left behind. When satisfied that all of the 'products of conception' had been removed (i.e., that the abortion was complete), the physician removed all surgical instruments. So ended the surgical aspect of the abortion

procedure), namely creation of negative pressure in the uterine cavity in order to produce a cleavage plane between the products of conception and the myometrium” Hodgson, “Abortion”: 228.

procedure, which, if uncomplicated, took between five to ten minutes to complete. With this description, I aim to have oriented readers to the typical yet often hidden physical or material reality of ‘the freestanding abortion clinic.’

I have suggested that very little is known about the history of nurses’ work in and around freestanding abortion clinics. Relatedly, an inside-the-doors perspective on clinic development and operation in general is missing from extant historiography. Though the in-clinic processes described above (and nurses’ participation in them) are crucial considerations, scholars and writers of abortion and women’s history have more commonly explored the broader political and social significances of freestanding abortion clinics. Clinics have subsequently been understood as a political tool for challenging the state’s regulation of abortion,⁴⁰ a symbol for women’s increased social and reproductive autonomy,⁴¹ and as a target for anti-abortion activism.⁴² As noted, these historical understandings of freestanding clinics have in many ways come into relief through histories focused on the actions and perspectives of women, activists, politicians, and others, but not of practitioners in freestanding clinics as such. Indeed, I put forward that physicians who have featured prominently in abortion historiography have more commonly been analyzed in terms of their social and political activities and broader negotiations of power with lesser attention to their clinical contributions to abortion’s actual provision.⁴³ As for nurses, although a few historians have narrowly captured some aspects of their abortion-related

⁴⁰ Jenson, “Getting to Morgentaler”.

⁴¹ Thomson, “Winning Choice”; Weir, “Left Popular”.

⁴² Todd, “Secrecy”.

⁴³ I outline this argument in the next section.

history,⁴⁴ analyses of their work in and around freestanding clinics specifically—to say nothing of the political and social activities of those nurses or of their overarching professional commitments, especially to the bodily and emotional safety of women—have gone mostly neglected. It is primarily to these elements of nurses’ history in abortion services, then, that I aim to attend.

Historiographical Review

In order to provide a historiographical foundation for this dissertation, I now review some key scholarly analyses in the domains of abortion, women’s reproductive health, and nursing history. To address these domains, I follow the chronology of abortion provision from the late 1800s to the 1990s, pointing to the ways that nurses and their abortion work have been present in or absent from existing analyses.⁴⁵ Given the relative shortage of attention to nurses’ abortion work, I also include the ways that nurses and nursing have been understood more broadly, emphasizing how themes relevant to abortion and women’s reproductive health history have been addressed within the context of the profession more generally. Some important and intersecting considerations that arise in this review include ongoing negotiations of professional authority and women’s professional, social, and medical autonomy. Following the historiographical review, I address the theoretical and practical approaches I have brought to this research. Finally, in the remainder of this introduction, I briefly outline the three substantive chapters to come.

⁴⁴ Elliott et al., “CNA”; Haney, “Nursing Identity”; Haney, “Towards Legitimate Nursing”.

⁴⁵ In “Changing Voice,” Saurette and Gordon offer a valuable reference guide for the Canadian, American, and United Kingdom contexts. *See* their Appendix, “Glossary of Key Legal and Political Events, Organizations, and Individuals”.

Criminalization and Professional Establishment

I begin with the federal criminalization of abortion in Canada in the late 1800s. Major considerations that arise in this era include the state's strict regulation of abortion, the general establishment of regular medicine and modern nursing, physicians' pursuit of professional authority, and nursing's professional focus on a broad scope of health matters beyond the official hospital system and its treatment of disease. This early history sheds light on the beginnings of medical dominance and physician control over women's reproductive health through legal channels. The literature also highlights the historical separation between the medical establishment and the nursing profession, primarily in terms of professional focus and arenas of practice, which carry significant implications for the long development of nurses' abortion work and my analysis of it.

In 1892, abortion provision came to be federally regulated under the *Criminal Code of Canada*.⁴⁶ According to this legislation, anyone convicted of 'procuring a miscarriage' or 'killing an unborn child' could be held liable for up to life imprisonment.⁴⁷ Women procuring their own abortions were liable for up to seven years' imprisonment⁴⁸ and suppliers of abortifacient substances or

⁴⁶ Canada inherited its abortion law from the United Kingdom, specifically from the *Offences Against the Person Act* of 1861 and the *Lord Ellenborough Act* of 1893. Individual Canadian provinces quickly adopted and modified these laws before federal codification in 1892. For detailed analyses of early criminalization, see Backhouse, "Involuntary Motherhood" and Gavigan, "Criminal Sanction".

⁴⁷ Section 237 (subsection 1) and Section 209 of the Criminal Code of Canada, respectively.

⁴⁸ Woman Procuring her Own Miscarriage (Section 273).

related instruments faced up to two years' imprisonment.⁴⁹ Historians who have examined the initial federal criminalization of abortion and the implications of it for health care practitioners have typically focused on physicians' roles and experiences, commonly framing those practitioners as powerful political and social actors who were able to inform and benefit from abortion's criminalization.⁵⁰ Notably, historians have linked restrictive abortion legislation to physicians' early pursuit of social and professional status.

As a new category of practitioners around the turn of the century, historians have argued, *regular* physicians—that is, typically white, middle class men trained in exclusionary medical schools—sought to establish a formal medical profession and construct an overarching health care system led and ultimately controlled by them.⁵¹ They did so, in part, by developing and safeguarding specialized fields of practice, including obstetrics and gynecology, which allowed them to adopt women's reproductive health (including the management of pregnancy, childbirth, and motherhood) into their professional purview.^{52,53} Physicians' clinical approaches to establishing

⁴⁹ Supplying Means of Procuring Abortion (Section 274).

⁵⁰ Backhouse, "Involuntary Motherhood"; Light, "Shifting Interests"; McLaren, "Illegal". Note that these historians remind readers that physicians were not a homogenous group with identical perspectives, goals, and practices.

⁵¹ See Backhouse, "Celebrated Trial"; McPherson, "Bedside Matters"; or "Mitchinson, "Giving Birth" for more on the concept of "regular" physicians.

⁵² For more on the development of gynecological medicine, see O'Dowd and Phillip, "History of Obstetrics".

professional authority over women's health will be important to elucidate later in this review given that they are understood to have continued to reinforce their authority in abortion services in hospitals and freestanding clinics over time. However, of primary significance here is that physicians have been understood to have sought control over abortion through legal channels rather than strictly clinical measures.

Specifically, it has been put forward by historians such as Angus McLaren and Susanne Klausen, for example,⁵⁴ that physicians successfully advocated for legislation that prohibited abortion provision by non-physicians yet left a legal loophole for their own use. Abortion-related legislation indeed included recourse to a 'good faith' or 'life-saving' defence, provided it could be demonstrated that the procedure was performed to save a woman's life.⁵⁵ Some historians suggest that regular physicians were more or less legally secure in performing abortions whereas

⁵³ For more on early women's health history generally, see Mitchinson, "Nature"; Mitchinson, "Medical Treatment". For more recent collections, see Warsh, "Prescribed Norms" and Light et al., "Bodily Subjects". For international perspectives, see Leavitt, "Women and Health"; Shorter, "Women's Bodies"; and Smith-Rosenberg and Rosenberg, "The Female Animal".

⁵⁴ Klausen, "Doctors"; McLaren, "Illegal".

⁵⁵ *Killing an Unborn Child* explicitly includes this clause. One of the most famous cases of this successful defence was the UK's so-called Bourne case of 1938. Here a well-known physician, Aleck Bourne, performed an abortion on a fourteen-year-old girl who had been gang raped and impregnated as a result. His defence team argued that he operated in good faith to save the life and mental health of the girl. Bourne was acquitted on the charges of procuring an abortion, and the common law precedent had been set into UK law. See Gavigan, "Criminal Sanction".

irregular practitioners, such as midwives, Indigenous women, nurses, women physicians and physicians of colour (i.e., all practitioners who were unwelcomed by regular physicians) were not.⁵⁶ In his examination of abortion provision between 1886–1939, for example, social historian Angus McLaren explained:

Doctors' involvement in abortion was [...] likely to escape full judicial scrutiny. For an illegal operation even to be brought to light usually required medical testimony. When a case threatened the reputations of their hospital or their colleagues many doctors'

⁵⁶ Gender and race, then, seemingly played a significant role in regular physicians' quest for professional authority and control over abortion. For relevant analyses, *see* Beusaert, "Letitia Munson." She outlined the ways that public perceptions of mid-wife Munson's morality, social respectability, and legal responsibility were grounded in broader beliefs about gender and race. In the legal realm, Beusaert argued, Munson was found not guilty by reason of insufficient evidence. But in the social realm, she concluded, Munson was found 'guilty'—a judgement that was supported by demeaning racist and misogynist narratives. In "Taking Medicine," Kristin Burnett explored Indigenous women's practices around birth control, childbirth, and abortion in the context of colonization and reproductive justice in Southern Alberta between 1880-1940. She argued that Euro-Canadian physicians aimed to overtake Indigenous women's midwifery practices by framing them as irresponsible and dangerous, and by claiming that Indigenous women would be safer under the care and direction of regular physicians and their nurse colleagues. In "Celebrated Trial," Constance Backhouse highlighted regular physicians' rejection of women physicians in her examination of Dr. Emily Stowe's abortion trial in 1879.

natural response was to look the other way. Quacks and the occasional maverick physicians, who failed to enjoy collegial support, ran the greatest risk of being reported [and thus of being convicted, ostracized, and de-licensed].⁵⁷

The legal risk for non-physicians seemingly held true for nurses in this era. Their experiences of criminalized abortion practice and legal repercussions can be found embedded in some physician- and women-focused histories such as McLaren's article noted above. For his part, McLaren briefly mentioned three nurses who had been caught providing illegal abortions to women outside of hospitals in 1920, 1923, and 1938. Of one Vancouver case, McLaren noted, "Nurse Clara Jesson, despite three trials, enjoyed a reputation as a skilled practitioner, advertising her services for 'private maternity cases' at her home." Only in his endnotes does he provide more detail, noting that despite her reputation as a competent abortionist, nurse Jesson had been "tried in 1923 and sentenced to one year in prison." Moreover, she was "implicated in one successful abortion and one abortion death" in 1927.⁵⁸ Few other details are given about nurse-abortionists Jesson, Fromm, or Hazel Dalton in the article. There are some similarly brief glimpses of nurses' experiences with criminal abortion provision in other secondary literature.⁵⁹ As in McLaren's article, though, nurses have yet to be analyzed as a unique group of practitioners whose work was regulated and restricted by the state or in the context of physician-

⁵⁷ McLaren, "Illegal": 788–789. In "Doctors", Susanne Klausen made a similar argument in her study of the implications of criminalization for physicians in 1939.

⁵⁸ McLaren, "Illegal": 813.

⁵⁹ Beahan, "Abortion and Infanticide"; Klausen, "Doctors".

supported criminal legislation. A closer examination of nurses' experiences with abortion provision and state regulation in this timeframe is important but falls beyond the scope of this dissertation. Barring such an investigation, the historiography that attends to abortion practitioners and the early law belongs primarily to physicians and their legal (but not necessarily clinical) maneuverings, with nurses and their abortion practices subsumed therein.

If not abortion, the focus of nursing historians in regard to this time frame are similarly related to the themes of professional establishment and the scope of nursing knowledge and practice. The post-1850 era is considered to be the age of 'modern' nursing, that is, the time when nursing (conceptualized as particular women trained in particular ways to enact particular work) was solidifying and spreading westward across Canada.⁶⁰ Similar to regular physicians who were initially limited to white, middle-class men, some historians have noted that there were also expectations in nursing that only women of appropriate "age, education, health, & character" could enter the profession.⁶¹ Much historical focus on this period rests on the training and education of these 'appropriate,' typically white, women, with ample attention to influential leaders and significant institutions.⁶² Some historians also emphasize the ostensible push for nurses' adoption of secular and objectivist scientific epistemologies and an attendant move away from the experiential knowledge and traditional domestic roles that were understood to be

⁶⁰ Gibbon and Mathewson, "Three Centuries"; Paul, "Religious Orders".

⁶¹ McPherson, "Bedside Matters": 30.

⁶² Mansell, "Forging the Future"; Mortimer, "Introduction"; Mortimer and McGann, "New Directions"; Nelson and Rafferty, "Notes on Nightingale". For the USA context, *see* D'Antonio, "Introduction"; Dock and Stewart, "A Short History".

inherent to women.⁶³ This dichotomy is sometimes framed as nursing's professional versus vocational nature. Notably, nurses' attention to this dichotomy continues throughout nursing history and is significant to their beliefs about and uptake of abortion work.

Historians also report that nurses' formal education was largely provided in hospitals (often by physician-lecturers) and that Canada's newly developing hospital system was thus supported through the labour of student nurses rather than of graduate nurses.⁶⁴ Indeed, as the hospital system was developing in the 1920s, the majority of graduate nurses worked outside of it in the community either in private duty, that is by attending to the sick within families' homes, or in what arose as an important new field of public health nursing.⁶⁵ These nurses were shown to have paid attention to many aspects of health beyond the direct treatment of disease, including to more socially-inclusive issues of poverty, geographic isolation, public hygiene (including sewage treatment and community access to clean water), malnutrition, health education, and health promotion. Within these public health roles, some historians have argued, nurses were "committed to a social mandate of just and equitable care."⁶⁶ Many public health nurses are said to have demonstrated professional awareness of women's general social status and (in)equality,

⁶³ Nelson and Rafferty, "Notes on Nightingale"; Mortimer, "Introduction".

⁶⁴ McPherson, "Bedside Matters".

⁶⁵ Duncan et al., "Nurses as Evangelists"; McKay, "Public Health"; McPherson, "Bedside Matters".

⁶⁶ Duncan et al., "100 Years" attribute this attitude to nursing leaders such as Ethel Johns. For more on Ethel Johns, see Street, "Watch-Fires".

which can be interpreted as a feminist viewpoint.⁶⁷ Moreover, nurses' push for professionalization in public health roles for themselves was also embedded in early feminist and nurses' rallying around articulating nursing as a respected avenue to paid work for women, including a social role in alleged reform and 'nation building.'⁶⁸ In the primary sources and secondary literature I consulted, I did not find many accounts of nurses who were outspoken advocates of abortion access in this early criminalized era. A few, however, were shown to be in favour of providing women with contraceptive education and equipment.⁶⁹

In these topics, brought to light by historians through sociological, gender and labor history perspectives,⁷⁰ readers can observe the roots of many important considerations that proved relevant to this research. These includes, on one hand, hospital nurses' ostensible clinical alignment with physicians albeit, according to some, in an arguably subordinate position within a hierarchical hospital system. On the other hand, nursing's physical and ideological separation from the medical establishment (especially in the context of out-of-hospital nursing) are also

⁶⁷ Roberts and Group, "Feminism and Nursing".

⁶⁸ Brush et al., "Nurses of All Nations"; Dodd and Gorham, "Caring and Curing".

⁶⁹ Notable examples include Margaret Sanger in the USA (*see* Kennedy, "Birth Control") and the lesser-known Dorothea Palmer in Canada (*see* Dodd, "Canadian Birth Control"). Of note is that both women were not always identified as nurses per se. Palmer, for example, was sometimes identified as a social worker. Additionally, Palmer performed birth control-related work with greater than fifty nurses, who still remain embedded within narratives about Palmer. *See* "Dorothea Palmer Birth Control Trial".

⁷⁰ Melosh, "Physician's Hand"; McPherson "Bedside Matters".

echoed. Overall, abortion, women's, and nursing history literature point to the development of the medical and nursing professions while highlighting some of the avenues that led to the establishment of professional authority over a range of health topics and practitioners' respective scopes of practice.

Towards Liberalization and Professional Expertise

The next period of study encompasses the lead up to abortion's legal liberalization in 1969. Existing abortion historiography and practitioners' experiences of it are, again, concentrated on physicians and their negotiation of professional power and authority in the context of state regulation. The general argument for physicians' activities in the previous era was that in ushering in restrictive legislation, physicians sought to gain power over abortion by entrusting its overall regulation to the state but exploiting legal loopholes themselves. However, regular physicians soon came to understand that the law was vague, that the loopholes were unreliable, and that abortion provision was a risky endeavour for them.⁷¹ Ultimately, given that it

⁷¹ In 1962, J.J. Lederman, writing with both medical and legal credentials, provided a detailed legal analysis of the Canadian abortion law as it applied to physicians in the Canadian Medical Association's professional journal. For vulnerable physicians, *see* the cases of Vancouver's William McCallum and Toronto's Leslie Frank Smoling. McCallum provided abortions from his private medical office, beginning, he said in 1950. He was known as Vancouver's 'best loved' abortionist. But after a warrant was put out for his arrest in 1967, he turned himself in and was charged with nine counts of procuring miscarriage. He was "given a two-year suspended sentence," lost his licence to practice, and the medical council "erased Dr. McCallum's name

diminished their control over abortion practice, physicians perceived that criminalization had come to hinder their professional autonomy rather than strengthen it, as they had initially intended.⁷²

By the mid-twentieth century, physicians' clinical expertise over abortion was increasing, yet because of restrictive state regulation, their clinical authority over it was not. I suggest that their clinical expertise over abortion was increasing in part because they continued to initiate and provide abortions in and out of hospitals, which helped them to gain knowledge of it and refine their techniques of managing it (as they did in other areas of medical practice). Criminalization itself also arguably helped to facilitate their growing expertise. Criminalization led many women to undergo out-of-hospital abortions that were performed by untrained operators in unsafe and unsanitary conditions. These unsafe criminal procedures resulted in poor and sometimes catastrophic health outcomes for women, which hospital practitioners were then compelled to treat.⁷³ In treating them, I suggest, physicians increased their clinical expertise over abortion given that they now managed it in a wider range of situations. That is to say, in addition to the theoretically straightforward procedures that they initiated and monitored themselves, because of

from the register." He never practiced again. *See*, "Doctor charged in abortion case," 1967; Ross 1968. For Smoling, *see* English and Blatchford, "Doc skipped rap".

⁷² McLaren, "Illegal"; Klausen, "Doctors".

⁷³ According to Dunn and colleagues, "in 1966, more than 45,000 women were hospitalized after having tried to terminate a pregnancy, making it the primary cause of hospitalization for Canadian women that year". *See* Canadians for Choice, "Focus on Abortion." In their report, they cite Desmarais, "Memoires".

criminalization, physicians increasingly encountered and managed the complications of abortions attempted by others.

In a previous analysis of abortion discourses in professional nursing literature in the *Canadian Nurse* from the 1950s to the 2000s, I found that the medical management of those complications by physicians *and* nurses in hospitals became imperative.⁷⁴ By this time, the Canadian hospital system was relatively well established and the majority of the graduate nursing workforce was employed within it.⁷⁵ Many nurses thus practiced alongside physicians who by then had become entrenched as *the* professional leader of that system.⁷⁶ Moreover, as medical practice expanded, physicians began to transfer hands-on clinical responsibilities that had traditionally only been in the scope of physicians to Registered Nurses.⁷⁷ I have argued that the specialized treatments and equipment that they could subsequently access and administer (for example, antibiotic therapy, blood transfusions, and specialized monitoring)—whether or not they proved fully successful in saving women’s lives—were implicitly and explicitly cast as legitimate nursing practice when injured and dying women were brought to hospitals.⁷⁸ Owing to the methodology of historical discourse analysis and the scope of that study, however, I was unable to fully explore nurses’ actual experiences, practices, or perspectives of caring for women who had undergone unsafe abortions. A more complete analysis of nurses’ experiences in this era remains lacking. Still, that

⁷⁴ Haney, “Towards Legitimate Nursing”.

⁷⁵ McPherson, “Bedside Matters”:187; Melosh, “Physician’s Hand” (in the USA).

⁷⁶ McPherson, “Bedside Matters”; Mitchinson, “Giving Birth”.

⁷⁷ Toman, “Blood Work”.

⁷⁸ Haney, “Towards Legitimate Nursing”.

initial research provides some context for understanding nurses' future work in abortion clinics because nurses' alleged clinical alignment with physicians vis-à-vis abortion provision proved relevant throughout the 1960s to the 1990s.

Given the lack of nursing- or practice-focused research, it is histories of physicians' social and political roles that provide the primary context for understanding practitioners' desire and actual push for legislative changes leading up to 1969. Historians have argued that the pre-1969 reality of being responsible for treating, or curing, the bodily illness of abortion-gone-wrong yet being legally prohibited from providing safe abortions themselves was untenable for physicians.⁷⁹ In a notable turn of events, physicians (primarily through the mouthpiece of the Canadian Medical Association in partnership with the Canadian Bar Association) subsequently began to speak out against full state regulation and lobbied instead for an amendment to the abortion law.⁸⁰ The

⁷⁹ Gavigan, "Criminal Sanction"; Light, "Shifting Interests"; Jenson, "Getting to Morgentaler"; Thomson, "Winning Choice".

⁸⁰ *See above*. Note that historians point out that physicians advocated for legal changes in tandem with other powerful social groups (primarily comprising men), including the Canadian Bar Association and some religious leaders (clergymen from the United and Anglican churches), and political organizations (such as the Humanist Association of Canada). *See* Ackerman and Stettner, "Public Not Ready"; Saurette and Gordon, "Changing Voice". To their ranks, historian Shannon Stettner adds Canadian women, who articulated their support for abortion law reform through letters to the Royal Commission on the Status of Women [RCSW]. The RCSW then put their perspectives forward, Stettner, "Unwanted". Tracy Penny Light, in "Shifting Interests" has

argument holds that criminalization was unsafe for women, it was at odds with physicians' growing clinical expertise, and it diminished the profession's social and clinical authority and autonomy.⁸¹ In response, they called for loosened regulations that would reflect and support their actual abortion practices while minimizing their legal risk.⁸² In other words, physicians now lobbied for a change in legal regulation that would correspond with their clinical expertise and sustain their authority. Historians tell us that, as with criminalization, physicians again became a driving force in liberalizing the abortion law by again mobilizing their collective social power to bring about legislative change.

Liberalization and the Therapeutic Abortion Committee System

Partly as a result of physicians' political maneuvering, in 1969 the abortion law was amended or liberalized.⁸³ Under the new law, physicians could provide legal abortions under several medical

argued that women also made their voices heard through those of their physicians, who brought their concerns to the broader arena of abortion politics and law-making.

⁸¹ Backhouse, "Involuntary Motherhood"; Jenson, "Getting to Morgentaler"; Light, "Shifting Interests" and McLaren, "Illegal" have argued that the lead up to abortion's liberalization and some physicians' advocacy for fewer restrictions owed to their professional commitments to the promotion of women's health and their broader desire to help improve women's social status.

⁸² Light, "Shifting Interests"; Palmer, "Choices".

⁸³ Criminal Code of Canada, 1970, Chapter c-34. Section 251/ Section 237, Subsection 4.

restrictions, which were adjudicated by their peers.⁸⁴ Specifically, a committee of three physicians known as a Therapeutic Abortion Committee [TAC] was required to authorize the abortion. The TAC, which could not include the operating physician, had to agree that the abortion was necessary for the protection of a pregnant woman's life or health, which thus rendered the abortion 'therapeutic' or medically justified. Fetal anomaly was not built into these medical exemptions. The TAC had to document their medical justification for the abortion, which they were required to surrender, along with women's other health records, upon the request of the provincial health minister for legal review.⁸⁵ Finally, the procedure had to be performed by a physician in an accredited hospital. Abortions that could not be proven to satisfy all of these conditions remained illegal, subject to the maximum penalty of life imprisonment. Unlike the previous law that criminalized abortion for everyone (albeit with an unreliable loophole that some physicians were nevertheless able to exploit), liberalization explicitly exempted some practitioners (namely, in-hospital physicians and, by extension, their nurse colleagues) from criminal sanction. For this study, I conceptualize this approach to abortion provision under the 1969 law amendment as the *TAC system*.

⁸⁴ See Section 271 of the Criminal Code of Canada, 1970. As part of the omnibus Criminal Law Amendment Act, Bill C-150 liberalized abortion and decriminalized homosexuality. At the same time, Bill S-15 decriminalized contraception.

⁸⁵ Note also that there were other technical clarifying clauses related to accreditation, hospital boards, 'qualified medical practitioners,' the structure and operation of the Therapeutic Abortion Committee, and consent. See Criminal Code of Canada, 1969, Section 237.

Unlike those of the Canadian Medical Association, nurses' collective voices and social advocacy for abortion's legal changes are largely missing from this dominant historiographical narrative. In my previous study, I did find some evidence that the national nursing leadership organization, the Canadian Nurses Association [CNA], publicly called for less restrictive abortion laws and the desire for increased access to birth control for women in an editorial in *Canadian Nurse* as early as 1967.⁸⁶ In their comprehensive overview of the activities of the CNA between 1908 and 2008, Jayne Elliott and her colleagues similarly pointed out this catalyzing editorial.⁸⁷ Both myself and Elliott's group highlighted this move as the start of an ongoing debate within the profession about abortion-and-nursing in the 1970s (after liberalization), which would continue for the next two decades. Again, the substantive and methodological scopes of these investigations were necessarily limited, and neither investigation could fully explore the leadership's political engagement with abortion at the federal or policy-making levels before or after liberalization. Further investigations of nurses' political abortion-related advocacy by way of the CNA are still needed but they, too, go beyond the scope of this dissertation, which is focused on the day-to-day hands-on abortion work of practicing nurses (but which includes their political and social advocacy and leadership roles in developing abortion services).

Other non-abortion-focused analyses of top-level nursing leadership in the 1960s have largely centered on nurses' advocacy for professional self-determination⁸⁸ and improved social and

⁸⁶ Haney, "Nursing Identity".

⁸⁷ Elliott et al., "CNA".

⁸⁸ Allen, "Comparative Theories".

professional status for nurses through higher education,⁸⁹ resolving nursing-specific workforce issues through labour negotiation,⁹⁰ and expanding nurses' scope of practice.⁹¹ Generally, the 1960s are marked as the era where a call for improvement of nursing education and an overhaul of the longstanding, but now deemed ineffective hospital-based training system was growing louder, and the acknowledgement of a persistent lack of 'enough' nurses was identified as a significant impediment of much need hospital and health care expansion. The call for nursing education reform reflected in many ways a push to expand nurses' reach in the rapidly expanding health industry, both in numbers and quality. In addition to a focus on education and labour, existing nursing historiography on mid-twentieth century and late twentieth century health care has attended to nurses' increased specialization in the hospital environment. Foci have included, for example, the involvement of nurses in developing intensive care or surgical and Operating Room nursing but not abortion specifically.⁹² My forthcoming analysis of nurses' participation in the development of the specialized care required to provide abortion services contributes to that body of literature, though I do not necessarily approach it from the lens of professionalization explicitly.

More relevant to this study is that those existing analyses arguably indicate that nurses were in some ways also engaging with larger social movements that were rooted in the 'liberalization' of

⁸⁹ Baumgart and Kirkwood, "Social Reform"; Duncan et al., "100 Years"; Paul and Ross-Kerr, "Origins"; Pringle et al., "Building the Future".

⁹⁰ Kealey, "No More."; Ross-Kerr, "Emergence of Unions".

⁹¹ Fairman, "The Roots"; Twohig, "Great Transformation"; Twohig, "We Shall Arrive".

⁹² Moszczynski, "Operating Room".

society in general. These broader perspectives were in part related to a wide-ranging scope of ‘women’s issues,’ which nurses seemingly implicitly or explicitly brought to bear on their ideas about their education-as women, their labour-as-women, and their status as women-professionals. Broader shifting social attitudes included perspectives related to improved social, political, and economic status for women and the reconsidering of rigid ideologies about women’s labour and education, womanhood, motherhood, and sex and sexuality.⁹³ Also relevant to these women-focused considerations, according to abortion historians Katrina Ackerman and Shannon Stettner, was broader “activism around issues related to civil rights, the movement to ban the nuclear bomb, the anti-war movement, the student movement, the women’s movement,

⁹³ A wealth of scholarship has addressed a range of broad social changes in relation to women’s lives and health. Canadian historians have put forward that these reconsiderations included weakening motherhood’s status as the ideal and only path for women, examining the constrictive meanings attributed to and enacted through the structure of the nuclear family, and advocacy for fair employment opportunities, equal pay, and access to childcare for working women. Like historians of nursing, they have also examined the move towards the wider inclusion of women into universities and their operation. Further, they have highlighted the reconsideration of women’s experiences of sex and sexuality, the growing acceptance of ‘free love’ and sexual orientation beyond heterosexuality, and the development of increasingly accessible modes of contraception. Finally, historians of women and of nurses have looked at the lives and rights of them through the lens of race. Notably, all of these categories are understood to intersect with and affect the health of and provision of health care to women. *See* Ladd-Taylor, “Mother-Work” or Sangster, “Transforming Labour,” for example.

and Indigenous rights in the late 1950s and 1960s.”⁹⁴ According to the 1970 report from the *Royal Commission on the Status of Women*,⁹⁵ these shifts were engendered in Canada in part by post-war “technological developments, urbanization, industrialization, and the progress of medical and other scientific research.”⁹⁶ The development of nursing and nursing practice was indeed taking place within these contexts.

The ways in which nurses were involved with these social movements around liberalization more widely in the 1960s and 1970s still largely has to be written. However, it is increasingly understood that overall focus on liberation movements, whether for the cause of civil rights, patient rights, or women’s rights, did have an impact on and were informed by nursing. Some small-scale studies that have begun to explore linkages between social engagement, whether from a feminist or social technological perspective, and nurses’ activism for more equitable health are only beginning to emerge.⁹⁷ Nursing historian Geertje Boschma’s analyses of nurses’ roles in the critical psychiatric movement by way of taking on particular practices in the contentious area of electroconvulsive therapy [ECT] in the Netherlands or in enacting and then

⁹⁴ Ackerman and Stettner, “Not Ready”: 242.

⁹⁵ The RCSW was founded in 1967 and intended to: “inquire into and report upon the status of women in Canada, and to recommend what steps might be taken by the federal government to ensure for women equal opportunities with men in all aspects of Canadian society,” RCSW, “Report”: Terms of Reference. This primary report offers a clear window onto some of these early shifting perspectives.

⁹⁶ RCSW, “Report”: 1.

⁹⁷ Fairman, “Economically Practical”; Vanderspank-Wright et al., “Development of ICU”.

managing the after-effects of psychiatric deinstitutionalization in British Columbia, provide two good examples here.⁹⁸ Tommy Dickinson's investigation of nurses' practices in the similarly contentious field of aversion therapy for the "treatment" of "homosexuality" in mid-century psychiatry in the United Kingdom⁹⁹ offers another look into the connection between nursing practice and broader social movements that critiqued and reacted "against the domination of established authority and old way[s] of life."¹⁰⁰ In existing nursing historiography, then, much attention has been paid to how nurses have challenged the dominant health care system and restrictive social mores to the benefit of the overall profession or with the aim of strengthening the profession-as-such while more emerging scholarship has connected nurses' day-to-day or hands-on clinical practice with social engagement, which, as this study will show, also played out in nurses' negotiation of their equally contentious and socially-minded abortion work.

Particularly important here is the understanding that self-determination for nursing (be it in terms of education, labour conditions, or clinical practice) was also connected to nursing's longstanding attention to and articulation of the profession's theoretical underpinnings.

Questions around nursing epistemology (i.e., the nature and scope of nursing knowledge) and nursing ontology (i.e., the nature and scope of *doing* nursing or of *being* a nurse), which had indeed been considered in the earlier days of modern nursing, were becoming increasingly explicit and wide-ranging by the 1960s, when the call for access to and incorporation of nursing within the regular education and academic system became louder and clearer. Part of the

⁹⁸ Boschma "Deinstitutionalization"; Boschma, "Electroconvulsive Therapy".

⁹⁹ Dickinson, "Curing".

¹⁰⁰ RCSW, "Report": 1.

argument was to establish nursing expertise as a knowledge-based practice with a relevant social mandate justified by (scientifically based) knowledge development and university, professional education rather than hospital-based hierarchies and power structures. In the midst of these shifting social contexts, nursing grappled with theoretical questions around the profession's commensurate approach to health and health care.¹⁰¹ These conversations would continue to grow—and become framed as ‘nursing theory’—as the profession further constructed, considered, and fiercely debated its potential theoretical underpinnings well into the 1990s.¹⁰² Significantly, in doing so, nursing continued to question its ambivalent alignment with and arguable subsumption into the medical establishment and the commonly-articulated perspective that medicine's general approach to health relied on the in-hospital management of disease.¹⁰³ This dissertation highlights some of the connections between the construction and enactment of nursing's professional theoretical underpinnings, wider social perspectives, and nurses' abortion practice. Part of that discussion will pertain to nurses' roles in developing and operating, and in some cases rejecting, the new TAC system.

In terms of the TAC system, historians have generally investigated the administrative rather than the day-to-day clinical operation of it, physicians' perspectives of managing the committees

¹⁰¹ Boschma, “Holism”.

¹⁰² Andrist et al., “History of Ideas”; Boschma, “Holism”; Thorne et al., “Nursing's Metaparadigm”.

¹⁰³ Nelson and Gordon, “Complexities of Care”.

overall, and the implications of the system for women's (poor) access to abortion.¹⁰⁴ They have concentrated, for example, on the ways that TACs were supported or resisted through hospital policy-making via hospital boards and through physicians' willingness or unwillingness to join such committees, which resulted in restrictive policies around accreditation, quotas, or consent, for example.¹⁰⁵ They have also reflected on the continued legal restrictions for physician practice. The general suggestion is that the law remained ambiguous, was scientifically outdated, and hindered physicians' ability to meet the health needs of women.¹⁰⁶ In shedding light on and investigating these matters, historians have well highlighted the inequitable distribution of TACs in Canadian hospitals and women's subsequent unreliable access to them. Ultimately, historians and historical actors have argued that women could not obtain in-hospital abortions reliably nor could physicians reliably provide them even though it was then ostensibly legal to do so. For

¹⁰⁴ Palmer, "Lonely"; Palmer, "Choices"; Weir, "Left Popular". For major primary source material, see Badgley et al., "Operation".

¹⁰⁵ Palmer, "Choices".

¹⁰⁶ Specifically, the legal terms 'life' and 'health' were vague. They were susceptible to competing interpretations both on the part of practitioners and the court, which rendered physicians' decisions about whether or not any abortion was therapeutic legally tenuous. The law was also out of sync with advancing science and medicine, as physicians were increasingly able to treat a range of maternal conditions while sparing the fetus. Additionally, physicians were better able to predict or accurately diagnose a range of fetal conditions that they argued warranted therapeutic termination, yet the 1969 amendment held no such provision.

both women and physicians, then, the 1969 legislative amendment was said to have hardly liberalized abortion access at all.¹⁰⁷

Relatedly, some historians have analyzed women's responses to poor TAC access and their actual strategies for obtaining safe abortions outside of the Canadian TAC system.¹⁰⁸ They have documented, for example, women's travels to the United States, Europe, or Japan, where safe abortions were theoretically more accessible (for well-connected, well-funded women, that is).¹⁰⁹ They have illuminated the ways that women created and joined advocacy groups and health service providers that helped facilitate access to safe abortions by providing in-print, telephone, and in-person information about where and how to obtain abortions and by operating abortion referral services. These groups included influential Canadian organizations such as the Birth

¹⁰⁷ Badgley et al., "Operation"; Gavigan, "Criminal Sanction"; Light, "Shifting Interests"; McLaren and Tigar McLaren, "Bedroom and the State"; Pelrine, "Abortion in Canada"; Thomson, "Winning Choice"; "Abortion and Women's Liberation Booklet"; "Abortion Handbook".

¹⁰⁸ Note that this section attends to women's responses to poor *access* to abortion within the TAC system rather than women's responses to the *nature* of available abortion services. The latter will be discussed in Chapter Two.

¹⁰⁹ Badgley et al., "Operation"; Pelrine, "Abortion in Canada"; Sethna et al., "Choice Interrupted"; Thomson, "Winning Choice". In 1983, Linda McQuaig et al., in "Stop Signs" reported that "2600 Canadian women [...] each year go to the United States for abortions": 36. Ackerman and Stettner, in "Not Ready" claimed that "in 1975, almost 10,000 women travelled to the United States for an abortion": 245.

Control Committee of McGill University's Student Council in Montreal,¹¹⁰ the Women's Caucus of Greater Vancouver,¹¹¹ and the Calgary Birth Control Clinic.¹¹² They were joined by sister organizations in the USA such as the Jane Collective in Chicago and the Boston Women's Collective.¹¹³ Historians have also examined these groups' and others' responses to the unsatisfactory nature of obtainable abortion services in Canada, which I will discuss more fully in Chapter Two. For now, my focus is on their approaches to actual access.¹¹⁴

As in earlier histories, a few nurses can be glimpsed within these groups and were noted to be taking part in their efforts to increase abortion access. The Vancouver Abortion Information Service [AIS] offers one such example. This service, developed by the Vancouver Women's

¹¹⁰ Sethna, "Birth Control Handbook".

¹¹¹ Deibert-Turner, "Golden Speculum"; Thomson, "Winning Choice"; Wasserlein, "Arrow"; Women's Caucus of Greater Vancouver, "Abortion Information Service [AIS]".

¹¹² Palmer, "Choices". Note that there were apparently many women's groups operating across the country but not all identified formally as 'organizations,' and not all have been documented or analyzed. *See* Boscoe et al., "Women's Health".

¹¹³ Kaplan, "Jane"; Morrow, "Our Bodies".

¹¹⁴ Note that these groups are commonly understood to have operated under the umbrella of the women's health movement and in response to detrimental medicalizing practices that contributed both to decreased access to abortion and, when they were accessible, problematic abortion services. As noted, I will discuss the women's health movement itself, medicalization, and responses to available abortion services within the TAC system and illegal freestanding clinics in Canada in the substantive chapters of this dissertation.

Caucus, provided counselling around pregnancy, birth control, and abortion in addition to performing free pregnancy tests for women at a time when they were otherwise reliant on slow-moving physicians or laboratories. They vetted, kept track of, and partnered with abortion-providing or abortion-supportive physicians, noting which ones were respectful, competent, and safe, and then quietly sent women in their direction.¹¹⁵ Embedded in Ann Thomson's account of this group is non-practicing nurse Mary Stolk.¹¹⁶ Stolk was apparently an early leader in the AIS given that she not only helped develop and participate in those teaching and counselling sessions but also because she acted as a prominent spokeswoman for it.¹¹⁷ Similarly, nurses have also been briefly mentioned in newspaper reports and records of the Calgary Birth Control Clinic, which facilitated women's international travel to abortion clinics.¹¹⁸ Yet, as in earlier eras, analyses of nurses' experiences with and perspectives of the on-the-ground strategies of these groups are generally lacking in the dominant historical narrative. Given that they were indeed there as witnesses and as participants, an analysis of nurses' historical work within these organizations remains an important avenue of further inquiry. I do not explore that avenue here. Rather, part of my analysis in Chapter One focuses on the on-the-ground work of nurses within the TAC system. That is to say, I address the lesser examined clinical functioning of the TAC

¹¹⁵ Vancouver physician Robert Makaroff was one of their significant partners. *See* Thomson, "Winning Choice".

¹¹⁶ *Ibid.*

¹¹⁷ *See* Stolk, "Abortion Information" or Kass, "Abortion Advice", which quotes Mary Stolk as the spokeswoman of the AIS.

¹¹⁸ "Calgary experiments": 1.

system with attention to women's (in)ability to access legal in-hospital abortion from nurses' perspectives therein.

The Establishment of Illegal Freestanding Abortion Clinics

Similar to the groups noted above, some Canadian physicians and nurses also broke away from the TAC system with the aim of increasing access to abortion by offering additional services to women, albeit illegally. Specifically, these practitioners moved to develop freestanding abortion clinics and began to provide the procedure from there. This move, and nurses' participation in it comprises the heart of this dissertation. The current historical narrative holds that women's poor access to in-hospital abortions under the TAC system was indeed one motivating factor for physicians—and physician Henry Morgentaler in particular—to establish illegal freestanding abortion clinics in the late 1960s through to the mid 1980s.¹¹⁹ Though they are included in some descriptions of these events, nurses' participation in doing so as nurses, or in other words, as a unique category of historical actor, is rather under-explored.

As previously noted in my review of abortion clinics, Morgentaler is understood to have opened one of the earliest freestanding abortion clinics in Canada in Montreal in the late 1960s. This clinic immediately withstood a tumultuous developmental period rife with state scrutiny, police interruption of its operation, and ongoing legal battles.¹²⁰ By the mid 1970s, however, the Montreal clinic had proven a successful clinical and political model. Clinically speaking,

¹¹⁹ Bierne, "Rough and Risky"; de Villiers, "A Man"; Dunphy, "Morgentaler".

¹²⁰ These conditions are discussed in Chapter One.

Morgentaler reported it as medically safe based on the statistical data he collected there.¹²¹ And politically speaking, the Montreal clinic came to be supported by the general public, who, as jury members, refused to convict Morgentaler of abortion related crimes three times over.¹²² Absent those jury convictions, the provincial government (the Partis Québécois) deemed the law “unenforceable.”¹²³ In 1976, this government withdrew its efforts to uphold federal legislation, opting instead to support abortion service provision by way of the Morgentaler clinic and by supporting the development of additional freestanding clinics (that were neither owned nor operated by Morgentaler) across the province.¹²⁴

Emboldened by the albeit slow and difficult victory in Quebec, historians note that Morgentaler and other physicians (with some mention but few analyses of nurses’ participation here, which is consistent with accounts of the founding of the Montreal clinic) expanded into other parts of

¹²¹ In 1973, Morgentaler reported that they had performed over five thousand abortions with only about thirty women exhibiting related complications, including infection, incomplete abortion (i.e., failure to fully empty the uterus), and depression but no deaths. Morgentaler, “Report”.

¹²² Day and Persky, “Supreme Court”.

¹²³ Ibid.

¹²⁴ See Day and Persky, “Supreme Court”: 7. Morgentaler reportedly helped establish those other clinics in Quebec by training practitioners in the vacuum aspiration procedure there. See Morgentaler, “Report”. These non-Morgentaler clinics have not been studied for this project. For more on those centres, see Cornacchia, “On record” or Canadians for Choice, “Focus on Abortion”.

Canada.¹²⁵ They next opened clinics in Winnipeg and Toronto in May and June of 1983 respectively. Just as they experienced in Montreal in the 1970s, the clinics in Winnipeg and Toronto in the 1980s underwent legally tumultuous developmental periods. For, although the Quebec government had ceased to enforce the federal abortion law, the Manitoba and Ontario governments continued their attempts to uphold it when those clinics opened. Indeed, the clinics in operation between 1968 and 1988 and all of the abortions performed there were illegal given that they contravened the TAC regulations. To wit: although abortions were performed by skilled practitioners in clinically safe facilities, the clinics were unaccredited out-of-hospital settings; clinics failed to employ TACs to provide medical approval; and barring any major medical contraindications, the women who could access these clinics obtained abortions at their own discretion (for their own reasons). Finally, abortion clinic staff were unwilling to surrender women's medical records to authorities.¹²⁶

In this primarily Morgentaler-dominated historical narrative, the illegal freestanding abortion clinics have been understood by historians as a tool for challenging the law and not necessarily as a unique and pioneering place of clinical practice, neither for physicians nor nurses. Indeed, Morgentaler and, to a lesser extent, his physician partners in Toronto and Winnipeg (Leslie Frank Smoling and Robert Scott) are considered notable for their political and legal activities rather than for their clinical practices. Specifically, the argument typically offered is that they opened the clinics with the primary goal of challenging the law, purposefully and loudly flouting it in order to incite criminal charges. They wanted to defend the clinics in court in order to

¹²⁵ For example, *see* Ackerman and Stettner, "Not Ready": 246.

¹²⁶ Dunphy, "Morgentaler".

demonstrate that the 1969 laws and the TAC system were illogical and unenforceable and to incite the government to legalize or decriminalize them—which they did. Less is said about the actual techniques they developed within those clinics.¹²⁷

Much historiography, then, is dedicated to these physicians' legal battles outside of the clinic doors and their subsequent contributions to abortion's full decriminalization in 1988. Little is said, however, about the battles, or the real effects of the state's regulation of abortion that went on inside of them. Less still has been analysed in terms of nurses' contributions to challenging the abortion law, both inside and outside of the clinics. Moreover, much like their physician colleagues, nurses' clinical contributions to the development of abortion services through their hands-on (or 'bedside') work with women are also missing from this narrative. It is to these considerations that an examination of nurses' hands-on work inside the clinics can contribute. Shedding light on the ways that nurses undertook and understood their work in the clinics, in addition to the ways that other non-clinical actors understood and presented nurses' clinic work, can increase understanding about the overall development of illegal freestanding clinics, expand the abortion history narrative beyond Morgentaler's story, and link nursing's role in clinical abortion practice to state regulation (and the legal and political maneuverings of physicians *and* nurses) and to the broader transformation of nurses' professional self-understanding.

¹²⁷ For an exception, Morgentaler is credited with bringing the vacuum aspiration machine to Canada and for refining the vacuum aspiration curettage technique. *See* Dunphy, "Morgentaler": 82–83. Morgentaler also credits himself for doing so in Morgentaler, "Report". *See also* Hengel, "An Interview."

Major questions for the profession of nursing throughout the liberalized abortion era continued to centre around nursing's approach to health and health care and nursing's relationship to the medical establishment. Some theoretical analyses by nursing scholars and historians of women's health alike have generated a largely feminist critique on the seemingly gendered dominance of (typically male) medical control over the lives and health of women.¹²⁸ Specifically, beliefs about medicine's and to some degree nursing's attendant commitment to a biomedical, or disease-oriented, approach to health continued to be questioned and seen by nurses and others as a constraining force that restricted nursing's professionalization (both in terms of education and labour) and women's equitable access to appropriate health services as patients.¹²⁹ Contemporary theorists and historical actors have sometimes framed this biomedical dominance as 'medicalization'—a perspective that came to be applied not only to the general system of health care but also to the clinical provision of in-hospital and freestanding abortion services in rather significant ways.¹³⁰ Although this language of feminism and medicalization was not always taken up by nursing explicitly, it is clear that they engaged with these underlying concepts generally and throughout nursing history. In terms of abortion services, the historical record demonstrates that medicalization proved a formidable lens through which (largely self-identified feminist) women interpreted and responded to the nature of what was available to them in both

¹²⁸ Andrist et al., "History of Ideas"; Chinn and Wheeler, "Feminism"; Roberts and Group, "Feminism and Nursing".

¹²⁹ Thomson, "Winning Choice".

¹³⁰ For contemporary theorists, *see* Light, "Functionally Inaccessible" or Riessman, "Women and Medicalization". For a contemporaneous critique by a 'historical actor,' *see* McDonnell, "Not an Easy Choice".

the legal TAC system and the illegal freestanding abortion clinics. The ways that nurses engaged with the same concepts in relation to their abortion work remain under-examined but will be explored in this dissertation.

Medicalization Critique

Women's and practitioners' dissatisfaction with the TAC system was not only related to inequitable access as discussed above. It was also related to the nature or character of services provided therein, which some historical actors and historians have argued also carried over to the operation of freestanding abortion clinics. In general, they perceived available services in hospitals and freestanding clinics as fundamentally controlled by (typically male) physicians, which resulted in the ongoing medicalization of abortion and the provision of it in medicalizing ways, which was detrimental to women socially and clinically. Following the so-called liberalization of abortion, an emerging feminist critique of the medicalization of women's health in general and of abortion services grew louder.

Most generally, the medicalization critique holds that medicalization has been (and is) detrimental to women.¹³¹ It is understood as engendering and reinforcing medical practitioners'

¹³¹ Medicalization and its critique are not limited to analyses of women's reproductive health.

Other speciality fields of practice, such as psychiatry, disability, homosexuality, aging, childhood conditions, and other 'women's conditions' (e.g., body size, menopause, osteoporosis, and women's cancers) have also been subjects of this critique. Notably, medicalization emerges as an important feature in fields that focus on or 'treat' people who are seen as (or are perhaps rendered by medicalization as) marginalized or dis-empowered, in which, some argue, women

authority and control over women's health—here, their reproductive health—which in turn has suppressed women's control over their own bodies and lives in two major ways. First, as physicians gained and retained status as the legitimate practitioners of health services (as can be seen as early as the criminalized era of abortion and the establishment of medicine as a profession), they disrupted and misappropriated the practices and social positions held by women healers. As a result, these women seemingly lost their relatively powerful social or professional positions. Instead, they were labelled and treated as quacks, hacks, and illegals, their status ever diminishing by a growing inability to legitimately participate in and earn from their practices. Second, in this enduring medicalized system, critics have argued that women as 'patients' were positioned merely as passive recipients of health services rather than as engaged and knowledgeable participants. Through medicalization, the critique holds, women were identified and treated as non-experts who were best managed by physicians irrespective of their personal or collective experiences and knowledge. The critique of medicalization has often, but not always, been voiced as a feminist perspective. The underlying perspective is argued to be a gendered one given that the medicalizing system is one in which primarily male medical practitioners were willing and able to discourage and prevent women from making decisions about whether, where,

are over-represented. For discussions of medicalization in general, *see* Conrad, "Medicalization" or Nye, "Evolution". For more on the medicalization of women's conditions, *see* Findlay and Miller, "Medical Eyes"; Mitchinson, "Feminism"; Warsh, "Prescribed Norms" or Weitz, "Politics".

and how they conceived,¹³² nurtured or terminated their pregnancies,¹³³ delivered their babies,¹³⁴ and mothered their children.¹³⁵

A general understanding of the processes of medicalization is now offered to inform my discussion of abortion services as potentially medicalized or medicalizing. In general, to medicalize an experience or condition—which may be physical, psychological, or social—is to privilege its clinical or bio-medical aspects over and above its social and political ones by assigning primarily “medical meaning” to it. In so doing, one’s experiences or conditions are rendered separate from or different than ‘normal’ and so-called ‘healthy,’ that is, not pathological or illness-related, circumstances. Medical meaning is made and assigned through discourse and practice whereby conditions are framed as abnormal or deviant—that is, as illnesses, pathologies, and diseases that subsequently require monitoring, treatment, or curing. Crucially, in the medicalized approach, it is only certain people (in this system, physicians) who are deemed qualified and thus permitted to properly construct those meanings, diagnose medical

¹³² Note that in her investigation of “Eugenics in the Community,” Amy Samson brings the participation of professional women, including nurses, to the fore.

¹³³ For international pregnancy and childbirth scholarship, *see*, Leavitt, “Brought to Bed” and Leavitt, “Women and Health” (for the USA); Oakley, “Captured” or Treichler, “Feminism” (for the UK); and Bryder, “Rise and Fall” (New Zealand).

¹³⁴ Strong-Boag and McPherson, “Confinement”.

¹³⁵ *See*, for example, Arnup, “Education”; Arnup et al., “Delivering Motherhood; Comacchio, “Nations”; Dodd, “Advice”; Mennill, “Ideal Births” and Wood, “Luxurious”.

conditions, and direct the ways that those conditions are monitored, treated, and potentially cured.

In the medicalization paradigm, physicians are therefore authorized and expected to take on expert provider roles owing in part to their ostensibly unique understanding of scientific knowledge and their attendant ability and willingness to participate in ongoing cycles of developing and implementing specialized clinical practices and technologies. As noted, positioning particular conditions and treatments, such as pregnancy and abortion, under the exclusive purview of physicians affords them a measure of power over and above their women practitioner colleagues and women ‘patients.’ This power differential, enacted in social and material contexts, is understood to be an essential aspect of medicalization. Nurses’ general engagement with questions around medicalization, whether as theorists, hands-on practitioners, or as players in secondary historical analyses, are important to review. But first I wish to explore the ways that some historical actors and scholars have argued that the medical establishment gained control over abortion provision insofar as physicians seemingly developed, safeguarded, and were positioned as gatekeepers to it.

The TAC system proved a significant site for the critique of abortion’s medicalization. Given that the abortion procedure had to be conceptualized and defended biomedically to ensure the legal protection of physicians and women, the TAC system necessarily medicalized abortion. In order to gain approval for an abortion, a woman’s unwanted or unintended pregnancy had to be assigned ‘medical meaning.’ These pregnancies were thus framed by the state and the medical

establishment (both willingly and reluctantly, historians have noted)¹³⁶ as illnesses in and of themselves or as complicating aspects of other physical or psychiatric conditions (e.g., serious cardiac or renal disease or severe depression). Unwanted or unintended pregnancies *had* to be conceptualized as diseases such that continuing the pregnancy endangered a woman's life or health. Because unwanted or unintended pregnancy thus constituted a pathology or an illness, abortion could logically serve as its 'cure' or as an appropriate medical treatment or therapy. Hence, such procedures were commensurately termed "therapeutic abortions." In the wake of the 1969 law, in-hospital abortion was constructed as a legitimate life- or health-saving medical practice, physicians were enabled to take up expert roles in its provision, and women seeking abortions were obligated to present themselves as patients or passive recipients of care for judgement. This continued form of medicalization, some have argued, served to entrench hospital physicians as the clinical and social gatekeepers of both abortion practice and knowledge over and above the self-identified wants, needs, and experiences of women. Owing to these intertwined legal and clinical factors, the TAC system of in-hospital abortion provision had arguably become a distinctly medicalized one.

Women, practitioners, and historians have offered that the TAC system was not the only medicalized site of abortion provision. Some, primarily self-identified feminist, critics also identified the existing freestanding (i.e., Morgentaler) clinics as similarly medicalizing even though they provided abortions outside of state regulation and the physician-led TAC system.¹³⁷ Though many feminist women and groups, such as the Canadian Association for the Repeal of

¹³⁶ Light, "Shifting Interests".

¹³⁷ Thomson, "Winning Choice".

the Abortion Law or Canadian Abortion Rights Action League [CARAL], generally supported Henry Morgentaler,¹³⁸ others rejected his politics and clinics outright. For example, some, perhaps radically leaning, feminists put forward the strong critique that the Morgentaler clinics were inherently male-dominated and medicalizing. They argued that Morgentaler's 1970s and 1980s claims to feminism were disingenuous. They subsequently rejected Morgentaler's operation of those clinics.¹³⁹ A flyer I encountered in the Women's Collection of the University

¹³⁸ See Dunphy, "Morgentaler"; Jenson, "Getting to Morgentaler"; Palmer, "Choices"; and Thomson, "Winning Choice" for more on Morgentaler and feminist support. The Canadian Association for the Repeal of the Abortion Law (known as the Canadian Abortion Rights Action League after 1988), was a non-hierarchical organization that worked toward "legislative reform" and "providing support both for women in the community who choose to have an abortion and *doctors* who agree with the aims of the pro-choice movement." See "CARAL hopes": 5. CARAL was initially "formed in 1974 to protest the incarceration of Dr. Henry Morgentaler." See Saurette and Gordon, "Changing Voice": 374. Saurette and Gordon also provide a clear list of several key organizations and individuals.

¹³⁹ It is worth pointing out that Morgentaler was indeed initially interested in the issue of abortion from broad human-rights lens rather than an explicitly women's-rights perspective. This grounding perhaps owes to the historical context (that is, arguably before the second wave 'women's rights' movement had taken hold) or to his particular political interests. In 1967, Morgentaler appeared before the parliamentary Federal Health and Welfare Committee, which had been charged with re(evaluating) the criminal abortion law at that time, arguing that the law needed liberalizing. He proposed that in the first trimester of pregnancy, women ought to be able to obtain abortions at their own discretion. He put forward that a woman's ability to do so ought

of Ottawa Archives, which was published by a group called the “Resurgent Feminists,” articulated this perspective in a particularly striking way. It read:

ABORTION – YES! MORGENTALER – NO!

ALL males thrive on the oppression of women: Morgentaler is no exception! [...]. WOMEN ARE DYING! DON'T SUPPORT THE ENEMY! WE DEMAND THE RIGHT TO OUR OWN BODIES...OUR OWN MINDS... OUR OWN ACTIONS... ALL OUR ENERGY IS OURS!¹⁴⁰

Similar to the Resurgent Feminists, other women perceived the medicalization of abortion—be it in the TAC system or at the freestanding Morgentaler clinics (even if they supported those clinics in some ways)—as limiting to their control over and meaningful participation with abortion provision, which, it is worth noting, ultimately happened within their bodies. Notably, a woman physician-abortionist in Toronto later espoused this view, reporting in 1988 that “the Morgentaler clinic[s] furthered women’s rights but [were not] intentionally feminist in structure to be legally protected under the *Criminal Code* ‘not as a privilege, but as a right’. It is important to note that he appeared before the committee not as a physician or practitioner per se but as a representative of The Humanist Fellowship of Montreal, espousing the humanist philosophy that the state’s restriction of abortion violated women’s rights as *humans* generally. In 1967, Morgentaler’s primary interest in abortion law was thus politically focused and human (but not specifically women) centered. *See* Beirne, “Rough and Risky”.

¹⁴⁰ Resurgent Feminists, “Abortion Yes.” Emphasis original.

or provision of health care.”¹⁴¹ Partly in response to the ongoing clinical medicalization of women’s reproductive health, a women’s health movement came into being. In terms of abortion, its members focused their critique on the nature of abortion services. Moreover, as they did with abortion access, members of the women’s health movement continued creating strategies that aimed to dismantle medicalized abortion services. The women’s health movement and the post-1970s feminist critique of medicalization is a substantial topic in the historiography of women’s health and abortion. It also exists within some nursing literature, both of the historical and contemporary variety, though not in the context of abortion provision specifically. The analysis presented in this dissertation demonstrates that the women’s health movement and the critique of medicalization proved significant to nurses and their abortion work in freestanding clinics. As such, I provide a general overview of that movement next.

The Feminist Women’s Health Movement

Some scholars have closely analyzed the Canadian and US American development of the women’s health movement (which is also known as the women’s self-help health movement), its members’ rejection of medicalization, and the move toward women’s medical self-determination.¹⁴² Women and their allies who opposed medicalization found major footing in and in turn contributed to building the international feminist ‘women’s-health movement,’ which gained visibility in the late 1960s and early 1970s and continued throughout the period of this study into the 1980s and 1990s. This movement developed in parallel with shifting professional

¹⁴¹ Shanahan, “Exciting Developments”.

¹⁴² Hess et al., “Science, Technology”; Looker, “Women’s Health”; Morgen, “Into Our Own”; Morrow, “Our Bodies”; Nelson, “More Than Medicine”; Tuana, “Speculum”.

and social perspectives about women, health, and abortion, and drew from the range of social movements that informed the initial liberalization of abortion legislation, which I discussed above in the section of this introduction entitled “Towards Liberalization and Professional Expertise.”¹⁴³ Women’s health advocates who were working toward challenging and dismantling

¹⁴³ *See above*. It is important to note that the original movement toward self-determination via increased abortion access from a ‘pro-choice’ perspective at this time focused on the needs and wants of typically white women of privilege with less attention to the intersections between medicalization, classism, and racism, for example. Scholars are now turning their attention to the more inclusive reproductive justice framework, *see* “Introduction” in Stettner, “Without Apology”. Moreover, it is important to note that some second wave feminists (in Vancouver’s Women’s Caucus, for example) had articulated that their primary feminist concerns were not centered on abortion access, and that they wanted to promote women’s equal opportunities elsewhere—for example, to join the labour force and receive equal pay, to ensure access to affordable childcare, resist domestic violence and rape, or advocate for peace and resistance to nuclear warfare before tackling abortion rights. Yet the movement took up abortion as a primary goal and site of advocacy seemingly owing to its visibility and the potential for immediate tangible results. This move, then, was not without controversy. Note that this dissertation offers neither a full analysis nor a critique of these developments but rather a discussion about how abortion was situated within that particular history of second wave pro-choice feminism and the ways that nurses and other providers navigated and engaged with it. For more on those developments, *see*: “Abortion Handbook” or Thomson, “Winning Choice”.

restrictive abortion *practice* acted, then, in tandem with other feminist partners who were deeply committed to challenging and dismantling restrictive abortion *legislation*.¹⁴⁴

Together, many feminists argued that state regulated and medicalized abortion provision “put women in a degrading, powerless position, subject to the personal and often arbitrary predispositions of mainly male lawmakers and medical personnel.”¹⁴⁵ While some abortion advocates focused on legislative changes, women’s health activists focused on the medicalizing structures and practices embedded in the post-1969 system of clinical abortion provision. They sought to de-medicalize it. First, they aimed toward increasing abortion access, as previously discussed. They also sought to ‘demystify’ women’s health and abortion by sharing previously hidden or safeguarded knowledge and practices and by developing individual and collective ‘self-help’ strategies for women seeking abortion. These included publishing and distributing

¹⁴⁴ Historians have been exploring the political activities of other, non-physician, social actors (namely, feminist women) who fought for abortion law repeal. These women and their allies undertook a variety of projects towards that aim, including individual and collective letter writing campaigns (Stettner, “Unwanted”); participating in more formal governmental/high-level policy-focused activities such as the Royal Commission on the Status of Women Inquiry (RCSW, “Report”; Stettner, “Unwanted”; Badgley et al., “Operation”); organizing national protests such as the Abortion Caravan (Palmer, “Choices”; Sethna, and Hewitt, “Clandestine”; Stettner, “We Are Forced”) and establishing coalitions such as CARAL that (among other activities) lobbied for the freedom to establish legal freestanding abortion clinics (Palmer, “Choices”).

¹⁴⁵ Sarti, “Women’s group”: A15.

forthright literature such as the *McGill Birth Control Handbook* (published by the McGill Students' Union Collective in 1969) and *Our Bodies Ourselves* (published by the Boston Women's Collective in 1970). These examples and a number of other pamphlets, books, and manuals provided information about birth control and abortion, women's bodies, and other women's health conditions.¹⁴⁶ They clarified medical jargon and generally focused on coming to know one's body and enacting the subsequent increased ability to monitor and make decisions about it.¹⁴⁷ These strategies can be understood as de-medicalizing insofar as they challenged the professional safeguarding of knowledge.

Women's health advocates also set up feminist spaces from which to put that literature into practice, as it were. They provided learning and practice sessions on a range of topics, including, as is commonly highlighted in this historiography, performing one's own pelvic exam (i.e., visualizing, assessing, and monitoring the vulva, vagina, and cervix) with the use of a medical speculum.¹⁴⁸ Using the vaginal speculum was particularly significant in women's health advocacy because it was a piece of specialized medical equipment developed and used primarily by physicians to access, peer into, and thus gain control over women's bodies. In clinical settings, the speculum was typically used without women's participation (that is, the physician inserted, operated, and removed the speculum) and perhaps without their explicit consent (i.e., its

¹⁴⁶ Vancouver Women's Caucus, "Report".

¹⁴⁷ Boscoe, et al., "Women's Health"; Morrow, "Our Bodies"; Nelson, "More Than"; Tuana "Speculum".

¹⁴⁸ See Tuana, "Speculum": 8 for the self-exam instructions included in the 1973 edition of *Our Bodies Ourselves*. 8.

use was ‘a given’ in gynecological exams whereby the physician decided whether or not to use it)¹⁴⁹ Fittingly, speculum-aided self-exams grew into a powerful and iconic symbol of feminist de-medicalizing approaches to women’s health from that time.¹⁵⁰

Primary professional nursing literature indicates that some nurses were also considering medical dominance (though not necessarily in the language of medicalization and feminism) and the ways that it affected the health of women patients before abortion’s decriminalization. One such nurse reported in *Canadian Nurse* that the goal of teaching women “how to do their own pelvic examinations” was “to increase their awareness of how their bodies looked and functioned,”¹⁵¹ a process for which she advocated. These comments remain but a glimpse into nurses’ engagement with these perspectives. Their beliefs about and participation as allies in the women’s health movement have not yet been fully uncovered or integrated into the historiography of the women’s health movement.

There is some hint, however, that nurses were understood to be part of ‘the problem,’ that is, perceived not as allies, owing to their apparent subordinate alignment with the medical establishment and their theoretically attendant bio-medically driven practices.¹⁵² The critique that nurses failed to support the women’s health movement, I found, was also articulated by nurses themselves. Indeed, for many years, some nurses suggested that the profession had not

¹⁴⁹ Sandelowski, “Most Dangerous”.

¹⁵⁰ See especially Tuana, “Speculum”.

¹⁵¹ Vachon, “Letter”.

¹⁵² Thomson, “Winning Choice”.

sufficiently contributed to de-medicalizing approaches and had thus failed to support larger feminist goals in general. Consider that in her 1974 *Canadian Nurse* article in support of “A self-help health clinic for women,” Audrey Hall lamented, “Nurses are a conservative group, reluctant to take risks. The reaction of most to anything that smacks of ‘women’s lib’ is negative.”¹⁵³ Similarly, more than a decade later, in 1986, nurse Mary Wilke asserted in the *Registered Nurses Association of BC Newsletter*, “As an association of professional women dedicated to self-help and serving the public, we could be most effective [in addressing women’s concerns]. For in truth, we do know of these things—from both sides of the fence.”¹⁵⁴ Yet, she suggested, nurses had not been effective in that role. She noted that even though nurses were professionally and socially held in “low regard” themselves, they nevertheless “were among the most reluctant women to accept the feminist movement” that was fighting against society’s low regard for all women. She was left wondering, then: “Why are we [nurses] so silent? So compliant? So complacent?”¹⁵⁵ Again, nurses’ beliefs that they might have been constrained from participating in the women’s health movement are missing from the larger historical narrative, as are nurses’ beliefs about why they may have been constrained from doing so.

Preliminary exploration of primary source material seems to indicate that nurses theorized that, like their women-patients, nurses had been similarly oppressed within a male-dominated hierarchical system that continued to be supported by broader (misogynist) social norms in which they as professional women had been socialized and to which they were deeply

¹⁵³ Hall, “Self-Help”: 36.

¹⁵⁴ Wilke, “Nurses”: 6.

¹⁵⁵ Ibid.

accustomed.¹⁵⁶ As late as 1990, a group of nurse-authors in *Canadian Nurse* identified restrictive social factors such as “the patriarchal system, economics, politics, the judicial system, technology, the media, the education system, and the processes of socialization and acculturation”¹⁵⁷ as detrimental to nurses’ ability to promote feminist health strategies. Mary Wilke had expressed this perspective rather succinctly, writing, “the price of a generation of conditioning is a profession marked by timidity.” Essentially, the critical line of argument held that the profession of nursing was profoundly embedded in the physician-driven, hierarchical health care system that was supported by ingrained and apparently not yet fully liberalized social values. As a result, then, they were arguably constrained from supporting and enacting the values of women’s health advocates. Though these examples are compelling, these ‘hints’ have yet to be explored and substantiated further in the context of the women’s health movement.

What historians have suggested and substantiated is that at this time, the profession of nursing in general continued to express some ambivalence toward their alignment with medicine outside of the women’s health movement. They grappled with the ways that their alignment undermined their professional and social status but in other ways helped reinforce nursing’s legitimacy by way of clinical expertise development and claims to scientific knowledge. It is in this context (i.e., the focus on nurses as working women—rather than as practitioners working *with* women) that historians of nursing have commonly examined nursing and feminism.¹⁵⁸ As such, nurses’ explicit engagement with the women’s health movement in general makes for another important

¹⁵⁶ Baumgart, “Nurses”; Baumgart, “Women”.

¹⁵⁷ Archibald et al., “Promoting”: 38.

¹⁵⁸ Melchior, “Feminist”.

avenue of inquiry and is a needed addition to the women's health movement historiography. I do not pursue that broader scope in this project. Rather, I explore nurses' perspectives of and experiences with the women's health movement and its ongoing calls for de-medicalization in the context of decriminalized abortion provision specifically. For, abortion clinic nurses came face to face with advocates of de-medicalized approaches to women's health when other women became more involved in critiquing and re-developing abortion services from freestanding clinics following decriminalization.

Decriminalization and De-Medicalization

On January 28, 1988, in the context of Canada's new federal *Charter of Rights and Freedoms* (enacted in 1982), the Supreme Court of Canada struck the abortion law from the *Criminal Code*. In the *R. v Morgentaler* case, brought before the Supreme Court by physicians Henry Morgentaler, Robert Scott, and Leslie Smoling, Canadian Supreme Court Justices ruled in a five–two decision that the 1969 abortion regulations were “unconstitutional because [they] violated a woman's right to ‘life, liberty and security of the person.’”¹⁵⁹ This right was guaranteed by Section Seven of the *Charter of Rights and Freedoms*, which applied equally to men and women but not to the fetus. As a result, the criminal abortion law was overturned, rendering abortion and its provision decriminalized. In perhaps another medicalizing move, abortion became regulated as a medical procedure under the *Canada Health Act* rather than as a

¹⁵⁹ For an in-depth analysis of the change in law, see Day and Persky, “Supreme Court”: 13. This volume includes the full Reasons for Judgment text from four Justices.

criminal offence under the *Criminal Code*.¹⁶⁰ Canadian citizens and practitioners were left without a federal criminal law on abortion, and the provision and procurement of abortion were no longer indictable criminal offences.¹⁶¹

Though much historiography that is focused on the decriminalization of abortion closely examines the politicking involved in bringing it about¹⁶² and then challenging the legislative absence,¹⁶³ some historians have also highlighted the work of feminist women in attempting to shape actual abortion services.¹⁶⁴ By engendering a new legal context that allowed abortion clinics to be opened more freely, decriminalization opened a window for practitioners and others to ask questions about the ways that abortion services could and ought to be provided. New social actors, including feminist women who supported the women's health movement, now had better opportunity to re-imagine the meaning of abortion and its provision, to help open new

¹⁶⁰ The *Canada Health Act* was passed April 1, 1984. It guides the public administration and insurance of health care services and thus the division of funding and regulation between the federal and provincial governments. The Act holds that Canadian health service provision ought to be grounded in the principles of public administration, comprehensiveness, universality, portability and accessibility. Under the Act, health service provision is regulated and funded primarily by each province with partial reimbursement by the federal government provided those principles are upheld. For more on the Canada Health Act, see Madore, "Overview".

¹⁶¹ Day and Persky, "Supreme Court".

¹⁶² For example, Jenson "Getting to Morgentaler".

¹⁶³ Brodie, "Choice"; Johnstone, "After"; Morton, "Pro-Choice"; Richer, "Abortion".

¹⁶⁴ See, in particular, Thomson, "Winning Choice".

freestanding abortion clinics, and to organize overall service provision in ways that upheld their ideological commitments. Specifically, some historians have explored the continued feminist critique of abortion services and feminist women's aims to de-medicalize them in practice. Vancouver's Everywoman's Health Centre [EHC, and also known as "Everywoman's"] is a good example of a freestanding clinic that was envisioned and opened by feminists, the process of which historian Ann Thomson has well documented, and a site of nursing practice that I study here.¹⁶⁵ Another example is a group that unsuccessfully attempted to open a feminist abortion clinic in Toronto albeit prior to decriminalization.¹⁶⁶ And finally, I have found that like-minded

¹⁶⁵ Briefly, BC feminists helped organize the British Columbia Coalition for Abortion Clinics in January of 1987 and planned to achieve their specific aim of opening a feminist freestanding clinic on the west coast under its auspices. *See* British Columbia Coalition for Abortion Clinics, "Letter to Physicians for Choice".

¹⁶⁶ This group attempted to open a feminist abortion clinic in Toronto in the 1980s. They had recruited Leslie Frank Smoling to serve as its physician, believing that he would not interfere in their feminist pursuits (i.e., they determined that he would be satisfied to simply perform the procedure rather than direct the clinic's overall structure and functioning). Owing to the restrictive abortion law, however, this clinic never came to fruition under the direction of this group. The landlord of the space they agreed to rent had reneged on the contract out of fear of legal retaliation. The Morgentaler group adopted the foundations of the clinic, successfully opening it as the Toronto Morgentaler Clinic in a different space in 1983 ("Choosing to defy the law"). This article mentions two nurses in the original feminist group: one who unsuccessfully tried to abort herself twelve years prior and one who identified her feminism as a motivating factor for joining.

self-identified feminist administrators and counsellors joined other, less explicitly, ‘feminist’ clinics following decriminalization.

These women were typically committed to a feminist-collective operational model, which they saw as a rejection of what they perceived to be the existing physician-led medical and medicalizing approach. They wanted, instead, to build clinics based on de-medicalizing principles and practices. This approach called for: practitioner engagement with the complex social and physical contexts of women’s lives and health; the acknowledgment of ‘patients’ as individual women with unique abortion-related needs and wants; the demystification or transparency of practice, knowledge and discourse; and the disruption of professional-patient and practitioner-practitioner hierarchies. Additionally, from this perspective, practitioners were asked to recognize that women’s social contexts and differences—in addition to their biological conditions—influence their reproductive health and their abortion needs in complex and overlapping ways.¹⁶⁷ Practitioners were subsequently called to reject the conceptualization of unintended or unwanted pregnancy as primarily a disease or pathological condition whereby abortion functions as a medical cure or therapy.¹⁶⁸ In terms of the explicitly feminist aspect of this perspective, proponents of de-medicalization argued that women have been disadvantaged in many areas of their lives, which in turn has affected the ways that they were offered and experience clinical health services, including abortion, which has resulted in significant and harmful health inequities. In the wake of decriminalization, then, feminists sought to embark on

¹⁶⁷ Johnstone, “After”.

¹⁶⁸ This interpretation is compiled from multiple sources. *See*, for example, EHC, “Steering Committee Report” or EHC, “BC’s First Abortion Clinic”.

what they perceived to be a new path toward increasing women's control over abortion and diminishing practitioner's authority and gatekeeping behaviours by opening or joining new and existing freestanding clinics.

It is in this context that freestanding abortion clinics have been understood as a symbol for and potential place for enacting women's medical and social autonomy. Significantly, the dominant historical narrative is focused more so on the symbolic and administrative aspect of developing and operating a feminist clinic that promotes women's autonomy rather than on the implementation of those feminist principles in practice. An analysis of nurses' hands-on work in so-named feminist and medically driven abortion clinics lends some insight into the ways that freestanding clinics could or did function as a place for promoting women's actual medical and bodily autonomy. Again, it is clear that nurses were indeed players in this history given that they are embedded in the narratives that centre around organizational activities. Ann Thomson, for example, reveals that Registered Nurse Bettie Scheffer helped to develop Everywoman's in its early days.¹⁶⁹ Similarly, a newspaper report briefly mentioned that nurses alongside social workers were involved in the organization of the would-be feminist clinic in Toronto.¹⁷⁰ My forthcoming analysis in Chapter Two uncovers more of the story of nurses' involvement with developing new and existing abortion clinics, with attention to their negotiation of actual practice amid the medicalization critique and call for women's medical autonomy.

¹⁶⁹ Thomson, "Winning Choice".

¹⁷⁰ "Choosing to defy the law".

Decriminalization and Anti-Abortion Activism

The lead up to decriminalization and its actual manifestation opened the door to questions not only about the ways that abortion ought to be provided from freestanding clinics but also about whether or not abortion ought to be provided from freestanding clinics at all. The latter concerns surfaced before decriminalization, when illegal freestanding clinics were established and operating safely, and they continued to resonate in an ongoing public debate after decriminalization, when additional abortion clinics were opened, stayed open, and operated safely and efficiently across the country. Indeed, illegal and legal abortion clinics immediately became a target of an emerging resistant anti-abortion movement that only grew and intensified following decriminalization.¹⁷¹ Freestanding clinics thus comprised a place of great tension and

¹⁷¹ Discourse and rhetoric around abortion is complex and contextual, resulting in multiple ideology-laden terms for abortion-resistant and abortion-supportive perspectives. In this study, anti-abortion(ism) was also termed *pro-life*, typically by those who held anti-abortion perspectives, which usually indicated an aim to protect fetal life. On the other hand, many of the abortion clinic nurses interviewed here used the term *anti-choice* for those activists, pointing to their [the nurses'] belief that the unwavering protection of fetal life hindered women's ability to make choices about if and when they bore children. Abortion-supportive perspectives were primarily termed *pro-choice*, which indicated support for women's ability to make choices about their reproductive lives. I use anti-abortion as a general descriptor throughout this narrative, employing *pro-life* when quoting primary sources. For more on abortion discourse more broadly, see Stettner, "Without Apology". For abortion and nursing discourse more specifically, see Haney, "Nursing Identity"; Haney, "Towards Legitimate Nursing". Anti-abortion discourse making will also be further discussed in Chapter Three.

have been understood as historically significant contested cultural spaces¹⁷² plagued by anti-abortion protests and violent attacks. Some attention has been paid to the experiences of people who worked at these targeted clinics—though primarily physicians and, to a lesser extent, counsellors, but not to nurses-as-such—and the women who attended them.¹⁷³ However, deeper historical analysis dedicated to the interplay between in-clinic services and broader cultural challenges to abortion provision in addition to the connections between anti-abortion activism and abortion-supportive nursing practice are needed.

A large part of anti-abortion historiography instead focuses on the development of the anti-abortion movement at large.¹⁷⁴ Scholars have examined, for example, the organizations and coalitions of anti-abortionists who developed and participated in the movement.¹⁷⁵ They have also analyzed the political activities of individuals and governments who challenged the (absent) abortion law by introducing new proposals for restrictive legislation that would, in essence, recriminalize abortion.¹⁷⁶ And, similarly, they have explored the ways that anti-abortion

¹⁷² Brown, “Contested Spaces”.

¹⁷³ For one counsellor’s account of working at EHC in Vancouver, *see* Lochwin, “Blinded”.

¹⁷⁴ For a list of anti-abortion organizations and their chronology, *see* Ackerman and Stettner, “The Public”: 240.

¹⁷⁵ Saurette and Gordon, “Changing Voice”.

¹⁷⁶ Brodie, “Choice”; “Stettner and Ackerman, “The Public”. For some examples: former NDP cabinet minister from Manitoba, Joseph Borowski, was as a prominent political anti-abortion activist who mounted a quest to legally defend fetal rights; BC premier Bill Vander Zalm

governments continued to regulate abortion with new medical restrictions—such as requiring two physicians’ agreement that the abortion was therapeutic—or withholding medical insurance payments for some or all abortions.¹⁷⁷ Within these analyses, much attention has been paid to underlying philosophies or guiding principles, including religious (i.e., Christian) ideologies, scientific knowledge, or broader social perspectives on womanhood, motherhood, and the family, for example.¹⁷⁸ Yet in keeping with abortion historiography in general, little is known about nurses’ participation in the anti-abortion movement, the anti-abortion principles they espoused as professionals, or the activism they undertook as part of the broader cultural resistance to abortion provision from freestanding clinics. Relatedly, the ways that abortion clinic nurses perceived and managed anti-abortionism by nurses and others need to be brought to light. I take up these considerations in Chapter Three.

This review of dominant historiographical narratives in abortion, women’s health, and nursing reveals that nurses’ perspectives of, experiences with, and contributions to abortion services are neither well documented nor fully understood. Yet many of the investigations reviewed here also indicate that there *are* significant histories of abortion-and-nursing that have yet to be uncovered, explored, and analyzed. In this absence, there remain nursing-shaped gaps in current understandings of abortion, women’s health, and nursing history. Bringing to light and interpreting nurses’ abortion histories as I do here, I suggest, contributes to deepening and

attempted to withhold medical insurance payment for ‘non-therapeutic’ abortions; and Prime Minister Brian Mulroney campaigned for legal abortion restrictions.

¹⁷⁷ Ackerman, “Not in the Atlantic”.

¹⁷⁸ Saurette and Gordon, “Changing Voice”.

nuancing understandings within those three domains of knowledge. In the following section, I discuss the ways that I have taken on this research in order to do so.

Methods, Methodology, Theoretical Underpinnings

Oral History and Archival Research

This investigation primarily comprises an oral history project supported by the tools of social and cultural history.¹⁷⁹ I endeavor to hear, value, and include the stories and actual words of the nurses who participated in abortion provision in freestanding clinics before and after decriminalization. As direct eyewitnesses of and active participants in the development of abortion nursing, through their stories these nurses offer unique insight into the history of this under-studied nursing specialty.¹⁸⁰ Through oral history analysis, I examine the history of abortion nursing “from below” with the aim of locating nurses and their ‘bedside’ nursing

¹⁷⁹ For key works in oral history, *see* Abrams, “Oral History”; Bornat and Diamon, “Women’s”; Gluck, “What’s So Special”; Gluck and Patai, “Women’s Words”; Grele, “Envelopes”; Perks and Thomson, “Oral History Reader”; Portelli, “What Makes”; Sangster, “Telling”. For more on social and cultural history, *see* Burke, “What is Cultural”; Hopkin, “The Ecotype” or Stearns, “Social History”. For a cultural history study in nursing *see* “Bates, A Cultural History”. For more on the use of historical frameworks in nursing history research, *see* Buck, “Using Frameworks”.

¹⁸⁰ Other scholars of Canadian nursing history have identified oral history as a useful methodology for capturing and interpreting nurses’ histories. *See*, for example, Boschma, “Accommodation”; Boschma, “Conducting Oral History”; Flynn, “Moving Beyond”; Ronquillo, et al., “Beyond Greener”; Vanderspank, “Social Construction”.

practice within the broader structures and events of abortion history and the profession at large. This approach can be understood in contrast to a more ‘top-down’ inquiry that might focus on abortion primarily in the context of nursing leadership, professional policy making, and education rather than on nurses’ hands-on clinical practice ‘on the shop floor,’ if you will.¹⁸¹ I additionally consulted archival sources such as newspaper and magazine articles, professional nursing literature, hospital and abortion clinic records, niche newsletters, and secondary accounts of this history.¹⁸²

Oral History Participants

Participant recruitment was initially facilitated by my general openness about the project. I began to share my research plans and my previous discoveries about nurses and their abortion history in classes and at academic conferences. This visibility generated interest. Each time I spoke about the project, nurses invariably approached me. Many of those women were content to share a few thoughts and stories briefly and informally. However, through one of them I was able to connect further with several nurses from the freestanding abortion clinics in Vancouver. Some of those nurses in turn connected me with nurses from Ontario. Through this snowball sampling

¹⁸¹ This is not to suggest that abortion clinic nurses or indeed Registered Nurses in general occupied *the* bottom rung of social or professional hierarchies at this time or that they were powerless in their positioning. Indeed, the following analysis reveals that abortion clinic nurses occupied very powerful positions in the freestanding clinics in some contexts. I do suggest, however, that in the context of nursing, abortion nurses have been marginalized as practitioners and gone overlooked as subjects of historical inquiry.

¹⁸² For a list of archival collections consulted, *see* the Bibliography of this dissertation.

technique,¹⁸³ I was able to recruit eight practicing and retired Registered Nurses (six from British Columbia and two from Ontario) to participate in one-on-one oral history interviews. Although a few other nurses had declined to participate in the study after an initial conversation, no one who agreed to the interview revoked consent or dropped out prematurely.

This was a heterogenous group of women who shared the general experience of providing hands-on care to women at freestanding abortion clinics in the late 1980s and 1990s. They worked at the Morgentaler clinics in Toronto and Ottawa and at the Everywoman's and Elizabeth Bagshaw clinics in Vancouver after decriminalization in 1988. Before working at abortion clinics, each nurse had practiced in one or more large urban hospitals in various fields, including in hospital-based abortion services, gynecology, transplant services, pediatric emergency, and general medicine. Two had worked in public health birth control clinics (one in Toronto and one in Vancouver). Half of the nurses had begun their nursing education and careers in the mid- to late-1960s (three of those nurses were retired at the time of the interview) while the others were educated and had begun practicing in the late-1970s to mid-1980s. The nurses were variably educated largely in keeping with the shifting trends and requirements in nursing education at the time of their training. Three held diplomas, four held baccalaureate degrees, and one held a baccalaureate and a master's degree. A few nurses mentioned that they trained at Catholic-affiliated institutions but did not emphasize this fact. Three nurses self-identified as feminists while two explicitly characterized themselves as 'not feminists.' In terms of other personal details, some nurses talked about their general upbringing, current families, and sexual

¹⁸³ Polit and Beck, "Nursing Research".

orientation. None of the nurses discussed their ethnic identities.¹⁸⁴ Readers will encounter these nurses in all chapters of this dissertation. Further biographical details are provided the Appendix.

With these participants I conducted semi-structured oral history interviews.¹⁸⁵ Only then could I analyze some new first-person narratives in conjunction with a range of other source material. Each interview lasted between one and a half and three hours. With consent, all were recorded digitally and transcribed thereafter.¹⁸⁶ The overall experience with this group was telling. In Vancouver, I had tea at nurses' kitchen tables while we talked. I pored over one nurse's photographs, nursing textbooks, and 'feminist tomes' (as she put it) on her living room floor. Another nurse met me at the university, while another invited me to talk in the break room at a public health clinic before her shift. One nurse spontaneously took me on an after-hours tour of an abortion clinic. Finally, two nurses from Ontario each talked with me on the phone for a few hours each. Throughout all of these conversations, the nurses appeared to speak forthrightly. They shared stories that were by turns familiar, surprising, shocking, funny, frightening, and

¹⁸⁴ It is difficult to say more about these or other nurses' personal identities beyond their professional ones. The oral history interviews I conducted were primarily centered around nursing and the practice of it. I also found very little information about the identities of or general demographic information about Registered Nurses in the 1980s and 1990s. Kathryn McPherson made some mention of a "greater ethnic diversification and identification" for Canadian nurses around that time in "Bedside Matters": 258. Yet, I was not able to consult any compiled information to draw these identities forward.

¹⁸⁵ For practical oral history research techniques, *see* Yow, "Recording Oral History".

¹⁸⁶ Quotations throughout this manuscript have been edited for clarity.

deeply moving, which I in turn share throughout this dissertation. Only twice did I “turn off the tape” at nurses’ request to keep particular details private. Overall, these nurses were generous with their homes, their time, and their stories.

Nurses in the Archives

In order to capture more experiences and perspectives of nurses, particularly of those who had worked in illegal freestanding clinics prior to 1988, I turned to the archival documents and secondary sources noted above. The names of two nurses in particular recurred in this material: Joanne Cornax and Lynne Crocker. These women were head nurses of the Montreal and Winnipeg Morgentaler clinics, respectively.¹⁸⁷ They helped manage the administrative organization of the clinics and provided hands-on care to women as well. Other named clinic nurses embedded in these sources included Lynn Hilliard and Barbara Burr from the Winnipeg clinic. Readers will learn more about these and other nurses from illegal clinics primarily in Chapter One. Further details about them are also included in the Appendix.

From the archives I also found evidence and testimony from nurses who held anti-abortion views and engaged in anti-abortion activism in and around freestanding abortion clinics. Four non-practicing nurses were particularly prominent here, namely sisters Rita and Helen Burnie, Ita Venner, and Cecelia Von Dehn. Their activities were well reported in mainstream newspapers such as *The Globe and Mail* and niche publications such as *The Interim*, a nation-wide anti-abortion newsletter. The Burnie sisters and Ita Venner also featured prominently in the book *Silhouettes Against the Snow*, a volume of short biographies celebrating the lives and activities

¹⁸⁷ Dunphy, “Morgentaler”.

of anti-abortion activists published under the Interim umbrella organization in 1991. All of these nurses protested the freestanding abortion clinics among other anti-abortion activities. Readers encounter these and other nurses who held anti-abortion beliefs in Chapter Three of this dissertation. Further details about them can be found in the Appendix.

Taking all of these sources into account, I bring together multiple layers of unique ‘data’ by way of the articulated and reported experiences and perspectives of individual abortion nurses (i.e., the people *who were there*) with some of the broader contextual social and cultural developments that informed and were informed by their work. These sources, especially nurses’ oral histories, are key to this analysis, as they join individual experiences, invite more questions, and have helped me construct an interpretation or understanding of nurses’ experiences and their collective engagement with broader contextual considerations.

Critical Feminist Inquiry

This research is informed by an overarching critical feminist perspective. Similarly focused on ‘ordinary’ people, researchers guided by critical inquiry are interested in the connections between the lives of often-disadvantaged or marginalized individuals and groups and the larger structures or institutions that affect and are affected by them.¹⁸⁸ More specifically, historians who draw from a critical perspective aim to enlighten (or shed light on) factors that have facilitated

¹⁸⁸ Bronner, “Critical Theory”; Gluck and Patai, “Women’s Words”; Sangster, “Telling Our Stories”.

and reinforced power imbalances for social actors.¹⁸⁹ The categories of race, class, and gender have long been dominant avenues of inquiry for critical investigators.¹⁹⁰

In this analysis of a particular historical and professional context, the dynamic social constructions of gender for women, both as practitioners and as patients, are particularly relevant. As such, I consider how ongoing shifting constructions and embodiment of ‘woman’ have been connected to and played out in the profession of nursing, the nature of nursing practice (and nurses’ abortion practice in particular), the meaning of abortion, and ideological and material approaches to women’s health. I take up abortion nurses as a category of women-professionals who were located (and have sometimes, but not always, been constructed as disadvantaged) within a hierarchical health care system dominated by men and men’s work (i.e., medicine).¹⁹¹ More specifically, they practiced in a unique field of women’s health, which has been highly contested, stigmatized, and marginalizing for both practitioners and women seeking and undergoing abortion.¹⁹² From a critical feminist perspective, then, I examine these conditions as I uncover and lay bare the un(der)analyzed and un(der)reported professional experiences of nurses who worked in abortion clinics. Oral history methods prove key to the facilitation of this

¹⁸⁹ Ibid.

¹⁹⁰ Scott, “Gender”.

¹⁹¹ Davies, “Gender”; McPherson, “Bedside Matters”; McDonald, “Issues”. for example.

¹⁹² Chiappetta-Swanson, “Dignity”; Bolton, “Women’s Work”.

process, especially in the construction and elevation (or bringing-to-light) of nurses' accounts of and reflections on their experiences with women as women.¹⁹³

Conceptualizing Abortion Provision as a Technological System

A technological systems approach emerges as useful interpretive framework for this project.¹⁹⁴ Rooted in the academic field of *Science and Technology Studies* [STS], this framework guides me in marrying the material and immaterial aspects of abortion provision (i.e., the technical with the social), and positing that they are necessarily interwoven.¹⁹⁵ Conceptualized as a technological system, abortion provision functions as a web of intersecting and entangled factors (or threads) that inform and are informed by each other. For a few examples, the threads in this study include individual and groups of social actors such as nurses, physicians, activists, and women seeking abortions along with the ranging values and professional and political commitments that they held and acted upon. Other threads include the material aspects of abortion provision, such as women's and nurses' bodies, nurses' hands-on clinical work, medical equipment, and the clinic buildings themselves. Overarching social structures, such as abortion

¹⁹³ For more on oral history-making as a feminist practice, see Geiger, "What's so Feminist". For more on feminist history, see Bennett, "History Matters" or Morgan "Feminist History".

¹⁹⁴ Please note that the purpose of this research is not to study fully *the* science and technology of abortion provision or even of abortion nursing specifically but rather to employ the technological systems framework as a tool to help interpret and explain some aspects of nurses' historical abortion work more generally.

¹⁹⁵ The relatively new interdisciplinary field of STS is varied and vast. For some reviews of the field, see Bijker, et al., "Social Construction"; Hackett et al., "Handbook"; Hess et al., "Science".

legislation, professional hierarchies, and shifting perspectives on the meaning of abortion, nursing, and ‘women’s health’ make up still others.

This technological systems framework of interwoven threads, or this conceptualization of abortion provision as an intricate web, allows me to visualize and acknowledge the fuller complexity of abortion provision, which one study, or indeed one framework, could never fully capture. Adding the viewpoint of abortion as a technological system helps me to also frame the development of nurses’ abortion work as an interconnected network or system of state regulation, shifting theoretical and practical approaches to health, and as shaped by the dynamics of abortion activism, which includes pro-choice and anti-abortion activism. In the following chapters, I consider the actual work of nurses in the contexts of some of abortion’s broader (and indeed, power-laden and at times gendered) overarching sociocultural or socio-technological structures.

Chapter Outlines

The structure of this dissertation is both thematic and chronological from the mid-1960s to the 1990s. Specifically, I provide three substantive chapters that offer an analysis of both the hands-on work of nurses and their perspectives of it. In Chapter One, I attend to nurses’ experiences and perspectives of the state’s regulation of abortion and nursing work in hospitals, community settings, and freestanding abortion clinics between approximately 1965 and 1988. In Chapter Two, I contextualize nurses’ experiences and perspectives of the clinical and professional negotiations of their abortion work in legal freestanding clinics after 1988. And in Chapter Three, I focus on the cultural dynamics around abortion provision and nurses’ work in defending

freestanding clinics amid intensifying anti-abortion activism before and after decriminalization. Overall, this analysis of nurses' abortion work reveals that, individually and collectively, nurses *were there*, were actively present with, and bore witness to a wide range of women's illegal and legal abortion experiences. It demonstrates that some nurses subsequently came to particular understanding of abortion provision and that they created and negotiated their hands-on abortion work accordingly. Readers will see in general that these nurses developed the field of abortion nursing at complex intersections of the political, professional, and cultural aspects of abortion provision. Ultimately, I conclude that nurses took on this work and negotiated it amongst several challenges with the essential goal of, as one abortion clinic nurse put it, "help[ing] women have safe abortions."¹⁹⁶

In the following section, I outline the chapters more specifically. In Chapter One, "nurses abortion work and state regulation before 1988," I examine the state's regulation of abortion and nursing work between the mid-1960s and 1988. I thus attend to the criminalized and liberalized eras of abortion legislation. Drawing from the oral histories of nurses who worked in hospitals, public health birth control clinics, and illegal freestanding abortion clinics, and supplementing these accounts with hospital records and newspaper reports, I provide an analysis of the state's intrusion into and influence on nurses' abortion work in these contexts. The chapter is divided into three major sections comprising the early roots of nurses' abortion work in the pre-1969 era from about 1965; nurses' in-hospital abortion work inside the TAC system after 1969; and nurses' ongoing work in illegal freestanding abortion clinics from the late 1960s to 1988. Interpreting these sections together, I suggest that nurses were intimately involved with a range

¹⁹⁶ Lisa E [Lisa E]. 1286. Interview by author, December 2015.

of women's legal and illegal abortion experiences. They subsequently articulated a deep understanding of the state's ongoing regulation of abortion, in particular its constraining influence on nursing practice often to the detriment of women's health.

Going further, I argue that it was these experiences and understandings that drove many nurses to help develop legal and illegal abortion services and to help women navigate them as best they could. Furthermore, nurses both reinforced and disrupted some longstanding professional hierarchies in order to meet the challenges posed by state regulation. In some ways, this chapter shows, nurses acted both as clinical and political actors while doing so. Ultimately, I conclude that these abortion nurses continually demonstrated their fundamental commitment to promoting women's safety throughout this long and strictly regulated era. Abortion nurses, in fact, proved willing to remain with women and to help manage their shared obstacles in a range of challenging circumstances.

Whereas in the previous chapter I examine legislative control over abortion provision and nursing practice, in Chapter Two, "negotiating abortion nursing amid the critique of medicalization," I switch focus to the clinical challenges of providing abortions following decriminalization in 1988. The primary sites of study here are the Morgentaler clinics in Toronto and Ottawa and the independent-from-Morgentaler abortion clinics in Vancouver. Through oral history interviews, newspaper reports, abortion clinic records, and key secondary sources, I examine the development and operation of freestanding abortion clinics and the services provided there at a time when a group of new social actors—namely non-nurse and self-identified feminist women—began to more fully participate in founding or otherwise working in

freestanding clinics. This chapter traces the actual work that nurses did with women before, during, and after their abortion procedures and the ways that nurses negotiated that work with their new and familiar colleagues.

Here I argue that while they were developing and refining their hands-on abortion practices, abortion clinic nurses continued to grapple with long-standing professional questions about the nature of nursing and their commensurate approaches to women's health. In particular, they reflected on their biomedical expertise and their long-standing experience in promoting women's emotional or social safety in many fields of nursing practice. As abortion clinic nurses, I suggest, they considered these elements in parallel with an emerging feminist critique of the ongoing medicalization of abortion provision. In that context, I explore clinic nurses' ongoing ambivalence toward medicalization, their alignment with the medical establishment (both in theory and practice), and their professional separation from it. Overall, I highlight the ways that abortion clinic nurses endeavoured to balance potentially medicalizing practices with women's control over and self-determination around their own abortion experiences. In some ways, then, abortion clinic nurses demonstrated that they aspired to engage with abortion provision as both a medical and social phenomenon in order to achieve their overarching aim of keeping women safe in the clinics.

The third chapter, "abortion nursing in freestanding clinics amid anti-abortion activism," attends to the ways that abortion clinic nurses encountered and managed growing cultural resistance to their work in the lead up to decriminalization and in its aftermath. My analysis of oral history interviews, newspaper and magazine reports, professional and lay literature, clinic security logs,

letters to the federal health minister, and other archival material makes it clear that even amid wider social acceptance of abortion and the development of safe services and procedures, abortion clinic nurses encountered immense cultural *intolerance* for their work. Their practice was shaped by heated public debate around the morality of abortion provision and a growing anti-abortion activist movement that was, in part, engendered by wider social acceptance and decriminalization itself.

In this chapter I move forward to explore clinic nurses' experiences with anti-abortionism, including by a contingent of anti-abortionist nurses, and the strategies that they developed in order to construct, adopt, and enacted the identity of 'abortion provider' so that they could do their abortion work appropriately within a chaotic cultural context and material environment. I put forward that abortion clinic nurses engaged in this kind of work in order to promote the safety of their patients, their colleagues, their families, and themselves.

In the following pages of this dissertation, I invite readers to explore these three chapters that shed light on and offer my analysis of nurses' heretofore unexplored histories in developing Canadian abortion services from the 1960s to the 1990s. I encourage readers to consider the stories of these nurses for how they highlight nurses' experiences with and perspectives of coming to understand and putting into practice what Joan W identified as "what was medically required, the plight of the patient and their conditions, what the doctors expected, and the politics of the issue." I ask readers to join me in specifically considering the ways in which nurses encountered and managed ever-shifting attempts at state regulation, the negotiation of professional expertise, women's medical autonomy, and the cultural dynamics of abortion

provision and to recognize the ways that those factors informed and were informed by nursing work. I especially draw attention to abortion nurses' fundamental commitment to promoting women's safety, which was well articulated by Lisa E when she explained: "the primary thing we do is help women have safe abortions."¹⁹⁷ And finally, I hope to facilitate reflection on Joan's claim that of taking up and engaging with these complexities? "Well come on. That's nursing!"

¹⁹⁷ LE 1283.

CHAPTER ONE: Nurses' Abortion Work and State Regulation Before 1988

On July 5, 1983, a woman in Toronto was undergoing an abortion procedure at the freestanding Morgentaler clinic. Little did she know, city police were marching up the stairs to the Operating Room where she lay on the operating table. She was not aware that officers were “raiding” the illegal clinic from top to bottom, that they were looking for evidence of illegal abortion activity, and that they were hoping to round up witnesses (such as herself) and arrest the criminals (such as the nurses and physicians) who were providing abortions there. The job of the police was straightforward given that all abortions performed at freestanding clinics at that time were illegal and that every physician and nurse who worked there was criminally liable. In 1983, all practitioners could face up to life imprisonment for procuring abortion outside of hospitals.¹⁹⁸

According to the report of the raid in *The Globe and Mail*, when Toronto police officers made their way into the clinic, they “grabbed the keys [to the locked Operating Room] from a nurse who was trying to *block the door with her body*.”¹⁹⁹ Once inside, they reportedly “shouted at a nurse to drop a cotton swab she was holding and seized [other medical equipment].” By this time, the woman was dressed but “terrified.” According to her, a nurse had remained by her side throughout the raid except when all of the clinic nurses had been ““asked by the police to pose for pictures,” which “all of them did.” At the end of the raid three nurses with other clinic staff were taken away for questioning. Before they went, a nurse turned to the woman to say, “You’ll

¹⁹⁸ See Criminal Code of Canada, 1892, Sections 271 and 272; 1986, Section 251.

¹⁹⁹ Gadd and Slotnick, “Abortion clinic”: 1 (my emphasis).

be all right.” Of the incident, the woman remarked, “I give the nurses and the counsellor real credit. ... They were with us until the end.”²⁰⁰

In this chapter, I explore nurses’ abortion work in the context of the state’s regulation of it in the 1960s, 1970s and 1980s. The police raid of the Toronto Morgentaler clinic in 1983 described above provides but one clear indication that nurses’ abortion work was affected by the state’s attempt to uphold the abortion law in the lead up to abortion’s decriminalization in 1988.

Evidence also demonstrates that nurses’ abortion practice was informed by and informed abortion’s broader legal context in significant ways throughout the duration of the criminalized era under study here (i.e., from about 1962 to 1969, when abortion was still strictly illegal) and the liberalized era (i.e., from 1969 to 1988, when only some in-hospital abortions were legal).²⁰¹

The stories and reported experiences of nurses within this timeframe indicate that the state directly and indirectly restricted their ability to do abortion-related work in both eras. They emphasize that state control hindered nurses’ ability to support women’s access to safe abortions, and that many nurses demonstrated considerable frustration with these constraints and the attendant harmful outcomes engendered for women. The nurses’ stories that I share highlight some of the ways that they subsequently worked to help women access safe abortion care and to

²⁰⁰ Gadd and Slotnick, “Abortion clinic”; Slotnick, “Woman terrified”.

²⁰¹ I provide a more detailed overview of the abortion law in the Introduction of this dissertation.

For thorough legal analyses of the development of Canadian abortion law, *see* Backhouse, “Involuntary Motherhood”; Backhouse, “Celebrated Trial”; Backhouse, “Physicians” and Gavigan, “Criminal Sanction”.

promote women’s physical, legal, and emotional wellbeing despite restrictive legislation. I particularly highlight the work that nurses did within the in-hospital Therapeutic Abortion Committee (TAC) system and in the establishment and defence of illegal freestanding abortion clinics. In this chapter, then, I consider some of the ways that nurses perceived and navigated the legal restrictions that bound their practices in the lead up to abortion’s full decriminalization.

Bearing Witness to Women’s Illegal Abortion Experiences 1960s-1969

I begin with a brief consideration of nurses’ experiences with abortion in the pre-1969 ‘criminalized’ era. This examination provides a foundation for understanding nurses’ later work in the freestanding abortion clinics. I first examine the ways that nurses navigated abortion work in their ‘off-duty lives’ and then turn my attention to their more official roles as on-duty practitioners in hospitals and physicians’ offices before 1969. I turn now to the “bad old days.”²⁰²

Nurse-Friends and Nurse-Neighbours

Beginning with nurses’ community experiences, newspaper reports indicate that off-duty nurses were sometimes called to monitor women (both friends and neighbours) who were recovering from illegal abortion procedures at home. Evidence suggests that women relied on nurses to assist them when they suffered complications—such as hemorrhage or infection—that required medical attention. *The Globe and Mail* reported two such cases in 1962 and 1964, respectively.²⁰³ In the former case, a twenty-two-year-old woman elected to recover from her illegal abortion at the house of her friend, a nurse. And in the latter case, neighbours (seemingly

²⁰² LE 83.

²⁰³ “MDs not available”: 23; “Tried miscarriage”: 5.

strangers) called on a nurse living nearby to see to a woman who had attempted her own abortion by “drinking 13 ounces of gin and swallowing quinine tablets while sitting in a hot mustard bath.”²⁰⁴ In both cases, the nurse-in-attendance determined that, indeed, these women required medical attention: the first woman’s temperature was rising dangerously (pointing toward infection) and the other woman had lost consciousness in the bathtub.

The reports of the subsequent actions by these two nurses and their inability to fully respond as practitioners were similar. As they were trained and presumably accustomed to doing given the hospital-focused structure of healthcare at that time,²⁰⁵ the nurses attempted to engage physician colleagues to assist. Yet despite the nurses’ repeated calls, the requested help was not forthcoming. Over the two cases, three physicians refused to appear outright, one hospital failed to dispatch an ambulance, citing “no permission from the doctor”²⁰⁶ to do so, and one ambulance arrived to help only after an hour’s delay. Tellingly, one physician who agreed to see the woman at the nurses’ house conducted a decidedly non-abortion-related assessment. He reportedly declined to examine the woman’s abdomen, determined she had pneumonia, and administered a dose of penicillin. He recommended neither further at-home treatment nor hospital consultation. Yet the pathologist who later reviewed this case learned that the woman “had been five months pregnant and her womb had been infected.”²⁰⁷ Significantly, both women in these examples died.

²⁰⁴ “Tried miscarriage”: 5.

²⁰⁵ The majority of the nursing workforce was employed in the hospital system by the 1960s. *See* McPherson, “Bedside Matters” or McPherson and Stuart, “Writing Nursing History”.

²⁰⁶ “MDs not available”: 23.

²⁰⁷ *Ibid.*

The first woman, misdiagnosed with pneumonia, perished of septic infection 45 minutes after her arrival to the hospital. The second woman, whose ambulance had been delayed, succumbed to “extensive burns over 30 per cent of her body”²⁰⁸ eight minutes after reaching the hospital doors.

As practitioners, the two nurses in these cases demonstrated that they understood the need for further medical help. It is likely that they also knew that abortion provision was a criminal act and that they could be implicated and punished for it.²⁰⁹ However, in an apparent effort to help keep these women medically safe in a tenuous legal situation, they risked calling for outside help. Their options proved limited seemingly because physicians wished to avoid implication in illegal abortion provision. Witnesses in the second woman’s case testified as much at the Coroner’s Inquest. And moreover, one physician affirmed that physicians “didn’t want to get involved themselves [... and that] the best procedure in such [a] case [i.e., one of grave medical danger] was to call the police [instead].”²¹⁰ The wariness of physicians to participate in abortion-related activities was embedded in a socio-legal context wherein some physicians were experiencing punishment related to abortion. Indeed, multiple physicians had (and would) face

²⁰⁸ “Tried miscarriage”: 5.

²⁰⁹ Remember that in “Illegal,” McLaren noted that some nurses in older cases had been charged and convicted with abortion-related crimes. Whether cases from earlier periods were widely known by nurses is unclear. Note that nurses were given warnings via *Canadian Nurse* in the 1950s and 1960s to not get involved in abortion given the legal risk. See Haney, “Nursing Identity”; Haney, “Legitimate Nursing”.

²¹⁰ “Tried miscarriage”: 5.

the law and the subsequent professional and personal consequences for their abortion work.²¹¹

Though some nurses in their communities attended to and tried to promote women's safety after their criminal abortions, this evidence suggests that they were thwarted by a medical system in which all practitioners were constrained by broader legal elements.

Though some nurses' would-be actions were limited by the law, they nevertheless demonstrated a willingness to engage in the work of being present for women, bearing witness to their difficult abortion experiences and attempting to provide care. These nurses were permitted and requested by strangers and friends to be with and to attend to women during the private, frightening, painful, and medically risky moments of their criminal abortions. It could be that nurses were asked and permitted to do so owing in part to their identities as nurses. That is, perhaps women demonstrated an expectation that they could rely on even off duty nurses to function as practitioners who could and would monitor them and act appropriately if things went wrong. Arguably, they anticipated that nurses possessed relevant and potentially necessary skills and knowledge that were gained through their clinical training and experience. For, although nurses were friends, neighbours, and strangers in their communities, it is clear that women called upon them for help with abortions as *nurse*-friends, *nurse*-neighbours, and *nurse*-strangers. I suggest that in their willingness to enact the work of being present with and bearing witness to women's criminal abortion experiences, some nurses seemed to resist the state's regulation of that work. Although the extent to which nurses participated or declined to participate in illegal abortion work in their communities in the mid-1960s is unknown, these two cases point to at least a few nurses' participation in acting in contravention to the criminalized system.

²¹¹ See the cases of Smoling and McCallum as described in the Introduction of this dissertation.

Hospital Nurses

Nurses' stories and reported experiences of working in hospitals in abortion's criminalized era help to illuminate another layer of their clinical experience and concomitant understanding of criminal abortion, which, I suggest, they gained and deepened by taking up the work of being present with and bearing witness to women's abortion experiences there. When women (finally) arrived at hospitals seeking life-saving treatment following their unsafe procedures,²¹² nurses were permitted and expected to attend to them as 'patients' officially. In doing so, I offer, they continued to develop particular understandings of abortion, the state's regulation of it, and the close-up and overarching implications for women and nurses. In particular, some nurses articulated that they found their ability to help keep women safe—even in the legal hospital context—was constrained. Moreover, they expressed considerable fear, frustration, and distress as a result.

In one example, Joan W shared some of her enduring memories of her mid-1960s experiences with hospitalized women following criminal abortions. She remembered:

We had this little 4-bed area [on the general hospital ward], and there would be blood and *heaven knows what else* all over the place. [...]. I do remember this, and this has lived with me as a

²¹² According to Dunn and colleagues, "in 1966, more than 45,0000 women were hospitalized after having tried to terminate a pregnancy, making it the primary cause of hospitalization for Canadian women that year." See Canadians for Choice and Fédération du Québec pour le planning des naissances, 2010: 12. In their report, they cite Desmarais, 1999, "Memoires".

memory [since 1964]. This beautiful woman. A strawberry blonde. A big lady, full bodied, tanned with lots of freckles and healthy as anything – dead on a stretcher from a criminal abortion. And I remember another one where they admitted her to the four-bed room, and she just absolutely had these thin arms all entwined around this metal bed frame and an IV running.²¹³

Recounting these vivid memories more than fifty years later, Joan W shared her pervasive sense of fear for these women at the time, concluding with emotion, “I was *terrified* they were all going to die.”²¹⁴

In addition to oral histories, articles published in the flagship professional journal for Canadian nurses (*Canadian Nurse*) and retrospective accounts in city newspapers further revealed nurses’ in-hospital experiences of criminal abortion at that time. They particularly exposed the traumatic aftermath of criminal abortions, which, when complicated by infection or sepsis, were often fatal. Like Joan W’s memory, these articles highlight nurses’ intimate presence with women. Three articles in particular offer a deeper glimpse into the specifics of women’s embodied experiences of criminal abortion in the context of nursing practice.²¹⁵ In a 1965 article in

²¹³ JW 156–170.

²¹⁴ JW 70.

²¹⁵ Hollobon, “MD urges”; Maki and Perlmutter, “Nursing Care”; Roulston, “Causes”. Note that I examined and analyzed the language of Roulston and Maki and Perlmutter in my study of

Canadian Nurse, for example, Winnipeg gynecologist Thomas M. Roulston (who later became an outspoken advocate for specialized legal abortion clinics)²¹⁶ described the clinical situation for nurse-readers:

These [septic or infected] abortions are almost always criminally induced by the passage of unsterile instruments or introduction of fluids or foreign bodies into the uterus. The products of conception become infected and the process spreads. The patient often arrives [at the hospital] as an emergency with a high fever, chills, vaginal bleeding and evidence of lower abdominal peritonitis.²¹⁷

Winnipeg gynecology nurses M. Maki and F. Perlmutter added in a companion article that the hospital nurse thus commonly encountered and attended to women who exhibited diaphoresis (excessive sweating), rigors (severe shaking), delirium, decreased level or loss of consciousness, haemorrhage (blood loss), “foul vaginal discharge,” and sometimes had passed the “macerated fetus” (which the nurse then managed).²¹⁸ Roulston emphasized the often inevitable and hopeless

abortion discourse in nursing literature in Haney, “Nursing Identity” and Haney, “Legitimate Nursing”.

²¹⁶ Hollobon, “MD urges”.

²¹⁷ Roulston, “Causes”: 810.

²¹⁸ Maki and Perlmutter, “Nursing Care”: 812.

prognosis for these women, warning nurse-readers that: “such patients are in grave danger” and “indeed, most of the deaths that now occur in pregnancy result from septic abortion.”²¹⁹

One other nurse’s first-person account illustrates the complex situation that hospital nurses faced. In 1991, Joan Hollobon shared her memories of criminal abortion with the *Edmonton Journal* in remarkable detail. ““We moved her from the stretcher to the bed,” the nurse remembered. “Her hair was unkempt, and her legs were bloody. Her abdomen was hot and hard.”” In caring for her, Hollobon bathed the woman and continued to witness the visceral effects of the illegal abortion on her body. She found that her patient was ““bruised as if she had been held down. Her thighs were bruised, and one shoulder was bruised.”” Echoing Joan W’s fears and astute grasp of the situation, this nurse also remembered, ““I understood from the beginning that she would probably die.”” The appropriate nursing action or practice, she decided, was to support the woman by remaining present with her and bearing witness to her death both in the hospital and later when she testified to what she witnessed in this public newspaper. She seemingly valued that action as one she could offer in her capacity as a hospital nurse, enacting it as a critical professional goal to promote the woman’s wellbeing even in her dying. She concluded: ““I stayed with her the whole time and *shared her dying* with her.””²²⁰ In other words, she, like the nurse at the Toronto raid and Joan W in the hospital setting, was with her patient until the end.

These stories and reports point to a unique location from which nurses were permitted to be present with women experiencing criminal abortions: namely, hospitals and communities. They

²¹⁹ Ibid: 810.

²²⁰ Moysa, “Horror,”: E3 (my emphasis on sharing).

revealed the additional clinical elements that on-duty nurses encountered there with women, and they emphasized presence and bearing witness as work that nurses perceived to be supportive of women who journeyed toward recovery or who faced their final moments. It is clear that nurses-as-such were afforded the opportunity to gain not only increasingly intimate familiarity with women's criminal abortion experiences—both through direct experience and professional literature—but also to come to deep understandings of criminal abortion and nurses' related roles and abilities with it. Specifically, a sense of fear, inevitability, and helplessness emerged from this picture of nurses' negotiation of in-hospital abortion work under state regulation. Yet, that perspective was somewhat tempered by some nurses' commitment to supporting women by being with them in meaningful ways.

Nurses at the End of the (Telephone) Line

At the end of the criminalized era, I found that physicians' offices—or at least Henry Morgentaler's office—comprised one other location that permitted and called for nurses' presence with women seeking abortions. This story begins in 1967 at Morgentaler's Montreal general practice office with the deceptively simple nursing task of answering the telephone. At this time, it was 'head nurse' Joanne Cornax who was responsible for answering the phone and scheduling patients for appointments. Notably, only general medical services were offered by Cornax and Morgentaler then. They typically provided treatment for common conditions (presumably such as coughs, colds, minor injuries, or stable chronic illnesses).²²¹ In early 1967, Henry Morgentaler and Joanne Cornax did not provide abortions. Why, then, were women calling the office requesting them?

²²¹ For more on Joanne Cornax, see Appendix.

In the years leading up to 1969, many medical practitioners—including Morgentaler—had been lobbying the federal government to relax the criminal abortion law.²²² Morgentaler proved a prominent advocate for abortion’s legal liberalization when, in 1967, he appeared before the federal Health and Welfare Committee, which was charged with re(evaluating) the criminal abortion law. Morgentaler proposed that women in the first trimester of pregnancy (i.e., approximately until the end of the twelfth week after conception) ought to be able to obtain legal abortions at their own discretion. Furthermore, he put forward that a woman’s ability to do so ought to be protected under the *Criminal Code of Canada*, “not as a privilege, but as a right.”²²³ Significantly, he did not appear as a representative of the Canadian Medical Association, but rather on behalf of the political group the Humanist Fellowship of Montreal. In 1967, Morgentaler’s primary interest in abortion law was not practice-focused or physician-centered. Rather, it was political and in the context of human rights.

However, when Morgentaler’s political call to liberalize the abortion law was subsequently reported in Canada’s major print and television media,²²⁴ politics and practice collided for him and Cornax. Women from across the country began to call the office seeking abortions. They well knew that abortion was illegal and medically risky.²²⁵ Respected physicians had been

²²² See Introduction of this dissertation for more detail.

²²³ Beirne, “Rough and Risky”: 38.

²²⁴ See, for example, Stevens, “Humanists”.

²²⁵ Some examples of women’s pre-1969 abortion experiences can be found in primary source materials such as Badgley et al., “Operation” (especially the section “Illegal Abortion Before

arrested, charged, and convicted for abortion crimes, and were no longer providing the procedure.²²⁶ Canadian women seeking abortions in the late 1960s recognized that they faced few to no options in their pursuit of safe abortion—except, they perhaps reasoned, in this one outspoken, abortion-supportive physician in Montreal.²²⁷ With that hope in mind and in this climate of secrecy and legal risk, women made the time and found the privacy to dial Morgentaler’s office in Montreal. They picked up the telephone looking for a legitimate practitioner who was able and willing to provide them with clean, safe, and respectful procedures. On the end of that telephone line was the office nurse, Joanne Cornax.

Acting in this capacity, it was Joanne Cornax who, according to Morgentaler biographer, Catherine Dunphy, first “fielded all the calls from frightened, weeping women pleading for abortions.”²²⁸ Call after call, women from across Canada told their stories to Cornax—and she bore witness to those stories. They tried to convince her that they needed abortions, and that they needed Morgentaler to do them. But, as Dunphy reported, the physician would “not break the law. He [had been] speaking theoretically; he had been talking policy only.”²²⁹ In short, Morgentaler would not do their abortions. As he stood fast in his decision, nurse Cornax

1969”: 180–186 and “Personal Experiences”: 77–203). *See also* Childbirth by Choice Trust, “No Choice”.

²²⁶ For example, Smoling and McCallum’s cases as described in the Introduction of this dissertation.

²²⁷ Badgley et al., “Operation”.

²²⁸ Dunphy, “Morgentaler”: 83.

²²⁹ *Ibid.*: 65.

eventually “stopped putting [women’s] calls through”²³⁰ to him altogether, thus taking over the task by herself. For a time, then, Cornax became both the first and final person on the office telephone to whom many women confessed their conditions and expressed their abortion needs. Cornax was the practitioner who was ‘present’ to hear them.

Absent from Dunphy’s biography, the details of the phone calls to Cornax remain unknown. Many relevant-to-nursing questions about them thus go unanswered. These include: Who were those women? What stories did they tell the nurse? What needs and experiences did they highlight? How did they sound? Readers are left wondering about the details that women generally perceived as appropriate or necessary to tell a nurse when looking for an illegal abortion at the time, and why they perceived them to be so. On the flip side, many questions about Cornax’s perspective also remain. What was her attitude toward these women? What, if any, advice did she give them? Perhaps more poignantly, I wonder, how did she end those conversations? It remains unclear how Cornax perceived herself as a nurse and interacted with women on the phone as such.

Although the details remain lost, this slice of Cornax’s story offers a glimpse into her early abortion work: she answered the telephone, she heard women’s stories, and was obligated to turn them away. In some ways, then, Cornax functioned as she was expected to under state regulation. In turning women away, she helped to reinforce the criminalized system of abortion provision. Yet she also provided a professional presence for the women across Canada who shared their criminal abortion experiences with her and implored her to assist them in obtaining

²³⁰ Ibid: 83.

safe medical treatment. In the criminalized era, as a nurse working with an out-spoken, abortion-supportive physician who nevertheless did not do abortions, Joanne Cornax occupied a unique role in which she was present with women, bore witness to, and came to an understanding of criminal abortion and its implications for women and nurses. She was, after all, the nurse at the end of the telephone line.

The Decision to Move Forward

Bearing witness to women's stories and traumas in the community, in the hospital, and, in Cornax's case, on the office telephone was not easy or simple work for nurses. It appeared to be emotional, exhausting, and, with few options available to them, frustrating for nurses who would or could not break the law. The work of being present and bearing witness, I suggest, informed nurses' broader understandings of criminal abortion and, in some cases, drove them to move forward with developing abortion services further. Joan W, the nurse who remembered that she had been terrified that all of the women in the hospital were going to die, for example, went on to have a long career in abortion services, which is explored throughout this dissertation. She practiced in hospitals, public health clinics, and a (legal) freestanding abortion clinic. She explicitly articulated that the roots of this long career took hold in those early experiences, telling me emphatically:

Those were the early years that really did it for me. I could see it all around me and I just knew that it wasn't right. So that's, I think, what got me into it [abortion work] in the first place.²³¹

²³¹ JW 185–188.

Meanwhile, at Morgentaler's general medical practice in Montreal, the story was similar for Joanne Cornax. The torrent of phone calls from women seeking abortions overwhelmed both her and the physician until they finally decided to take action and do an abortion. Legend has it that on the January 9, 1968, Morgentaler performed his first abortion for the daughter of a close friend. He was still reluctant to break the law but agreed to do so because he "knew [the patient] by sight and by reputation."²³² She was a student nurse. Cornax explained to Morgentaler's biographer, Eleanor Wright Pelrine, that her assent to take on abortion work both at this time and going forward arose from her early experiences of listening to women on the telephone. Cornax noted that witnessing and understanding women's stories outstripped even her religious beliefs against abortion. She explained:

It was against everything that I was taught. I was brought up strictly Roman Catholic, and abortion was a very bad word. But after listening to so many personal stories and talking with so many women who used birth control that failed, (I changed). People wanted to get help, and they couldn't get it anywhere [else].²³³

Joanne Cornax and Henry Morgentaler began to provide illegal abortions in the office—a practice that they would quickly develop into the first freestanding Morgentaler clinic, which I will

²³² Dunphy, "Morgentaler": 81.

²³³ Pelrine, "Morgentaler": 31.

explore in a later section.²³⁴ Bearing witness to women’s illegal abortion experiences emerges, then, as a fundamental, motivational, and foundational aspect of both Joan W’s and Joanne Cornax’s future abortion work. Given that this work ultimately grew into developing and providing actual clinical abortion services more consistently after 1969, some nurses, indeed, proved willing to move forward. They became ready to put those ‘bad old days’²³⁵ of criminalized abortion behind them.

Nurses’ Work in Legal Abortion Services After 1969

Following the lobbying efforts of physicians and others, the criminal abortion law was amended in 1969 to allow for some legal protection for in-hospital abortion-providing physicians (and, by

²³⁴ Notably, nurse JW remembered that physicians who witnessed the impact of criminal abortion for women were similarly motivated. She remembered, “All the older doctors were the ones who were good supporters of the abortion issue. Because they watched too many women die. So that was an easy one to figure out. Boy! Was that ever true!”: JW 374–379. Morgentaler and other physicians also articulated this perspective themselves. Morgentaler said, “There was a news clipping at the time which helped me make up my mind. A woman died because her boyfriend injected air into her uterus with a pump to try and abort, and air got into the bloodstream. She would have been alive if she had come to me. And the woman who lived in agony after pouring Drano into her vagina in a desperate attempt at abortion. This wouldn’t have happened if she had come to me. So, I set up my clinic” (*see de Villier, “A Man”*: A8). Physician William McCallum tells a strikingly similar story of his own experiences in Ross, “Friendly Abortionist”: 19.

²³⁵ LE 83.

extension, the nurses who worked with them). This legislative shift offered nurses a new opportunity to help develop a legal abortion services by way of a Therapeutic Abortion Committee [TAC] system. Under this system, among other conditions, women could legally obtain an abortion only if a committee of at least three physicians (otherwise known as a Therapeutic Abortion Committee) deemed that the pregnancy threatened her life or health and that the termination was thus medically justified (i.e., that the abortion was ‘therapeutic’). In this section, I examine the abortion work that nurses undertook within and as part the TAC system in their efforts to support women seeking and obtaining safe abortions between 1969 and 1988, that is, amid ongoing yet shifted state regulation and restriction.

Working in the Therapeutic Abortion Committee System

In some cases, nurses strove to protect and improve women’s access to safe abortion by working within the bounds of the official health care system and its new legal structures. Namely, they took up key roles in developing and implementing the TAC system. Here, again, some nurses demonstrated that they were willing to step into and help create the conditions that permitted and called for them to become intimately familiar with women’s experiences of (now) ‘liberalized’ abortion. This work, nurses’ stories and reported experiences showed, continued to inform and (re)shape nurses’ abortion practices, the system in which they worked, and the ways in which they understood and responded to it.²³⁶

²³⁶ For the following sections, I drew from the oral histories of CM, who worked at Vancouver’s Pine Free Clinic (a birth control and family planning clinic) and JW, who worked at both the Bay Centre for Birth Control Clinic and Women’s College Hospital in Toronto. I also consulted

Nurses who did abortion work within the official health care system were fundamental to the development and operation of the TAC initiative. First, in their work in public health clinics and physicians' offices, they took up major roles in completing the initial assessment and referral processes for women. Obtaining approval for an abortion by a hospital TAC required a written referral from a woman's general practitioner, gynaecologist, or public health clinic that indicated that she was pregnant, suggested that the pregnancy threatened her life or health, and recommended that she receive a hospital abortion. This referral, which required a full physical and psychological assessment, was essentially a request that the hospital TAC review the case and authorize the procedure. Some nurses who worked in public health clinics facilitated this process. These nurses interviewed women about their conditions, needs, and plans, and they administered or organized pregnancy tests and other necessary clinical investigations. They also counselled women around their decisions in seeking abortion, and they completed the required paperwork for TAC review.²³⁷ Once satisfied that the woman and her paperwork would likely pass the review process, the public health nurse telephoned the hospital TAC administrator to refer women's cases onward. In some cases, this public health clinic nurse was thus the first link between a woman and a legal abortion.

meeting minutes, correspondence, and reports of the TACs of the Calgary Foothills and General Hospitals.

²³⁷ See CM and JW.

One referring nurse remembered that this process was often difficult. There were a limited number of appointments (i.e., actual abortion procedures) available from hospitals,²³⁸ and the telephone lines to contact them were always flooded. She remembered:

If I wanted to book a patient [for an abortion] in Toronto, I would have to go in [to the public health clinic where I worked] early in the morning because Toronto General only took their phone calls on Monday morning. And the lines weren't open until something like 9:00. And you had your finger on the dial to phone. And you just kept dialing and dialing. And we'd have 3 or 4 of us [nurses] all dialing like crazy, trying to get through for our patients [...]. You see, this is the stuff that nursing does! You would sit there, and you would hold the phone. We'd all sit there and hold the phone and then let go. We each had about 3 or 4 patients and we'd

²³⁸ The number of abortion procedures that the hospital could offer was subject various regulatory and logistical constraints. For example, abortion provision required adequate Operating Room time and staffing levels. Sometimes the requests outnumbered the quotas set forth by hospital administrators (or hospital boards comprised of elected hospital staff and community members. In her 2011 dissertation, "Lonely, Tragic, and Necessary," Beth Palmer explores these administrative restrictions more thoroughly.

try to get them in. They'd only take so many and then you were done and had to wait another week.²³⁹

Joan W and nurses like her were trying to reach the TAC administrators, who were sometimes known as the TAC “nurse counsellor.” These TAC nurse counsellors screened the applications and then made appointments for appropriate candidates to be seen in person.²⁴⁰ Again, it was the TAC nurse counsellor who typically met with the women, interviewed them a second time, and completed additional assessments and documentation (including of physical and social histories) to be reviewed by the 3-physician TAC. Essentially, she functioned as a bridge between the public health nurse, the woman, and the TAC physician(s).

²³⁹ JW 1223–1239. In 1982, newspaper columnist Michele Landsberg in “Women’s group” reported similarly that the “Toronto General[hospital] gets more than 75 calls a day but can book only six OHIP (Ontario Health Insurance Plan) abortions; if you're not lucky in the telephone lottery, you have to wait a week until more appointments are made. Women's College Hospital (...) allows only three OHIP abortions a week in its gynecology clinic, though its very own family planning clinic, the Bay Centre [Birth Control Clinic, where Joan W worked], has to scrounge the city for other hospital beds for 100 abortions a month”: n.p.

²⁴⁰ See, for example, *TAC Meeting Minutes, 1979*. AHSA 2014 01 56 10–10. Medical Advisory Committee TAC Reports, 1976-1979.

If appropriate, the case file was sent to the weekly TAC meeting for review and adjudication.²⁴¹ Notably, women seeking abortions were not seen by the TAC physicians directly. Rather, the TAC primarily relied on other practitioners' documented assessments—including those of public health nurses, TAC nurse counsellors, and other physicians (especially including psychiatrists) in making the decision to authorize an abortion or not. For some TACs, the nurse counsellor regularly joined in these weekly meetings, acting in an administrative role (for example, by taking notes, sending memos, and seeing to other miscellaneous paperwork).²⁴² Nurse counsellors could also take on higher-level roles in the TAC by helping to develop policies, compile statistics and prepare associated reports,²⁴³ and by evaluating and making suggestions

²⁴¹ For an example, see *Nursing Documentation of History and Physical Exam*, which includes the note: "Each patient is interviewed by the nurse counsellor and the notes of the interview [are] placed on the patient's chart," presumably to be reviewed by the TAC (in AHSA 2014 01 56 14-23, Medical Advisory Committee TAC Reports, 1974–1975).

²⁴² *TAC Meeting Minutes*, October 5, 1977 in AHSA 2014 01 56 10–9 Medical Advisory Committee TAC Reports, 1977–1978. It is noted in the *TAC Meeting Minutes* of May 17, 1978 that "Mrs. Robinson [the nurse] will arrange to have a supply (of forms that indicate the point system of adjudication) printed and distributed to the doctors" (in AHSA 2014 01 56 10–9. Medical Advisory Committee TAC Reports, 1976-1978).

²⁴³ *TAC Meeting Minutes*, December 14, 1977 in AHSA 2014 01 56 10-9 Medical Advisory Committee TAC Reports, 1976-1978). It is noted here that "Mrs. Robinson will prepare a report of the subject [of patients being referred to Calgary from Edmonton]".

regarding the TAC's operation, for example.²⁴⁴ After the weekly meeting, TAC nurse counsellors contacted the appropriate hospital staff to communicate which cases had been approved and, thus, who required appointments for the procedure. Some of these nurses seemed to keep track of the women who were approved for abortions and of the capabilities of the Operating Room staff to accommodate them in order to ensure abortion services were provided smoothly and safely.²⁴⁵ Women whose abortions were approved were then contacted to make appointments and scheduled for surgery.

Given the myriad roles that they played in this process, nurses appeared to have functioned as pivotal (if not official) members of the TACs despite their professional inability to authorize an abortion. In doing so, I suggest, TAC nurses helped develop and reinforce this system in line with the state's considerable regulation of it. They did this, I suggest, in the processes of stepping into and developing their roles in the TAC system and by continuing to enact the work of being present with women and bearing witness to their individual and collective abortion experiences.

²⁴⁴ TAC *Meeting Minutes*, October 26, 1977 in AHSA 2014 01 56 10-9 Medical Advisory Committee TAC Reports, 1976–1978. Note here that nurse Robinson suggested the approved format for “acquaint(ing) the patient with the procedures followed at Foothills Hospital and facilitate[ing] the admission procedure by having the patient telephone their Alberta Health Care Insurance number to the Admitting Department prior to coming to the hospital”.

²⁴⁵ Note that “Mrs. Robinson reported that some patients given approval for TAs at today's committee meeting would not have the procedure done until March 17 because of difficulties in getting Operating Room space.” As noted in *TAC Meeting Minutes*, March 2, 1977 in AHSA 2014 01 56 10-9 Medical Advisory Committee TAC Reports, 1976-1978.

Nurses met women (and girls) in the early and late stages of the referral processes. They heard, saw, and documented the details of women's circumstances. They listened to and helped women communicate their needs within rigid legal and clinical administrative structures. They assessed many different women physically and psychologically, multiple times, and in varied contexts. Finally, some nurses witnessed, and perhaps participated in, the TAC adjudication process, which, significantly, the women who were actually seeking abortions could not do. In so doing, nurses working in these community and hospital roles appeared to function as key coordinators of legal abortion services under that system. As a result of working within and helping to create and operate this legal system, some nurses indicated that they were willing to help women navigate its complexities and obtain the legal abortions they requested.

“Working” the Therapeutic Abortion Committee System

However, this ‘front-row’ seat to the implementation of the TAC system seemed to engender a particular understanding of the implications of that system for nurses and women. Notably, some nurses indicated that they understood that the TAC system constrained their abortion-supportive practices and, more broadly, that the 1969 legislative amendment did little to meaningfully increase women's access to legal abortions.²⁴⁶ In their day-to-day work, some nurses experienced that they had to find ways to work within but around the legislative and administrative regulations of the TAC system. In fact, some of these nurses remembered that they purposefully (and quietly) bent or broke the rules while still functioning within its structure. In so doing, they

²⁴⁶ These criticisms were similarly noted by abortion supportive activists, would-be patients, and government organizations alike. See Badgley et al., “Operation”; Palmer, “Lonely”; Pelrine, “Abortion”.

explicitly and implicitly articulated that they prioritized their clinical aims of helping promote women's safety over and above the rules and laws that regulated women's reproductive health and their own nursing practice. As one example, nurse Joan W shared her memories of working around shifting administrative rules for making referrals for women seeking abortions.

She had been working at a physicians' office that not only was affiliated with an abortion-providing hospital but was also housed in the same building. For many years, she and her colleagues had been processing referrals for women to the hospital's TAC when suddenly a new physician introduced a policy prohibiting the practice. Women, however, continued to attend the clinic requesting abortion referrals, the implications of which Joan W indicated she understood. As such, she determined that—as a good nurse—she ought to defy this new policy. She told me:

[When we heard the new policy,] we were like, 'WHAT?!' So, what we did, all of us, as nurses, we walked out the door [of the clinic], through the lab, and into [the hospital's] Admitting [department]. We interviewed the patients in Admitting and referred them from there! That was a hoot! We didn't want to be stopped and we didn't want to be appearing to be breaking the rules. We knew we were being smart-asses. But it was such a stupid rule! [...]. It was ridiculous! [...]. Nurses have to figure out ways [around the rules]. [...]. You get told to do something, and

yes, you [officially] have to do whatever it is, but there's some things you think, 'Okay! I'm not going to do this!'²⁴⁷

She clarified:

As nurses, you would have to accommodate that. Because here you are, looking at the patient [...]. The patient still needs an abortion even if [the physician] changed the rules. And you just try to find your way around it to best meet the needs of the client.²⁴⁸

Joan W and her colleagues knew they could be reprimanded for bending the rules, but after seeing many women (i.e., witnessing their needs), they took on that risk and incorporated it into the ways they negotiated and understood their work in legal abortion services.

Going even further, some nurses indicated they were ready to fully break the rules of the system in order to guide their patients through it successfully. I heard, for example, the following story of nurses helping patients under the age of eighteen to progress to the TAC.

So, what we would do is – [the patient] would fill out a chart and [...]. We would sit down and look at them and they would have

²⁴⁷ JW 428–443. Interestingly, at this point in the interview she asked me if I was a nurse. When I answered affirmatively, she said, “Well, then you understand.”

²⁴⁸ JW 465–469.

written down whatever their age was. Then we would talk about where they were at [with their decision to have an abortion] and get a sense of how capable they were and what the issues were. [...]. Then once you got kind of a sense that they were there, that they were clear, that they knew what they were doing, and they wanted to be put through [to the TAC] [...], what we would do is say to them, ‘You know, I think this chart would really look a lot better if we cleaned it up a little bit, so I’m just going to get a new chart and I’m going to ask you to fill it out again for me. And this time, maybe you’d take another look at that birth date.’ So, we’d do a whole new chart and put the ‘right’ birth date in there and nobody ever looked at it when they went to the hospital because nobody *wanted* to look at it in the hospital. And we did that from our end. We were not the only ones, I’m sure. But finding ways [to help women get abortions] when the need was really high? We did that!²⁴⁹

These particular memories comprise a few examples that reveal that some nurses bent and broke the rules of the TAC system while officially remaining within it, and that they did so in an effort to help women access safe legal abortions. While they indicated that they were generally pleased that the abortion law was changing, some nurses also perceived that the TAC system was not fully liberating or helpful to all women in need of abortion. These nurses became intimately

²⁴⁹ Anonymous.

familiar with the legal and administrative barriers that they and women continued to face. Although the abortion law had ostensibly been liberalized in the courts, nurses who actually worked in the provision of abortion services came to understand that legal nursing practice and women's access to safe abortion were minimally expanded. Indeed, some perceived that the system comprised "unjust laws and unfair situations."²⁵⁰ laws remained 'unjust,' which resulted in 'unfair situations.'²⁵¹

This perspective, or dissatisfaction with the system, I suggest, was born out of nurses' day-to-day experiences with being present with women and bearing witness to their legal abortion experiences. In the next section, I will offer that the drive to help women obtain safe abortions was strong enough that some nurses developed and joined the next significant avenue of abortion provision. Namely, they turned to illegal channels by helping to open, operate, and defend the freestanding Morgentaler abortion clinics in Montreal, Winnipeg, and Toronto.

Establishing and Defending Illegal Freestanding Clinics

In the early days of each of the illegal abortion clinics (i.e., the late 1960s in Montreal and the mid-1980's in Winnipeg and Toronto), even before any physicians were available to actually perform abortion procedures, nurses positioned themselves at the end of the telephone line. As discussed, in Montreal in the late-1960s Joanne Cornax heard the stories of women from across Canada when Morgentaler declined to do abortions. Similarly, it was reported that prior to opening the clinics for actual procedures, "two nurses [in Winnipeg] were on duty to book

²⁵⁰ Christena M [CM] 532. Interview by author, January 2016.

²⁵¹ Ibid.

appointments”²⁵² and that “staff on duty behind the locked clinic doors [in Toronto] were [also] taking appointments.”²⁵³ Although not reported in the newspaper, I would argue that it is likely that these nurses were doing more than scheduling women for future abortions. Given Cornax’s reported experiences, it is logical that many of the nurses were busy listening to women who now had professional—albeit still illegal—places to call and the ears of professional women who could listen and potentially help. In other words, many abortion clinic nurses seemingly began their work by offering a presence to women on the phone, listening to their needs, and, in this way, bearing witness to their abortion-related experiences thus far. Although the newspaper reports are vague, they indicate that in all three clinics, nurses ‘opened’ them by ‘opening’ the telephone lines.

Obtaining Illegal Equipment

Beyond answering the clinic telephone, in order to open the clinics for the actual provision of abortion procedures, some clinic nurses took on the necessary tasks of “readying the facilities.”²⁵⁴ This preparation included securing and managing illegal medical equipment—a complicated and legally precarious task given that both conspiring to provide out-of-hospital abortions and supplying abortifacients for non-hospital use were punishable by up to life imprisonment or two year’s imprisonment, respectively.²⁵⁵ According to Catherine Dunphy, Montreal nurse Joanne Cornax fulfilled a particularly significant role in obtaining illegal

²⁵² “Winnipeg abortion clinic opens”: n.p.

²⁵³ “Morgentaler opens in Toronto”: A6.

²⁵⁴ *Ibid.*

²⁵⁵ Criminal Code of Canada, 1970, Section 251/Section 237.

equipment for Canadian abortion clinics. For, reportedly, Cornax risked her freedom to acquire Canada's first vacuum aspiration machine, which was a key piece of equipment in developing clinical abortion provision.²⁵⁶ Dunphy recounted the story as follows:

Henry sent to England for the \$3,000 vacuum aspirator, and when it arrived on January 26, 1968, his nurse, Joanne Cornax, went to collect it at customs. Henry loved to recall how the very proper, middle-aged mother-of-two brazenly told a customs agent she was picking up some run-of-the-mill medical equipment, but that she would go to the trouble of opening the box for his inspection if he really wanted her to. He didn't, which was just as well, because instructions for using the [illegal abortion] equipment accompanied it.²⁵⁷

Here Joanne Cornax managed to circumvent the law undetected, which enabled her and Morgentaler to develop and begin providing safer abortion services in the Montreal clinic.

²⁵⁶ For more on the use of the vacuum aspiration machine, *see* the Introduction of this dissertation. The machine was first developed in China and was already in use there, in the UK, and Eastern Europe before Morgentaler brought it to Canada. Joyce W Leong's 2008 translation of a 1958 research article by Chinese practitioners Yuantai Wu and Zianzhen Wu claims the first design and use of the vacuum aspirator there (*see* Wu and Wu, "A Report").

²⁵⁷ Dunphy, "Morgentaler": 82. Unfortunately, there is no account of this story from Cornax's point of view.

Once the vital aspirator was acquired, perhaps less dramatically but certainly as significantly, clinic nurses worked to secure additional medical equipment and supplies on an ongoing basis. Moreover, they were obliged to source products from distributors who were aware of their intended illegal use (unlike the airport customs officer). Nurses indicated that they found this task necessary but challenging. The head nurse and the Toronto clinic, Sharon B, reported:

I did [order all the supplies.] I did that for a long time. I would have to set up new accounts and it wasn't always easy to get people [to work with us]. [... I had to do] some of my schmoozing and my smart-ass talk to get people to deliver things and to sell to us because, who knows? This is an illegal establishment and how do they know if they're going to get paid or not! [...]. A lot of people wanted names of other companies that you dealt with, the contact name. So, you'd do that. But also, I'd do that sort of schmoozing and joking. [...] I found I could get a lot of things I wanted. I was somehow pretty persuasive I guess.²⁵⁸

Notably, Sharon B recognized that performing this illegal role—and performing it well—essential to the continued and safe operation of an illegal clinic, explaining:

²⁵⁸ Sharon B [SB] 1279–1298. Interview by author, January 2016.

In that respect, we had to be so above the board [with suppliers], you know, because you're being scrutinized under a microscope about whether you were going to be good enough to ever be an account. So, you had to pay on time, and everything had to be right.²⁵⁹

Indeed, abortion clinic nurses individually and collectively found creative, and sometimes brazen, ways to reliably acquire medical supplies in order to ensure that abortions could be provided at the clinics. In circumventing the law, I suggest, some clinic nurses demonstrated their commitment to meticulous clinical practice and to promoting women's safety in the face of significant legal risk. They understood that appropriate albeit illegal equipment was essential for the best operation of the clinic and thus for promoting and protecting women's lives and health through good clinical practice. They showed a deep commitment to, as Sharon B put it, "standing up for what [they] were doing and what [they] believed in." This commitment and its enactment,

²⁵⁹ Nurses continued to value and perform this role after decriminalization. One oral history participant, JB, indicated that sourcing and managing equipment was a substantial and enjoyable part of her job. She framed it as her financial contribution to the clinic. By independently tracking prices, negotiating with suppliers, and evaluating (and altering when necessary) the clinic's supply use, she explained, she was able to help maintain the clinic's solvency, and thus its continued operation. Her work, and the way she conceptualized it as an important nursing task that was necessary for the continued operation of the legal clinic in the 1990s closely resembled and continued SB's early pre-decriminalization perspectives.

I will later argue, held powerful implications for supporting the broader non-clinical struggle to challenge the abortion law.

Police Raids

Although some clinic nurses successfully circumvented the law to acquire illegal abortion equipment, they could not fully escape the state's attempts to regulate and restrict abortion provision and their participation in it before 1988. Rather, when each illegal freestanding clinic opened and began operating, the state dramatically intervened in its daily operation in an effort to enforce the law. Even if it could not prevent the sale of illegal equipment to the clinics, the state still aimed to close them down, prevent practitioners from working there, and ultimately block that illegal avenue for abortion provision. In short, the state aimed, as one Deputy Police Chief put it, to uphold the "law of the land,"²⁶⁰ which affected nurses, their colleagues, and the women for whom they cared in significant ways.

The primary disruption tactic by the state was police raids of the clinics. Raids involved an external investigation shortly after each clinic opened. When law enforcement obtained sufficient evidence that illegal abortions were performed there, a search warrant was granted, and police officers were allowed to carry out the raid. In a police raid, such as the one in Toronto discussed at the beginning of this chapter, officers entered the clinic during operating hours in search of direct evidence of illegal abortion provision. They looked for and seized material artefacts such

²⁶⁰ Deputy Police Chief Jack Marks claimed that "the law of the land must be followed until it is changed" (in Gadd and Slotnick, "Abortion clinic": 1).

as equipment (including the vacuum aspirator) and patient records,²⁶¹ medical waste,²⁶² witnesses (including nurses and patients),²⁶³ and suspects (including nurses, physicians, and volunteers).²⁶⁴ The goal of a raid was to support the state in regulating abortion by charging practitioners with and convicting them of abortion related crimes.²⁶⁵

Nurses, their colleagues, and their patients in the clinics were not at all safe from the law—even behind closed and locked clinic doors. Rather, law enforcement found ways to infiltrate the clinics in order to carry out their raids, which interrupted clinic operation and challenged nursing work. Significantly, police sometimes used nurses and other staff to gain enough evidence to

²⁶¹ See, for example, “[...] uniform and plainclothes police carted out objects [from the Winnipeg clinic] they’d seized. They included an intra-uterine suction unit, blankets and several cardboard boxes containing file folders, surgical gowns and instruments” in “Clinic raided again”: np.

²⁶² From the first Winnipeg raid, “pathologist Peter Markesteyn [...] testified he had identified human tissue and small segments of embryo in specimens taken [...] from a garburator—a kitchen sink-type of disposer in the Operating Room” (in McNenly, “Trial told”: A13).

²⁶³ See, for example, “After two hours, a paddy wagon [sic] pulled up at the clinic’s back door to take away another group. This time [...] four women and a man, possible clients of the clinic [...]” (in Ross and Carlyle-Gordge, “A raid”). In “She won,” Cleroux reported that a star witness in the Montreal trial was “a 26-year-old unmarried post-graduate student from Sierra Leone on whom Dr. Morgentaler had just performed an abortion”: 7. She reportedly agreed to testify in the trial because she feared criminal charges and deportation.

²⁶⁴ Ross and Carlyle-Gordge, “A raid”.

²⁶⁵ See “Clinic raid” or “Clinic raided again”.

obtain the necessary search warrant. These nurses and other staff members were often performing their day-to-day work, a commitment of which law enforcement took advantage. Clinic staff were often attempting to help women obtain abortions or were merely providing information on how to get one. Some nurses did so despite the risk of revealing themselves to undercover officers.

Among other tactics,²⁶⁶ police monitored phone calls between clients and staff (presumably including nurses given that they commonly spoke with patients over the telephone). They approached staff in person and on the telephone while posing as patients looking for information, and sometimes they were even able to make false in-person appointments.²⁶⁷ A raid of the Winnipeg clinic on June 3, 1983, offers such an example. There, a policewoman deceived clinic staff by acting as a pregnant woman looking for an abortion. As reported in the *Toronto Star*:

Policewoman Cindy Subzcak testified she had been equipped with a hidden microphone when she went to the clinic on June 3 prior to the raid and pretended to be pregnant and seeking abortion. She told Provincial Judge Kris Stefanson she spoke a prearranged code

²⁶⁶ Other tactics included following women leaving the clinic and interrogating them. In one case, police arranged for one such woman to “have an examination at a hospital” (likely a pelvic exam in search of signs of abortion) after she left the clinic. *See* “Police forced tests”: B1. *See also* Campbell and McLaren, “Hospital visit” or Marotte, “Trip”.

²⁶⁷ *See* “Police sought” and “Delay abortion trial”.

word into her mike [sic] to the other raiding officers waiting outside [who then entered the clinic].²⁶⁸

A second Toronto clinic raid on July 6, 1983 offers a similar scenario. There, two undercover officers who had “posed as a couple from out of town desperate for help”²⁶⁹ went so far as to actually be interviewed by staff—presumably for whether the policewoman “patient” was an appropriate candidate for a clinic abortion. When the couple began to fill out the paperwork necessary to move forward with the procedure, they knew they had captured what they needed in order to proceed. The undercover officers signalled to some fifteen colleagues (including “morality squad officers and uniformed policemen”)²⁷⁰ waiting outside the building. With the sufficient evidence gathered from nurses and other staff, police could enter the clinic to search it and indeed raid it as they saw fit.²⁷¹

²⁶⁸ McNenly, “Trial told”: A13.

²⁶⁹ According to clinic spokeswoman Judy Rebick in English and Stancu, “We’ll keep”: n.p. Note that Rebick was an outspoken and well-known leader in women’s activism more broadly. See Rebick, “Ten Thousand Roses”.

²⁷⁰ “Abortion clinic raid”. Note that police morality squads focused on vice or offenses against public morality. They tackled issues such as prostitution, gambling, pornography, venereal disease, censorship, and abortion for some example. For more on vice squads and the policing of juveniles, see Myers “Caught”.

²⁷¹ See English and Stancu, “We’ll keep” and Gadd and Slotnick, “Abortion clinic”. For a similar example from the Winnipeg clinic (which took place before the Toronto raid), see Ross and Carlyle-Gordge, “A Raid”. For photos of the Toronto clinic raid, including of police carrying a

The ways that officers saw fit to enter and search the clinics in Montreal, Winnipeg, and Toronto can genuinely be understood as *raids*. These hours-long events were chaotic, violent, and invasive for patients and staff alike. For staff at reception areas or other front rooms of the clinic, the interaction with raiding officers was immediate and sometimes physical. After the team of police first entered the clinics, usually by suddenly “bursting in”²⁷² (it was important to law enforcement to surprise staff before they could destroy key evidence) and then barring the clinic doors (“thus preventing anyone from entering or leaving [the clinic]”),²⁷³ nurses and other reception workers were the officers’ first stop, their first barrier to the procedure rooms inside. As a result, some officers used those women to enter the back rooms, which included offices (where records and payments were kept), supply rooms (where illegal equipment was stored), and patient care areas, such as the Operating Room (where the procedures were performed) and the recovery bay (where nurses monitored patients for post-operative complications).

Comments on the Toronto clinic raid by spokeswoman Judy Rebick suggested that when those front-room staff resisted officers’ demands to search the clinic, the police resorted to physical force to move past them. *The Globe and Mail* reported Rebick’s account the day after the raid as follows: “When the receptionist tried to warn the other staff of the coming raid, Miss Rebick

box down the front steps of the clinic, escorting a woman out the back door with a towel over her head, and an ambulance on standby (in case a woman needed to go to hospital), see “Abortion clinic raid”.

²⁷² “Abortion clinic raid”.

²⁷³ Cleroux, “Morgentaler slams”: 2.

said, the undercover man ‘held her down and [only] then identified himself as police.’”²⁷⁴ When police similarly attempted to recruit a nurse to give them entrance to the locked procedure room, Rebick reported a comparable story, which Catherine Dunphy reported in her Morgentaler biography as follows:

[...] police bounded up the stairs and demanded a key to the locked Operating Room door from a nurse. [...] When she refused], Judy Rebick said police *forcibly* took the key out of the nurse’s pocket and opened the door themselves.”²⁷⁵

The newspaper account I referenced in the introduction to this chapter poignantly reinforced the physical nature of the raids and nurses’ bodily roles in defending against them: “Miss Rebick said [...] that] the [procedure room] door is kept locked while patients are inside, but [raiding] officers grabbed the keys from a nurse who was trying to *block the door with her body*.”²⁷⁶ In the early stages of the raids, nurses and other staff demonstrated that they were willing to confront—even if they were not fully able to stop—raiding officers. In other words, I suggest, some clinic nurses took up the task of literally confronting the state to defend the clinics and their patients, sometimes even by using their bodies, in order to stand up for what they believed in and what they were doing. Oral history participant Sharon B made the point clear in response to my

²⁷⁴ Gadd and Slotnick, “Abortion clinic”.

²⁷⁵ Dunphy, “Morgentaler”: 225 (my emphasis).

²⁷⁶ Gadd and Slotnick, “Abortion clinic”:1 (my emphasis).

question, “What are the successful qualities of a nurse working in the field of abortion?” She answered, “You had to be able to stand up for what you were doing.”²⁷⁷

As each raid progressed, so too did their intensity and invasiveness—especially for the women and practitioners who were in the procedure rooms. As in the case of the Toronto woman, sometimes when police entered the procedure rooms, practitioners were midway through or had just finished the abortion operation.²⁷⁸ That is to say, on multiple occasions, raiding officers forced opened closed doors behind which anxious and/or sedated women were undergoing a complex gynaecological procedure. This action was both physically and psychologically invasive. It is likely, then, that police startled and possibly frightened or angered patients and practitioners alike, which undoubtedly challenged clinic nurses in delivering the clinically safe and psychologically supportive abortion services they aimed to provide.²⁷⁹

²⁷⁷ SB 1168.

²⁷⁸ Mid-procedure raids happened in Winnipeg (*see* Dunphy, “Morgentaler”: 217). For Toronto (*see* “Abortion clinic raid”). In at least one Montreal raid, a woman remained on the operating table immediately following her abortion procedure when police entered the room (*see* “Abortion disrupted”).

²⁷⁹ Suddenly interrupted and unfinished abortions were invasive and clinically risky for women. If there was no opportunity to remove it all, retained fetal or placental tissue could lead to infection. Imprecise instrument handling could lead to internal damage and/or patient discomfort. Unknown officers entering the clinic could perhaps lead to psychological distress for women patients.

Indeed, the work of operating physicians and nurses was at times compromised by the raids. For one example, in one of the early Montreal cases when they had little to no experience with raids, nurses on duty failed to administer adequate analgesia to a woman who remained on the operating table when officers raided the procedure room. The patient testified of her experience, which was reported by *The Globe and Mail* as follows:

During her operation she was conscious and frightened, and felt considerable pain. She said that she was to receive medication for the pain when police arrived but their presence so confused nurses that they ordered her to dress [instead]. She said she did not have time to receive a pain-killer.²⁸⁰

Significantly, in the face of these challenges, nurses did not give up their freestanding clinic work. Rather, some clinic nurses took up deliberate roles in defending the clinics and caring for patients throughout the raids. And as they gained experience or learned of others' experiences of police raids, some seemed to develop a number of resistance strategies. For example, they stalled and outright challenged officers, they assisted in the quick but safe completion of the procedure, and they destroyed evidence of the procedures they had performed or assisted with. Moreover, they also relied on their 'old' strategy of remaining present with women even as authorities intruded. Some nurses elected to and were able to stay with their patients while police rushed

²⁸⁰ "Morgentaler induced abortion": 9. See also Cleroux, "She won".

around searching the clinic, interrupting surgical procedures, seizing equipment²⁸¹ and patient records,²⁸² laying hands on and shouting at nurses and other staff,²⁸³ taking photographs,²⁸⁴ and intimidating patients. Some nurses were able to stay beside their patients until the women left the clinic in police custody—either for transport to the hospital or to another location for interrogation. Overall, under threat of arrest and harassment, abortion clinic nurses confronted the state by continuing to provide clinical services to women, by remaining present with them in

²⁸¹ Seized equipment included the vacuum aspirator that nurses had worked so hard to get. For a photo of police carrying out the aspirator from the Toronto clinic raid on July 5, 1983, *see* “Clinic raid”. Other equipment included “blankets and several cardboard boxes containing file folders, surgical gowns and instruments” (*see* “Clinic raided again”: n.p.). In the Toronto raid, police also seized a garbage disposal unit from the procedure room, in which investigators found “traces of fetal tissue and bone. [...] The disassembled machine was brought into the courtroom” (in Makin, “Officer testifies”: M1).

²⁸² “The police had picked up the file cards on 795 women Dr. Morgentaler had aborted during the past five year, including correspondence and questionnaires patients had filled out after their abortions” (in Cleroux, “She won”: 7).

²⁸³ In one case, the *Globe and Mail* reported: “The patient had been examined and the doctor had just left the room when officers burst in, shouted at a nurse to drop a cotton swab she was holding and seized a vacuum aspirator” (*see* Gadd and Slotnick, “Abortion clinic”: 1).

²⁸⁴ Toronto police photographed nurses at the clinic. The woman who was still on the table during the raid reported to *The Globe and Mail* that: ““They [the police] asked the nurses to pose for pictures and they did. Then they took pictures of the whole clinic”” (in Slotnick, “Woman terrified”: 5).

general, and by bearing witness to these new kinds of abortion experiences in the new context of unpredictable and hostile illegal clinic environments.

The actions of nurses in the Winnipeg raids offer a particularly illustrative example of the ways that nurses fulfilled these new roles. One account of the (June 3, 1983) Winnipeg raid reveals head nurse Lynn Crocker's willingness to confront police and her creativity in stalling them. Biographer Catherine Dunphy has recorded Crocker's perspective. As the raid began, Dunphy noted:

Dr. Robert Scott and head nurse Lynn Crocker were in midprocedure. It was their habit to lock the door to the second-floor Operating Room. [...]. When police knocked on the Operating Room door, Crocker had the presence of mind to ask them to shove their badges under the door as proof of their identity. [The nurse later reflected], 'They were so upset when I opened the door, but [stalling them by asking for identification] gave us some time to get the patient up and off the table.'²⁸⁵

Journalists from the *Toronto Star* and *The Globe and Mail* recorded the scene from the police officers' point of view by reporting their court testimony of the raid. Their accounts similarly highlighted Winnipeg nurses' willingness to confront and stall police and, further, to destroy evidence while holding off law enforcement. One journalist reported that police testified they

²⁸⁵ Dunphy, "Morgentaler": 213.

noticed a receptionist triggering an alarm at the desk to warn the practitioners in the Operating Room, noting:

Constable Helen Wollard of the raiding party testified that as they arrived outside the clinic's Operating Room, a *woman in white* 'put her head out, slammed the door shut and you could hear the [lock] click. While we were waiting, we could hear sounds [behind the door] of metal clanging against metal, sounds of water running, [and sounds] of paper being crumpled'²⁸⁶

The reporter concluded that: "when the officers finally entered [the Operating Room], they found Dr. Scott, three staff members and a fully-clothed patient in the room."²⁸⁷

In this and other cases, nurses were not only holding off police, clothing their patients, and destroying evidence. Some nurses also stayed with women throughout the raids. They watched, listened, and supported their patients as best they could. Echoing their long history of doing so, these nurses continued to bear witness to women's abortion experiences. In the Winnipeg raid, four practitioners (three of them nurses) stayed behind with a woman in the Operating Room as the chaos wound around them. In Toronto, police testified that when they entered the procedure room, they found a nurse sitting beside a woman wrapped in a blanket while the raid went on

²⁸⁶ McNenly, "Trial told": A13 (my emphasis).

²⁸⁷ "Clinic patients testify": 9.

outside the door.²⁸⁸ This was the Toronto woman, who later testified that the nurse remained with her throughout the encounter until the police removed them from the clinic. She also proclaimed that she trusted the nurse and that, if needed, she would have confided her fears or problems to her, but not to the ‘authorities.’ To put her words into context, I present *The Globe and Mail’s* report that opened this chapter more fully.

Once [the police] came in, [... the patient] was covered with a blanket and led out of the Operating Room to a nearby bed. [The woman testified that] “The police were trying to be helpful, even if it may not have been genuine. I admire that, but I give the nurses and the counselor real credit.” A nurse accompanied her to the bed, and a gynecologist brought by the police sat next to her on a chair. “I was feeling okay,’ [she said], ‘but even if I wasn’t, I wouldn’t have told him [the police’s gynecologist]—I would have told the nurse. I had no confidence in him. I figured he was a quack.”²⁸⁹ [...]. [The woman] spent more than an hour on the bed [with the nurse nearby] while police combed the clinic for evidence. When she was allowed to leave [...] she was led out of the back door to a

²⁸⁸ Makin, “Officer testifies”: M1.

²⁸⁹ An interesting turn of phrase given that it was illegal abortionists who were identified as quacks by law-abiding physicians in the early criminalized period.

waiting police car [...]. “The nurses’ final words were, ‘you’ll be all right.’ [the woman stated,] ‘They were with us to the end.’²⁹⁰

Throughout the police raids, many clinic nurses demonstrated their willingness to stand up for what they were doing and believed in. They confronted the state through their clinic work as they attempted to care for women in harmful environments engendered by state intervention. They built on their longstanding foundation of circumventing the law to develop strategies to now confront it. And by taking on this risk, I suggest that these abortion clinic nurses continued to demonstrate their profound professional commitment to ensuring that women were safe medically, even when neither the women they cared for nor the nurses themselves were safe legally.

Legal Consequences

Indeed, freestanding abortion clinic nurses were hardly legally safe after liberalization and before the decriminalization of abortion. In the aftermath of the raids, they again had to find ways to defend themselves and their work against a larger legal and political system that was imposed on them. For, like physicians and women, clinic nurses, with their receptionist and counsellor colleagues, were targeted by law enforcement who acted on behalf of a state that aimed to uphold and enforce the federal abortion law. Abortion clinic nurses, because they unlawfully participated in the procedure or planned to participate in it (in other words, who ‘procured’ or ‘conspired to procure abortion’) were, according to law enforcement and Crown prosecutors, not

²⁹⁰ Slotnick, “Woman terrified”: 5.

to be exempted from state censure.²⁹¹ As one police superintendent in Winnipeg proclaimed specifically of nurses' illegal work: "as long as it's on the books, it's an offence."²⁹² During and in the wake of police raids, clinic nurses (variably) experienced the reach of the law, often suffering intimidation, harassment, and humiliation tactics along the way. Yet through those experiences, some abortion clinic nurses collectively developed strategies of defence, which, like their work throughout the in-clinic raids, was often defiant. Through these actions, clinic nurses stood up against the state's attempts to regulate their practice, in this context by confronting its broader legal channels outside of the clinics in addition to its practical avenues of brute force (i.e., police raids) inside them.

Specifically, throughout and following the raids in Montreal, Winnipeg, and Toronto clinic nurses were questioned inside and outside of the clinics. Some were taken into police custody, detained, charged with abortion crimes, jailed, and summoned to court. Clinic nurses were

²⁹¹ One Quebec Crown prosecutor argued that after Henry Morgentaler was incarcerated following the Montreal raids, the state's focus ought to shift to Morgentaler's colleagues. He suggested that the state "deal with four others, three doctors and a nurse, who face similar charges. [He mused], 'Why should we let the others stay free? [...]. It would not be fair to have a big expensive case against him [i.e., Morgentaler] and not have trials for the others.'" (*See* "Morgentaler still faces": 14). Similarly, following the Toronto clinic raid wherein no nurses were immediately arrested the *Montreal Gazette* reported that "Police [said] they [were] still investigating possible charges against three clinic nurses, a receptionist and a counselor" (*see* "Abortion disrupted": n.p.).

²⁹² Gory, "Expenses": n.p.

sometimes separated from their patients or colleagues during the raids, detained by police and questioned there. For example, Dunphy reported that during the first clinic raid in Montreal (June 1, 1970), “Henry [Morgentaler] was ordered into an adjacent examination room [and head nurse Joanne] Cornax and the other nurses were ushered into another room [for questioning].”²⁹³ Similarly, during a Winnipeg raid, Dunphy noted that the nursing “staff were herded into the kitchen [for interrogation while] the patients [were taken] into the waiting room.”²⁹⁴ In Montreal, Joanne Cornax was singled out by officers for closer interrogation, wherein she was tricked into providing unfavourable written and verbal testimony against both the clinic and Morgentaler under false pretenses. Dunphy noted:

[She] was shown a small part of [an incriminating] statement and led to believe Henry had signed it. She signed a statement of corroboration, not knowing she had just guaranteed she would be subpoenaed as a witness for the prosecution [against Morgentaler and herself in court] at some future date.²⁹⁵

However, perhaps demonstrating newfound knowledge, confidence, and commitment to their cause, when the Montreal clinic was again raided on August 15, 1973, the nurses did not repeat Cornax’s misstep. This time when questioned, they categorically refused to cooperate with law

²⁹³ Dunphy, “Morgentaler”: 90.

²⁹⁴ Dunphy, “Morgentaler”: 218. *See also* “Abortion disrupted”.

²⁹⁵ Dunphy, “Morgentaler”: 90.

enforcement. In defiance of the state, “all the nurses refused to sign anything implicating [Morgentaler or themselves]”²⁹⁶ while detained at the clinic.

The legal ramifications of police raids for nurses who did abortion work in freestanding clinics extended beyond police questioning inside the clinic walls, as did the nurses’ collective resolve to reject the law and the state’s intervention in their lives and work.

Outside the clinic, Joanne Cornax bore an exceptional legal burden. Whereas in other cases, nurses (including Cornax herself) had been arrested either at the clinic or while in police custody immediately following a raid, Cornax was also arrested at her home. In 1974, she was approached by police there and taken away in handcuffs on additional abortion-related charges.²⁹⁷ Yet Dunphy’s account and newspaper articles reveal that in that case, Cornax performed a remarkable act of defiance before the state. Reportedly, at the ensuing trial:

²⁹⁶ Ibid: 112. In a similar act of defiance, of the Toronto raid on July 5, 1983, “[Spokeswoman] Miss Rebick said the clinic’s nurses were questioned by police but refused to give any information except their identities (*see* Gadd and Slotnick, “Abortion clinic”. *See also* “Abortion clinic raided”).

²⁹⁷ She was detained under suspicion of aiding Dr. Yvan MacHabee in providing abortions while he filled in for Morgentaler at the clinic when Morgentaler was away. According to *The Globe and Mail*, Cornax had been “arrested at her home yesterday and charged under a preferred indictment with conspiracy to perform abortions. The 40-year-old nurse pleaded not guilty. [...]. Mrs. Cornax was arraigned on the same charge in February, but the proffered indictment means she will be sent directly to trial, bypassing a preliminary hearing.” (*See* “Montreal nurse”: 2).

[Cornax] infuriated the Crown attorney by refusing to identify [Dr.] MacHabee [her colleague who had been performing abortions with her while Morgentaler was away]. She told the court she couldn't identify the doctor because he was wearing a mask at the time [of the abortion procedure but not in the courtroom].²⁹⁸

Stepping away from her initial roles of quietly circumventing the law by holding off inspections by customs agents or of cooperating with law enforcement during the early raids, here Cornax confronted the state head-on. The implication in the story is that she perjured herself in court to protect her physician colleague directly (i.e., a man she undoubtedly recognized with or without a surgical mask) and, more indirectly, the women who needed clinic services. But Cornax suffered the consequences for her rebellion. The Crown lawyer was apparently so frustrated by her defiance, that in retaliation, he “resuscitated her testimony from one of Henry’s [earlier] hearings and charged her with being an accomplice [or conspirator with him]. She was immediately taken into custody, manacled and fingerprinted.”²⁹⁹ As for her charges, Cornax continued to stand up to and defy the state by “refusing to enter a plea on a charge of committing an illegal abortion.”³⁰⁰

²⁹⁸ Dunphy, “Morgentaler”: 108.

²⁹⁹ Dunphy, “Morgentaler”: 108.

³⁰⁰ *See* “Johanna Cornax (sic), former chief nurse of Dr. Henry Morgentaler, was sent to trial yesterday after refusing to enter a plea on a charge of committing an illegal abortion. [...]. Mrs.

Alongside Cornax, the nurses who perhaps experienced the most severe legal consequences for their illegal abortion clinic work were the Winnipeg nurses following the June 3, 1983 raid, “the second in three weeks” time there.³⁰¹ Four nurses were taken from that clinic, arrested, and then charged with conspiring to procure an abortion (all four nurses) and the more serious crime of actually procuring an abortion (two of the nurses). All of the nurses except one refused to post bail “in protest” of the law. They elected to go to jail instead. The experience was reportedly a harrowing one for these women. As Dunphy recounted:

[Winnipeg physician Robert] Scott was led to his own cell, content with a supply of books he always kept at the ready. The four women [three nurses and a receptionist] were put in one part of a compound on the fifth floor [of the jail]. They were strip-searched, not allowed a comb or toothbrush, had their belts and shoes taken

Cornax [...] is currently free on bail after being charged under a preferred indictment last week with conspiracy to commit several abortions between June 6 and July 4, 1973, with Dr. Yvan MacHabee” in “Morgentaler nurse committed”: 15. Not much more is reported about Cornax’s ensuing legal battles in the newspaper or Morgentaler biographies except that her trial was postponed once. Although the details are scant, presumably she escaped a criminal sentence. According to Dunphy in “Morgentaler,” Cornax moved to the USA soon after this experience. Similarly, little more is reported about Dr. Yvan MacHabee. The Morgentaler trials dominated the newspaper and biographical reports.

³⁰¹ “Morgentaler staff”. *See also* “Clinic members” or Davidson, “Abortion clinic workers”.

away and given nightshirts. To shower, one woman had to keep flushing the toilet to get hot water while another held the door closed.³⁰²

The Winnipeg nurses and a counsellor spent two nights in jail as they continued to refuse to accept the bail conditions offered to them. Had they accepted, the nurses would have been obligated to stay one block away from the clinic, which they were unwilling to do. Instead, they planned to return to the clinic upon their release to continue to do their illegal abortion work despite ongoing raids and the consequences they entailed. To eventually secure their release, the nurses were allowed to pay a fine of \$1000.00 and attend court at a later date. The nurses reportedly agreed, in part, because they could return to the clinic and carry on their work. Their plight was publicised in the media, and, like the physicians, these nurses found their professional reputations, freedom, and livelihoods at risk. Here was the outcome for doing abortion work, circumventing the law, confronting and defying the state, and standing up for what they believed.

Committing to and Leaving the Morgentaler Clinics

Perhaps one of the clinic nurses' most significant collective acts of defiance against the state was committing to the Morgentaler clinics by opening and re-opening them even while the threat of disruptive raids, challenges to their clinical practice, and serious legal consequences loomed. For, following the raids, sometimes months or days later, sometimes on the same day, and, in one

³⁰² Dunphy, "Morgentaler": 210

case, even “minutes” after,³⁰³ nurses and their colleagues returned to the clinics to continue doing whatever abortion work they could. I suggest that in doing so, they undertook a keen effort to continue to stand up for what [they] were doing, to help women obtain safe abortions as best they could, and to remain with women ‘until the end,’ whatever the end may have been.

When they reopened the clinics, nurses could sometimes continue to assist with actual abortions. Such was the case, for example, following the first raid in Montreal. There, the nurses reportedly returned to the clinic the next day, where, according to Dunphy, “it was business as usual, except that the staff were understandably nervous and the Operating Room nurses jittery whenever they heard a knock on the door.”³⁰⁴ Other times, however, staff could not offer the actual abortion procedure any longer, but they still reopened and set about doing different kinds of abortion work, which they regarded and enacted as valuable and essential to women. Without access to crucial procedure equipment (e.g., the vacuum aspirator that was seized by police) and with physicians variably available (having been jailed or were otherwise away),³⁰⁵ some nurses in all three clinics nevertheless returned and resumed their early-days’ work of answering phones and

³⁰³ *See*, for example, “Abortion clinic still open,” which reported that “A defiant staff reopened Dr. Henry Morgentaler’s Toronto clinic yesterday afternoon minutes after a 3 ½ hour police raid”: n.p. *See also* “Dr. Henry Morgentaler’s Toronto clinic remains open”.

³⁰⁴ Dunphy, “Morgentaler”: 91.

³⁰⁵ Morgentaler was arrested in Montreal, for example. *See* “Police arrest”. In Toronto, Morgentaler was away on vacation during raids. He did not return to perform abortions. Physician Scott also left the city while nurses continued to work. *See* Gadd and Slotnick, “Abortion clinic”.

listening to women, providing counselling, offering pregnancy tests, and making referrals to other facilities.³⁰⁶ They (collectively) did so until they had the opportunity to provide the abortion procedure once again.

However, for some individual nurses, this clinical and legal reality proved untenable. Perhaps unsurprisingly, keeping abortion clinics open and operating in the hostile and chaotic environment was, for some, an insurmountable challenge. Collectively, nurses opened, closed, and re-opened the clinics, which frustrated them. Some clinic nurses from each city, having suffered acute personal and professional effects as a result of state intervention, found that they could no longer work in the clinics. Cornax, for example, was reportedly “so horrified” that “she moved to Florida and worked as a nurse there.”³⁰⁷ In Winnipeg, a clinic nurse and her counsellor colleague left their positions following the arrest and incarceration. *The Globe and Mail* reported that, “Dr. Morgentaler said the process of having their fingerprints and pictures taken after their arrest gave [the women] an aura of guilt, and the pressure was too much for them.”³⁰⁸ And in Toronto, of the July 5, 1983 Toronto Raid, spokeswoman Judy Rebick “said [that] the questioning [by the police] was very aggressive and two of the nurses were ‘quite

³⁰⁶ For Montreal: see Squire, “I’m Married”. For Winnipeg: see “Morgentaler’s clinic reopens; Cleroux, “Five so far today”; or Cox and Marlin, “Winnipeg abortion clinic”. For Toronto: see “25 ask” or “Abortion clinic raid”.

³⁰⁷ Dunphy, “Morgentaler”: 108.

³⁰⁸ Gory, “Drop charges”. See also: “[Morgentaler] said that two of his staff members—one nurse and one counsellor—have not returned to work because of the pressure of facing the charges brought against them” in “Morgentaler opens in Toronto”.

upset' by it."³⁰⁹ Those nurses later quit. Morgentaler himself recognized that these experiences and the ongoing threat of legal penalty made it difficult for many nurses to take up or continue to work at the clinics. He reflected, "It's hard sometimes to find people [to work in a clinic] when they know there's a chance it will be raided again."³¹⁰

Other nurses decided to stop working in the clinics because they felt it was unfair to continue to subject women to demeaning raids and unsafe experiences. Winnipeg head nurse Lynn Crocker explained that while the clinic was repeatedly raided and staff were charged and incarcerated,

There were [still] women waiting in the wings to have the procedure done and it wasn't fair to them. [...] The more we [nurses] talked the more we knew there was no reason for us to continue anymore. And what were we going to say to the women? You may get hassled the day you come? You may have police burst in the day you come? You may get thrown in jail? You may get your name in the paper?³¹¹

Though some of these individual nurses left the clinics owing to these challenges, others chose to enter the field despite the risks and keep the clinics generally operational. Despite nurses' individual pathways into and out of the clinics, collectively speaking, I suggest that nurses

³⁰⁹ Gadd and Slotnick, "Abortion clinic"; Walker, "Can't re-open".

³¹⁰ "Nurses shun".

³¹¹ Dunphy, "Morgentaler": 220.

demonstrated a commitment to women’s safety by opening, operating, and defending illegal freestanding abortion clinics.

Nurses’ Political Action Through Abortion Clinic Work

In this section I offer some concluding thoughts about the intersections between nursing practice and the broader non-clinical challenges to the abortion law and state regulation. In many ways this analysis suggests that nurses’ abortion work in the illegal era, and especially their work in the freestanding abortion clinics, carried significant implications for the disruption of state regulation and abortion’s eventual decriminalization. The work that nurses undertook and achieved in opening, operating, and defending the freestanding clinics was crucial for protecting the health of women through increased access to abortion services. Nurses’ in-clinic work also functioned as a powerful act of resistance to a broader legal system grounded in ideologies that held that the state could and ought to regulate women’s health services and women’s reproductive lives. I argue in this section that nurses’ in-clinic work thus supported and augmented the non-clinical efforts of other actors—notably of their physician colleagues Morgentaler, Scott, and Smoling (who were engaged in legal battles outside of the clinics)³¹² and of women’s political coalitions (such as the Vancouver Women’s Caucus or the Canadian Abortion Rights Action League, for example),³¹³ who similarly rejected strict state-regulated abortion and fought for legislative changes. Likewise, in turn, the political efforts of those other actors supported nurses’ ability to continue to do their hands-on work from inside freestanding abortion clinics.

³¹² See Day and Persky, “Supreme Court”.

³¹³ See Palmer, “Choices” or Wasserlein, “Arrow”.

Nurses' Activism

Some nurses and non-nurses alike explicitly and implicitly acknowledged and supported freestanding clinic nurses' contributions to wider activist efforts. Lynn Crocker's defence lawyer, for example, announced one of her motivations for taking on and persisting in illegal abortion work despite—and perhaps because of—the legal consequences. Specifically, at her hearing he claimed that “[she], the head nurse at the clinic, and one of the accused, wanted to challenge the constitutional validity of Canada’s abortion laws.”³¹⁴ He thus positioned Crocker in a similar political activist role as Morgentaler; that is, as a practitioner who could and did challenge the law through performing illegal work and by getting caught for doing it.³¹⁵ Morgentaler himself echoed the lawyer’s declaration of clinic nurses’ (yet not only Crocker’s) commitments to challenging the law, explaining to a journalist, and thus the Canadian public that, “Our people are dedicated to the welfare of women who need abortions. They’re not going to say they haven’t done them. They are prepared to accept the consequences if they are arrested [...]”³¹⁶ Apparently, some abortion clinic nurses (and these men who seemed to speak for them) recognized that their work was an effective but risky vehicle for challenging the law. In some cases, nurses demonstrated a willingness to take on the legal risk in order to make a contribution to that challenge. They experienced that providing illegal abortions in such a public way

³¹⁴ “Lawyers plan”: 8.

³¹⁵ Morgentaler made this strategy clear to the public in 1973, explaining of his trial in Montreal (in which he was acquitted by jury, but the Crown appealed to overturn that verdict): “Even if I lose the appeal the point will have been made. [...]. It’s been an open secret for years [...] that I practice abortions. I actually wanted a test case” in Cleroux, “Five so far today”: 1.

³¹⁶ “Morgentaler slams”: 26.

demanded and indeed immediately received attention and intervention from the state. But although state intervention and legal consequences were distressing for their patients and for them, these nurses, like Morgentaler, Scott and Smoling, realized that when they were arrested, charged, and tried for breaking the law, they also earned an important and unique opportunity to defend their clinical actions in court. In this way, I suggest, nurses who worked at illegal freestanding abortion clinics supported the non-clinical (or political) efforts of other groups and individuals who similarly resisted the state's strict regulation of abortion.

Outside of the clinics, some of the nurses also aligned themselves with political groups that endeavoured to incite legislative changes through activist techniques. In 1983, for example, Lynn Crocker attended a pro-choice rally, which, I would argue was a demonstration of her political beliefs and alliances in and of itself. According to the *Globe and Mail*, she additionally took up the feminist activist language of 'choice,' proclaiming, "I am more and more convinced that women need this choice [of legal abortion] and that the general public is [also] in favor of choice"³¹⁷ In a similar example, albeit a decade earlier in 1974, Montreal nurse Joanne Cornax was expected to attend a pro-choice demonstration on International Women's Day—an event that culminated in a "mass demonstration on Parliament Hill." Though it is unclear if she attended the rally, the newspaper announcement for it promised her presence, reading: "Dr. Morgentaler will be there as well as his clinic's head nurse, Joanne Cornax."³¹⁸ Clearly, then, Cornax was a draw for the political event. For a final example, following the 1983 police raid of

³¹⁷ "Morgentaler nurse was silent". *See also* "Abortion clinic open".

³¹⁸ This announcement is untitled, appearing under Cherry, "After a fashion". I did not find confirmation on whether or not Cornax actually attended the rally.

the Toronto clinic, one nurse flashed the “victory sign” to the crowd and to reporters who were gathered to watch.³¹⁹ Significantly, this gesture was favoured by Morgentaler to communicate his good spirits and commitment to abortion advocacy in the face of legal opposition. These examples support Catherine Dunphy’s observation of the jailed Winnipeg nurses that “they hoped to make political points by their imprisonment.”³²⁰

There is also some evidence that pro-choice activist women in turn supported nurses’ efforts to continue to provide actual abortion services in freestanding clinics. One compelling story was the public reaction to the incarceration of the Winnipeg nurses. Dunphy reported that:

On Sunday, [feminist activist Ellen Kruger]³²¹ organized about two hundred supporters to come out to a rally in front of the jail [where the nurses and other staff were being held]. By climbing on another’s shoulders, [clinic employee Suzanne] Newman could look out at small window and see the supporters below, including her four-year-old son, Jesse, who had dressed in his Superman outfit and come to rescue his mommy. ‘We got teary then,’ Crocker admitted.³²²

³¹⁹ “Abortion clinic raid”.

³²⁰ Dunphy, “Morgentaler”: 218.

³²¹ According to Rachael Johnstone in “After Morgentaler,” Ellen Kruger was the “founder” of the Manitoba branch of the Canadian Abortion Rights Action League”: 60.

³²² Dunphy, “Morgentaler”: 191.

Other examples of nursing-supportive activism included a public march held in Vancouver protesting the charges laid against Joanne Cornax³²³ and fundraising efforts of the Ontario chapter of the prominent feminist pro-choice coalition, the Canadian Abortion Rights Action League [CARAL], “to help pay the court expenses of doctors *and staff members* of the Morgentaler clinic.”³²⁴ These actions perhaps helped wider audiences and nurses themselves to conceptualize and accept them as players in the political-activist context and their hands-on work as contributing to those non-clinical efforts.

Invoking Nurses as Expert Practitioners

Indeed, some non-clinical activists relied on nurses-as-such and more specifically of particular public constructions of ‘the nurse’ to support their goals. Significantly, nurses’ status and work as ‘expert practitioners’ was used by others to support the broader legal challenge and resistance to state regulated abortion. Specifically, nurses’ expert status as professional practitioner was invoked in defense of the physicians and nurses who were charged with abortion crimes. The legal defense strategy of Morgentaler’s team, after all, depended on making the convincing argument that although it was illegal, the provision of abortion services from freestanding clinics was safe and effective and moreover was necessary for protecting women’s lives and health. As such, proving nurses’ and other staff members’ successful and expert clinical practice was

³²³ “CARAL hopes”: 5.

³²⁴ Dunphy, “Morgentaler”: 194 (my emphasis). Note that oral history participant LE made a similar claim about the functioning of abortion clinics after decriminalization. She explained that “no one was allowed to die at an abortion clinic,” implying that a death would help bolster resistance against freestanding clinics.

essential for making and relying on that argument. In providing safe care, clinic nurses—whether they explicitly aimed to or not—thereby supported the legal challenge. Morgentaler put it succinctly when he claimed:

If it [the provision of abortion services from freestanding clinics] is not well done the whole *cause* will topple. And if it is not up to high standards, it would be terrible if we had complications or a death. It would be the end of the ideal that clinics [which heavily depended on nursing work] could provide those services.³²⁵

One reporter similarly explained:

Actually, the 5000 abortions [they did in the Montreal clinic] worked in Dr. Morgentaler's favour because it made it easier for his lawyers to prove he was competent. He's never lost a patient. There are seldom any "complications."³²⁶

The defense team and Morgentaler himself recognized that nurses made a valuable contribution through their work. These teams relied on nurses to continue to practice safely in order to support the clinics' successful operation and to legitimize their legal argument. Notably, when

³²⁵ Cleroux, "She won": 7.

³²⁶ Cleroux, "Honesty won": 7.

Morgentaler was not available to operate in the Toronto clinic, Sharon B remembered that he relied on the nurses to keep it running. She explained:

He knew that it was best to delegate [some work to me] and not to do all this alone. He couldn't do all these things by himself. And he didn't want to! He wanted me to do it! So, I did it!³²⁷

Feminist activist groups also relied on the in-hospital nurse-as-expert construction (or identity) to support their efforts. For example, the Vancouver Women's Caucus, who initiated the Abortion Caravan,³²⁸ reinforced their argument that legal abortion was needed in Canada by citing reports by nurses to support their cause. Spokeswomen for the Caravan did so in the news media. One

³²⁷ SB 323–529.

³²⁸ The Abortion Caravan was a dramatic cross-country procession of (primarily feminist) activists who travelled from Vancouver to Ottawa to protest the restrictive 1969 abortion laws. They brought with them a hearse and coffin decorated with coat hangers and signs, which symbolized and denounced women's horrific experiences of illegal abortion. They 'picked up' more and more activists as they travelled east through each city, and were supported (i.e., fed and sometimes housed) by Canadian women and families at their various stops. These activists described their purpose to one journalist as a massive protest in order "'to get the abortion laws changed so that any Canadian woman can have an abortion on demand'" (Kirkwood, "Feminists plan": W10). Many historians have examined the Abortion Caravan. *See* Thomson, "Winning Choice" (especially "Chapter Six: Invading Parliament": 51-61). *See also* Sethna and Hewitt, "Clandestine Operations" and Stettner, "We Are Forced".

journalist reported: “both doctors *and nurses* have told [a Caravan spokeswoman] ‘on and off the record’ that hospitals have quotas and doctors are encouraged not to send too many patients for abortions.”³²⁹ In the same article, another spokeswoman said: “a Toronto General Hospital doctor told her the hospital’s emergency department handles 70-120 botched abortions monthly [and that] nurses on emergency duty say they see three of four cases nightly.”³³⁰ By citing their perspectives and experiences, the women of the Abortion Caravan seemed to accept the idea that in-hospital nurses were indeed expert or particularly knowledgeable practitioners vis-à-vis illegal abortion provision. Moreover, they demonstrated a willingness to lean on nurses’ reports of their clinical experiences in order to illustrate and bolster their foundational arguments in the public eye.

The Hand-Holding Nurse

Somewhat in contrast with the clinical in-hospital expert nurse, some actors took up and invoked the identity of the ‘good’ or moral nurse to support their aims of challenging and weakening the abortion law. Clinic literature, media reports, and court testimony often highlighted that at the freestanding clinic, a nurse was available to hold a woman’s hand throughout her abortion procedure. This act of holding a woman’s hand was portrayed as a normal and ubiquitous nursing task designed to provide emotional support or comfort to women undergoing abortion. Ultimately, it was framed as a kind act provided by a kind nurse, which, after all, the assumption

³²⁹ Kirkwood, “Feminists plan”: W10 (my emphasis).

³³⁰ Ibid.

went, was what all nurses fundamentally were: kind and good.³³¹ In this tumultuous time, the hand-holding role of the abortion clinic nurse was decidedly made public. It was also noted that, “in the Operating Room, two nurses are present: one assists the doctor and the other attends to the patient, holding her hand and giving verbal support.”³³² A similar press report noted that clinic literature (i.e., pamphlets given to women) assured patients that, “the nurse will remain at your side all the time to look after you, to hold your hand, and to explain what is happening.”³³³ The idea of the ‘hand-holding’ abortion clinic nurse, I would argue, was intended to weave its way into the public consciousness in order to demonstrate that clinic abortion provision was legitimate—that it was respectable. It is reasonable to suggest that this construction was performed rather straightforwardly given that the concept of the good and kind and, indeed, hand-holding nurse in many other clinical contexts was already there. The goal here was to apply it to nurses’ abortion work.³³⁴

³³¹ This image is significant and contentious in nursing history. In her book on nurses in WWI, for example, historian Christine Hallett notes the way that nurses, by being present with and in some cases indeed holding hands with the soldiers for whom they cared provided emotional containment of the patients’ suffering. She described it as a way that nurses worked toward healing. *See*: Hallett, “Containing Trauma”: 164.

For more on the concept of caring in nursing, *see* Morse et al., “Exploring Empathy” and Morse et al., “Concepts of Caring”.

³³² Knes, “Morgentaler readies abortion clinic”.

³³³ “Morgentaler offers guide”.

³³⁴ Although this move was perhaps straightforward, it was not without controversy nor easily accepted, especially by anti-abortionists. For more on that, *see* Chapter 3.

Just as they relied on the identity of abortion clinic nurses as expert practitioners, Morgentaler's legal defence team also incorporated nurses' practice of hand-holding—and its association with nurses as kind and virtuous caregivers—into their strategy in court to argue that their abortion clinics could not be 'bad' or uncaring or malevolent places. At one of Morgentaler's trials, following the 15 August 1973 raid of the Montreal clinic, the hand-holding nurse featured prominently. She was raised by the defence team in order to argue that abortion services at the freestanding Morgentaler clinics were provided not only in clinically safe ways but also with care and kindness, which, they argued, supported their position that freestanding clinics promoted and protected women's health. *The Globe and Mail* journalist Richard Cleroux reported:

The Crown sought to prove accomplices were involved [in providing abortions, which included] nurses, aides, and a secretary. [But] the defence used the medical assistants to prove [that] the doctor really *cared* for his patients and that he even had a nurse around to hold the hand of patient.³³⁵

Morgentaler's defense team purposefully did not deny that Morgentaler and clinic staff were providing illegal services. Rather, they argued that those services were necessary, were safe, and moreover, that they were compassionate. In pointing to nurses' hand-holding roles, Morgentaler's team crafted and reinforced the concept of the kind or virtuous nurse, and they depended on 'her' into order to support their broader legal challenge.

³³⁵ Cleroux, "She won": 7 (my emphasis).

Morgentaler continued to craft and reinforce this construction in the media, which worked not only to support his defense but also to stand up for nurses. He appealed to the public, claiming that in doing illegal work in the abortion clinics, the nurses’ ““only intention was to offer a *helping hand* (my emphasis) to people badly in need of such help.””³³⁶ He chastised the state for pursuing and punishing these well-intentioned practitioners, claiming that it was uncivilized, indecent, inhumane, and unfair to do so. Similarly, following the June 3, 1983 raid in Winnipeg, he declared to *The Globe and Mail*, ““I’m very disappointed and indignant that the police took the uncivilized action of disturbing the patients and staff when they didn’t need to do so.””³³⁷ Moreover, at a press conference addressing the Winnipeg nurses’ trials, Morgentaler announced, ““I appeal to the Attorney-General to drop the charges against the nurses and counselors in the name of decency and humanity and fair play and justice.””³³⁸ In these public declarations, Morgentaler implicitly relied on the idea that nurses-as-such are good, that they are upstanding or beyond reproach, and that accusations and punishments laid against them, in short, were absurd. To treat the good nurses as anything but good, Morgentaler implied, was ludicrous.

I wish to leave the reader with one other compelling example wherein Morgentaler’s team (this time, his Public Relations team rather than his legal one) relied on the traditional construction that nurses in general are fundamentally virtuous, and, in this case, even ‘angelic’ in order to publicly defend the clinics. The details of nurses’ involvement in the case are scant but telling and significant. In the 1980s, newspapers began reporting the story of a woman named Sylvia in

³³⁶ Gory, “Drop charges”. *See also* “Drop charges: Morgentaler”.

³³⁷ Cleroux, “Winnipeg clinic”.

³³⁸ Gory, “Drop charges”.

a way that portrayed abortion services (and nursing work specifically) at the Toronto clinic as cruel and inappropriate.³³⁹ According to Dunphy, Sylvia remarked to the press that during her abortion she “had been given no painkiller, and when she’d told staff she didn’t want an abortion after all, she’d been forced back down on the operating table and had a sanitary napkin stuffed in her mouth.”³⁴⁰ When clinic spokeswoman Judy Rebick was approached by the media to confirm the story, she reportedly “ran up the stairs to talk with the nurses. They confirmed that Sylvia had panicked during the procedure, and they had given her a sanitary napkin to bite down on ([which was] a standard procedure).”³⁴¹ And then Rebick did something significant, she “chose *‘the most angelic looking nurse on staff’* to tell media the clinic’s version.”³⁴² It is my suggestion that Rebick hoped to rely on the enduring conceptualization of nurses as good and virtuous—or, to use her words, ‘angelic’—to counteract the damning story. If so, once again, the team invoked this particular nursing identity to support their broader cause. And once again, in doing so, they stood up for the clinic in general and for nurses specifically, which, I argue, supported nurses’ in pursuing their ongoing illegal clinical work.

This analysis begins to uncover some of the complex and perhaps overlooked intersections between abortion legislation and abortion practice. It points especially to a rich reciprocity between nursing practice and other non-clinical action aimed toward legislative changes, which contributed both to the eventual dissolution of Canada’s criminal abortion law in 1988 and to, I

³³⁹ Cleroux, “She won”; McLeod, “Mistreated’ patient”; Morotte, “Trip to hospital”.

³⁴⁰ Dunphy, “Morgentaler”: 263.

³⁴¹ Ibid.

³⁴² Ibid (my emphasis).

suggest, the enduring success of abortion provision from freestanding clinics. It also reveals, then, some of the collective power that clinic nurses developed as political actors. For, not only was abortion clinic nurses' creative, meticulous, and defiant abortion work essential to promoting the safety of women actually having abortions, but it was also shown to be an important move towards confronting and resisting broader ideologies that allowed for and supported legislative control over women's reproductive health (and, by extension, over nurses' own work itself). In practical ways, nurses' abortion work reached beyond the clinic walls to support the non-clinical (or political) efforts of other groups and individuals who resisted the state's strict regulation of abortion. In the next chapter, I turn attention to the nature of nurses' work within freestanding clinics after decriminalization.

CHAPTER TWO: Negotiating Abortion Nursing Amid the Critique of Medicalization

I wanted to get into abortion care. It was going to fit with my feminist activism and all the things I believed!" [...]. I understood the feminist model, which was quite leery of medicine, and I had read *Our Bodies Ourselves* and all that stuff ... you know, women and their own self-care and self-examination, all that sort of stuff. But in my opinion, abortion was surgery and it needed to have a medical model too [...]. [At our clinic], we wanted to do a medical model. A medical-feminist model.³⁴³

Whereas in the previous chapter I highlighted the challenges that women and nurses faced in improving women's access to legal abortion services prior to decriminalization, in this chapter, I concentrate on the nature of nurses' actual work and the services provided from inside freestanding clinics after decriminalization. I particularly focus on some of the tensions that arose from the growing feminist critique of medicalization and its relationship with abortion nursing practice. In this post-1988 era, I suggest, abortion clinic nurses increasingly negotiated their work amid multiple and ostensibly competing ideological and practical approaches to abortion and women's health. These were variably framed by nurses and non-nurses, both explicitly and implicitly, in terms of feminism, medicalization, and de-medicalization. Nurses' significant negotiations in this shifting social and practice environment have gone unexplored in the historical narratives of abortion, nursing, and women's health.

³⁴³ LE 191–505.

Abortion's decriminalization in 1988 was immediately significant for freestanding clinic nurses and the women for whom they cared. Given that their work was no longer illegal, nurses now had increased opportunity to join or remain in the field, to open and develop freestanding abortion clinics, and to refine the services that they helped provide there. Unlike in the previous criminal and liberalized eras, abortion clinic nurses could now openly do their work. They could legally order and receive medical supplies. They could carefully attend to their patients without worrying that the police would burst in and incite chaos. And they could do their work free from the looming threat of arrest or incarceration. Notably, in this arguably more open context, the functioning of freestanding abortion clinics and, to some extent, the work that nurses performed there, were made increasingly public and thus open to further scrutiny.

Clinic operations, for example, were highlighted (and in some ways advertised) in city newspapers. On the opening day of Ottawa's first freestanding abortion clinic in 1994, for example, Henry Morgentaler invited members of the media inside to explore and then report on the facility. The *Ottawa Citizen's* subsequent account read:

[Morgentaler] invited reporters into one of [the] empty Operating Rooms to explain the procedure: the patient is sedated, her cervix opened, and the contents of her uterus vacuumed out. A nurse/counsellor sits beside the patient throughout to provide emotional support. The procedure usually takes less than five minutes, after which the woman is shown to the recovery room

where there are bright yellow reclining chairs and lots of tea and cookies.³⁴⁴

Though certainly this article offered a colourful sketch of the clinic environment, the abortion procedure, women's experiences, and the roles that nurses and other practitioners performed there, it is nevertheless but a superficial glimpse into the complex inner workings of a freestanding abortion clinic. The observations skim the surface of abortion provision but reveal little about actual clinical practices or the social and professional principles that drove abortion practices in the Ottawa clinic and in freestanding abortion clinics in general.

The words of Vancouver abortion nurse Lisa E in this chapter's opening quotation, however, indicate that deeper undercurrents were at play for nurses who worked in the clinics (i.e., currents that ran deeper than the façade of a five-minute vacuum procedure, bright yellow reclining chairs, and lots of tea and cookies). In articulating that abortion care "would fit with [her] feminist activism" while simultaneously emphasizing that the procedure itself was "surgery," and thereafter suggesting that abortion provision therefore required a combined "medical-feminist model," Lisa E brought to the forefront a deeper engagement with her abortion clinic work. Throughout her oral history interview, she revealed that she had long been reflecting on the connections between multiple conceptualizations of abortion provision (including as a feminist-activist pursuit and as a surgical, or medical, procedure), the actual physical embodiment of it for both practitioners and patients, and her own approach to practice as an abortion clinic nurse as a result. Perhaps unsurprisingly, the nuances of abortion nursing, the

³⁴⁴ "Ottawa clinic": C1.

ways that nurses thought about it, and nurses' hands-on clinical work amid shifting social and professional contexts were not immediately captured by public media sources such as in the *Ottawa Citizen*. My analysis moves toward doing so, however.

Of particular significance in this era, as alluded to by Lisa E, is that she and her colleagues were living and working within the context of a strengthening feminist women's health movement that had emerged in the late 1960s. To orient readers to this foundational social and professional context for my analysis, I now briefly review the feminist approach to women's health.³⁴⁵ Central to this arm of the women's health movement was an ongoing evaluation of existing abortion services and a subsequent critique of what was perceived as the medicalized and medicalizing nature of them. Critics rejected what they saw as (typically but not always male) practitioner-driven and gendered hierarchical approaches to abortion provision. They rejected the 'medical' disease-cure model of abortion practice whereby unwanted or unintended pregnancies constituted a pathology or disease and abortion constituted a medical therapy or cure. They opposed the safeguarding of clinical knowledge and decision-making power by practitioners. Such practices were explicitly framed by some feminists as medicalized and were argued to be detrimental to women's lives and health.

These women called instead for women-driven and non-hierarchical abortion services. They insisted on the integration of a more socially oriented model of abortion practice whereby unwanted or unintended pregnancy constituted a relatively normal (as opposed to a pathological) event that took place within the complex totality of a woman's life and where abortion was a

³⁴⁵ See also my review in the Introduction.

normalized process within and beyond the medical context. They called for the transparency of clinical knowledge and a transfer of decision-making power from out of the hands of male physicians and into the hands of women-practitioners (such as women physicians, administrators, and counsellors—very little was said by them about nurses) and women-patients. They advocated for women’s increased capacity for knowledge, self-care, and self-determination. In this chapter, I conceptualize these feminist aims as strategies of ‘de-medicalization.’

After decriminalization, women’s health advocates aimed to put the ideology of de-medicalization into practice in freestanding abortion clinics. Whereas prior to abortion’s decriminalization, many members of the women’s health movement had focused on increasing women’s access to legal abortion by challenging the abortion law, when questions around legal access were, in some ways, able to be put on the backburner after decriminalization, wider cultural space had been opened up for reflection on the ways that abortion services were actually provided in freestanding clinics. Decriminalization, then, afforded feminist women’s health advocates the opportunity to reimagine and redirect abortion services. They did so by helping to establish new abortion clinics and by joining existing ones in which they worked toward the de-medicalization of abortion services.³⁴⁶

Turning again to my substantive analysis, Lisa E’s words indicated that she, too, brought the understanding that there was perhaps a separation to be made between so-called ‘medical’ and

³⁴⁶ The Everywoman’s and Bagshaw clinics in Vancouver, in addition to the Morgentaler clinics in Toronto and Ottawa, comprise the primary sites of study in this chapter. Other Morgentaler clinics are mentioned briefly.

‘feminist,’ or, as they are conceptualized here, de-medicalizing perspectives and practices. Yet she also put forward that there was perhaps a greater opportunity for blending or bridging the two (in, as she put it, a medical-feminist model). Lisa E’s reflection and other evidence provided in this chapter suggest that abortion clinic nurses meaningfully engaged with these considerations, which, I argue, informed and were informed by their hands-on abortion practice and their work with women’s health advocates inside the clinics. I offer that this specific engagement by abortion clinic nurses also reflected the profession’s broader (academic) attention to its theoretical underpinnings and nursing’s alignment with and separation from the medical establishment. These were professional ‘conversations’ that often took place beyond the explicit frameworks or language of ‘feminism’ and de-medicalization, but in many ways, they paralleled and echoed those approaches. In the abortion clinics, nurses did likewise. They demonstrated that they aspired to incorporate de-medicalizing strategies into their otherwise medically oriented work, and some, but not all, explicitly claimed feminist motives for doing so while others conceptualized it in terms of nursing more broadly. Overall, these abortion clinic nurses articulated that they approached their in-clinic practice with the overarching, non-negotiable professional goal of promoting women’s safety and wellbeing. In order to elucidate those arguments, I trace nurses’ work in the clinics from early facility development to their participation in preparing women for the procedure and supporting them throughout it.

Building Clinics: Enacting Leadership and Disrupting Professional Hierarchy

In this section I put forward that decriminalization helped nurses to create and enact new leadership roles as they brought previously non-existent freestanding abortion clinics into fruition. Specifically, they disrupted physician-nurse hierarchies and worked to create clinics that

promoted women's medical safety and general comfort. In these developmental pursuits, it can be seen that clinic nurses engaged in some de-medicalizing activities. Namely, they created and claimed top-level leadership roles that positioned them as equal (or close to equal) practitioners with their male physician counterparts, thereby moving towards shared power between men and women practitioners. Moreover, as they held women's comfort and safety in priority while designing new clinics, nurses perhaps helped to normalize abortion or cast it outside of the purely pathology/treatment or disease/cure model that had been constructed thus far.

Complicating this interpretation, however, was nurses' ongoing reliance on some familiar medical strategies and an attendant reinforcement of hierarchical structures whereby they as women practitioners held power above patients. Clinic nurses are thus shown here as approaching their abortion work from both medical and de-medicalizing positions. Yet, as in their earlier work prior to decriminalization, clinic nurses continued to claim an overarching commitment to promoting women's safety, which they seemingly aimed to uphold here by bridging these two approaches to abortion provision.

One of the immediate challenges facing nurses who aimed to open new legal freestanding abortion clinics was that they had to be developed and, in some cases, literally built from the ground up. Joan W of the Ottawa Morgentaler Clinic explained: "There was nothing, right? There wasn't even a building for us!"³⁴⁷ Nurses like Joan W and her colleague in Toronto, Sharon B, embraced the new opportunity to help to find, secure, and design under-developed clinic space. They took that challenge on and carved out long-lasting and wide-ranging leadership roles in doing so. Sharon B, who had worked closely with Morgentaler in the illegal

³⁴⁷ JW 1686.

Toronto clinic, for example, continued to partner with him in order to open additional legal clinics across Canada. She remembered:

So, [in 1992 ...] that was my job. To go find [a new building in Toronto]. [...]. I went out looking for a place and negotiated with—worked with—the real estate agent, and looked at buildings, and then, moving forward, worked with the architect, and the drawings, and the lawyers, and the construction company, and the administration. And [I did] the same when we did it in Ottawa.³⁴⁸

Here, then, was an opportunity for Sharon B to engage in a new kind of abortion work before the clinic doors opened. She demonstrated her willingness, determination, and capacity to function and flourish in the processes of imagining and organizing new clinics, which proved fruitful in Toronto and beyond. She explained:

I wrote the request [for government support and funding for the Ottawa clinic]. The proposal was accepted in 1993 and we moved in! [...]. Henry then wanted to open a clinic in Fredericton, and he said, ‘OK, me and you go to Fredericton and you do this there.’ [...]. I also opened the clinic in Newfoundland in the 1990s. And when they did that request, their proposal, we did that [too]. [...].

³⁴⁸ SB 271.

It just sort-of grew slowly, and actually it was very exciting, and I only have good memories of that!³⁴⁹

For Sharon B, this work was unfamiliar. It was different from the work that she had performed as a hospital nurse or at the illegal clinic in Toronto. She was expanding her scope of practice and taking on new responsibility as a nurse. Unsurprisingly, she sometimes found it unnerving. She confessed:

I had to learn to read drawings [or blueprints]. I would go over the drawings for the different clinics—the *potential* drawings [which I had to approve]. And it was like, at night sometimes I'd think, 'Holy Jesus, Sharon! What do you think you are doing?'³⁵⁰

Yet, she continued to take on this responsibility, telling me “Yeah, you just did it!”³⁵¹

Sharon B and nurses in other clinics also performed additional design (rather than scouting) roles once space had been secured. That is, they helped shape the way that women and practitioners would move through the clinic through administrative and reception areas, pre-procedure counselling rooms, the procedure or Operating Room, and post-procedure recovery spaces. In performing these roles, clinic nurses helped to (re)imagine how abortion clinics could function.

³⁴⁹ SB 280–301.

³⁵⁰ SB 1310.

³⁵¹ SB 320–321.

They articulated the desire to foster logical patient flow for how the procedure was carried out while also taking into account women's comfort. In other words, they seemingly aspired to create a woman-friendly (arguably feminist) space that simultaneously worked for practitioners. Doing both, or bridging these approaches, they put forward, would help them to promote women's safety both medically and emotionally.

Sharon B in central and eastern Canada and Jackie F in Vancouver both helped design their clinics in these ways. They articulated that they wanted to ensure "good flow" for women as they progressed through their appointments. Typically, this progression began in the reception and waiting room area, where the woman signed in for her appointment and waited to be called into the 'back.' Then she was guided to a pre-operative ['pre-op'] counselling room to discuss her social and medical history and to establish her expectations for the procedure. Thereafter she changed her clothes and was brought into the procedure room, or Operating Room, where the abortion surgery was performed. Finally, after the abortion, the woman was guided to the recovery area, where she was monitored for complications, was indeed offered tea and cookies, and prepared to go home.

In order to create or design a pathway from pre-op to recovery that 'worked' in accordance with the provision of a medical procedure, Sharon B and Jackie F drew from their previous work in providing abortions and other minor surgeries in hospitals and, in Sharon B's case, an illegal freestanding abortion clinic. From those places, they had developed an experiential understanding of efficient and effective pathways, which they suggested was a valuable—if not imperative—perspective to implement into the new freestanding clinic spaces. Sharon B noted

with some emphasis that she took on ‘design duty’ because she “wanted [the clinics] to work properly” and she “wanted them designed properly!”³⁵² For her, proper design and function entailed ensuring:

The best flow of patient care [... such] that you don’t run into one part [of the clinic repeatedly] and then you’re not backtracking for the patients. [You’re] providing space for different things that need to be done in the various areas.³⁵³

She appreciated the opportunity to build and design new clinics after decriminalization because, she noted, “when you’re working with a blank space, you can make it the best it can possibly be.”³⁵⁴ Vancouver abortion clinic nurse Jackie F articulated a similar perspective when she helped design the Everywoman’s Clinic. She remembered:

I helped design this clinic to look very similar to what we had at surgical daycare [in the hospital].³⁵⁵ [...] I liked the flow of how

³⁵² SB 343–350.

³⁵³ SB 348–350.

³⁵⁴ SB 1597.

³⁵⁵ Surgical daycare is a hospital department where short, relatively non-invasive procedures, including abortions, were performed. Surgical daycare patients were not fully admitted to the hospital (though they were registered). That is, they did not stay overnight ‘on the ward’ unless they experienced major complications. Typically, they were discharged on the day of surgery

surgical daycare was from pre-op around. And so, when we put the new clinic together, I made it sort of work [that way] because I thought it was a good way of working it.³⁵⁶

For women's health advocates who aimed to create alternative-to-medical approaches to abortion provision, nurses' reliance on their previous in-hospital and clinic experience to shape clinic design could be framed as a medicalized approach. Bringing the hospital to the new clinic, as it were, could emphasize a specialized, clinically-driven environment that reinforced practitioner-patient hierarchies and the long-standing bio-medical conceptualization of abortion as a cure or therapy in the treatment of the illness of unwanted pregnancy. It could arguably cast the embodiment of abortion into a rigid linear medical process, which was perhaps not always the way that women generally understood their abortions or even perceived or wanted their abortion appointments to proceed. Yet these clinic nurses, who indeed constructed and took up these designer roles in some of the clinics, trusted this strategy as an effective one for providing the 'best' services to women. Significantly, Sharon B suggested that thinking about and taking on design work in this way did constitute a *nursing* approach, which given her work, she obviously valued as an important feature in developing new clinics. She explained:

I'm using my nursing [knowledge and experience] to base my decisions on [...]. Because it all came back down to the nursing

from the surgical daycare department. At JF's surgical daycare department in a large Vancouver hospital, they performed, as she put it, "dentals and abortions."

³⁵⁶ JF [JF] 617/724. Interview by author, November 2015.

care of the patient, the patient care and how were you going to enable that to be the best that it can possibly be. You know, the nursing stuff, the skills and attitude [...] it is connected [to the development work]. It has to be connected. [...]. And I do see it that way.³⁵⁷

In addition to helping design a functional and efficient site for the provision of a surgical procedure, some clinic nurses also demonstrated an eagerness to help create an environment that was comfortable for women. I suggest that they illustrated an aspiration to bridge medical and more women-friendly, if you will, approaches in order to enable their care to be, as Sharon B put it, “the best that it can possibly be.”³⁵⁸ They engaged in this work in a number of ways. Nurses at Everywoman’s for example, chose to paint the walls of the procedure room turquoise instead of institutional white or beige. They hung posters around the clinic, including one above the exam table for women to look at during their procedures. Many of the freestanding clinics featured original and reproduction art throughout all areas, including the waiting room and beyond. And, for a time, Everywoman’s featured an enormous hand-painted mural on the exterior walls of the building.

Aside from these visual elements, abortion clinic nurses also helped create comfortable items for women’s direct use. At the Elizabeth Bagshaw clinic, for example, some nurses sewed cloth skirts for women to wear during their procedures rather than traditional patient gowns. They

³⁵⁷ SB 1593–1597.

³⁵⁸ SB 1597.

made fabric covers that concealed the suction canisters in the procedure room in order to obscure the blood and tissue that was collected there, which some women articulated they did not want to see. And they added soft stirrup covers and leg warmers to provide warmth to women in the cool Operating Room.³⁵⁹ In the recovery areas, nurses, just as the *Ottawa Citizen* somewhat flippantly suggested, indeed dispensed “lots of tea and cookies.” This action helped recovery room nurses to manage women’s physiological conditions (such as low blood glucose levels—they had typically fasted before the procedure) and to offer some comfort after what could prove an emotionally difficult event for women.³⁶⁰ The Recovery Rooms also did feature bright yellow and floral reclining chairs and other ‘homey’ accoutrements.

Like the *Ottawa Citizen* reporter, other (presumably non-medical) observers of the new clinics also indicated that staff seemed committed to fostering a warm, homey environment and not solely a medical- or institutional-feeling one. Of the Calgary Morgentaler clinic, for example, one journalist wrote: “Inside, the waiting room is pleasant. The overstuffed couch is comfy, coffee carafes are at the ready, and the work of local artists adorn the walls.”³⁶¹ Undoubtedly, nurses did not conceive of and perform this work on their own.³⁶² Yet, their contribution to constructing a comfortable clinic, I suggest, was as a significant role for them. This work can be understood as one avenue that nurses took toward promoting de-medicalizing practices. For, in

³⁵⁹ JB; RW.

³⁶⁰ See JB on the cookies; LR on the fasting.

³⁶¹ Gilbert, “Clients”: A1.

³⁶² Dunphy, in “Morgentaler,” describes Morgentaler’s wife’s involvement in decorating the illegal clinics.

doing so, they helped build a place not completely driven by the clinical needs of women and practitioners but one that also acknowledged and attended to women's emotional wellbeing. Clinic nurses, then, arguably helped to enact abortion provision as a more normalized event for which more familiar touches were appropriate. In designing and building clinically functional yet comfortable spaces, abortion clinic nurses demonstrated a willingness or aspiration to bridge the particulars of the medical world with the particulars of women's emotional needs and desires. Their work here highlights that some clinic nurses were engaged in doing so.

On the whole, from the new freestanding clinics, nurses articulated that they could more easily implement their own ideas and strategies for shaping the environment than they could within the constraining hospital system. They took up increasingly powerful positions, which I suggest contributed to a disruption of the established physician-led and physician-directed in-hospital health service model. Nurses such as Sharon B were able to harness decision making power, which, according to critics of the medical approach, had historically been assigned to physicians and hospital administrators. In some respects, then, this move was a feminist one insofar as it captured increased social and professional autonomy for women-practitioners, which was a key strategy for enacting women-centered health practices. Sharon B explained that she could achieve her goals in part owing to her collaborative relationship with physician Henry Morgentaler and to the autonomy she was able to cultivate as a result. She fondly remembered Morgentaler's readiness to approve her plans and facilitate her increasing independence in her design work. She shared many stories about that experience, including a time when she showed Morgentaler her new clinic plans. She recounted:

I said [to Henry], ‘We’ll put you here and then we’ll go this way and then you go down here and then you go there.’ [...]. [When] Henry saw the plans [...] he would say, ‘Well, yes, that’s fine. [...] Okay, okay, okay, that’s fine. Now let’s just go for lunch!’³⁶³

She elaborated:

My life with Henry was like that. You never knew what was going to happen. He could walk in one day and say ‘Sharon! I want you to open the clinic here. [I would say], ‘Okay I’m on it.’ And what you wanted was [approved] *cart blanche*. You’d say, ‘OK. I’m going to have to go here then.’ [He would agree, saying], ‘OK. Go! Do whatever you want. It’s up to you.’³⁶⁴

Morgentaler consistently showed that he shared power with Sharon B over clinic development. In fact, he told her, “‘Sharon, I’m going to phone (the lawyer) and I’m going to make you a director on this company so that if you find the space, you can do the signing for it.’³⁶⁵” Sharon B concluded, “I had a lot of autonomy. And when I talked, people listened.”³⁶⁶

³⁶³ SB 351–355.

³⁶⁴ SB 1178–1182.

³⁶⁵ SB 912–922.

³⁶⁶ SB 1184.

In a similar way, this history disrupts one branch of established ‘feminist’ historiography. There, nurses have sometimes been framed as ‘ordinary’ women who carved but a narrow professional role for themselves as women and remained ‘victims’ of patriarchal structures that rendered them subordinate to physicians. In such an interpretation, nurses were framed as mere handmaidens to physicians rather than collaborative partners or even autonomous practitioners in their own right.³⁶⁷ I posit that these abortion clinic nurses articulated that they enacted more collaborative and increasingly autonomous leadership roles in developing freestanding abortion clinics that functioned well clinically and supported women in broader ways. In their developmental work, some of these nurses were arguably balancing the ostensibly competing models of medical and de-medicalized abortion services—much to their own professional benefit and, perhaps in a more subtle way, to women-patients’ clinical and social benefit as well. As my analysis continued, it became clear that abortion clinic nurses’ willingness or aspiration to bridge multiple approaches to abortion provision extended well into their post-development roles. In the following sections, I examine the ways that nurses engaged with these concepts, both in their theoretical reflections and their hands-on practices.

Preparing for the Procedure: Promoting Women’s Safety and Wellbeing

Turning now to nurses’ direct in-clinic roles, I begin as women-patients did—in “pre-op.” Prior to the abortion procedure, women were guided from the waiting room into a small office-like

³⁶⁷ See Melosh, “Physician’s Hand,” for example. LE and RW reflected on this phenomenon as well.

room for counselling and screening. Through one-on-one conversation, the pre-op nurse³⁶⁸ typically explored with women their decision-making processes, assessed whether they felt secure and free in the choice to have an abortion, and obtained written informed consent for the procedure.³⁶⁹ She also reviewed and documented women's social histories, which could involve exploring sexual and intimate relationship experiences or other events that brought them to terminate a pregnancy. If appropriate, the woman received contraceptive teaching and, in some cases, medications such as oral contraceptives or prophylactic antibiotics to take home. The pre-op nurse also reviewed the actual abortion procedure with women—outlining, for example, what it entailed and what it might feel and look like—and addressed any questions or concerns women had at the time. She also reviewed and documented women's (bio)medical histories prior to surgery and discussed potential complications with her.

In this domain of abortion clinic work, nurses demonstrated that they aimed to approach it in contextual women-focused ways while also keeping women's biomedical conditions in mind. This combination, nurses said, supported their primary goal of helping women to have safe abortions. In the pre-op role, for example, some nurses perceived that they could help de-medicalize abortion provision by acknowledging and identifying the wide range of women's

³⁶⁸ There is some question about who performed this role: a nurse or a non-nurse counsellor. For this section, I speak about the pre-op role as a nursing one. I will discuss the counsellor uptake and nurses' negotiation of that role in the section of this chapter entitled "Feminist Abortion Services: An Interdisciplinary Tension."

³⁶⁹ A sample consent form of the Everywoman's Health Centre in 1993 can be found in CoVA Prochoice Records AM 1486 E-1-12.

abortion wants and needs. They suggested that they could consider women's unique social positions and psychosocial conditions (in addition to their bio-medical ones) in order to more fully prepare women for the procedure. This approach reflected a hallmark of de-medicalized health services, which asks that women foremost be understood as "contextualized in their diverse social and economic circumstances."³⁷⁰ This strategy can be de-medicalizing in abortion provision when practitioners acknowledge that women's social factors and differences impact their health and abortion needs in complex and overlapping ways and then help to provide services accordingly.

Abortion clinic nurse Joan W expressed how she enacted this de-medicalizing (and, according to her, feminist) approach, explaining that in the freestanding clinics pre-op nurses had an increased opportunity to 'get to know' women or to "learn about women" in the context of their lives beyond the 'medical' realm. She emphasized that only by doing so could abortion providers offer the most appropriate services to women and promote their emotional wellbeing. One way to learn about women, she suggested, was to listen to (and she implies to accept as legitimate) the range of reasons why women decided to terminate their pregnancies, including ones related to economic positioning or family-relations, for example. This practice falls into the de-medicalizing approach insofar as it helps to reject the disease-cure framework and acknowledges the broader meaning and experience of abortion for women. Joan W remembered that in the in-hospital abortion system, for example, providers failed to get to know women at all, assigning to them arbitrary labels instead. She explained:

³⁷⁰ Morrow et al., "Women's Health": 9.

They never knew why women had abortions. [...]. They never knew. They never asked. [...]. And they said, ‘Well, she must be this’ or ‘she must be that.’ [...]. There’s always been stories about why women do things. And that was a really big issue for me! We [in the hospital system] learned nothing about women.³⁷¹

She countered that:

If you *asked* women [about their circumstances], what they’ll give you as an answer is: ‘Well, my mother ... Well, my husband ... Well, my other children ... Well, my job, my financial situation.’ And they’ll go around every one of those things as part of the way they are putting their decisions together. And then they will define what is the most responsible action based on their relationship to those components in their lives.³⁷²

Joan W noted that practitioners who labelled or (pre)judged women instead of learning about them and incorporating their perspectives into abortion services generally dismissed them, which was problematic for her. She remembered thinking: “‘Just ask them!’ But No! We couldn’t do

³⁷¹ JW 297–304.

³⁷² JW 2035–2041.

that. [... Instead] it was like, ‘We’ll just tell women what’s good for them. We know what’s good for women.’”³⁷³

The practice of privileging practitioner assumptions rather than listening to women reinforced practitioners’ ostensibly superior status, which Joan W, like many women’s health advocates, found “elitist.” She objected, “That’s such an elitist notion [the attitude of], ‘if you just listen to me, then we will get it right, and you’ll live happily ever after.’ I mean that whole elitist notion was so offensive.”³⁷⁴ That approach, she demonstrated, erased women’s individuality and complexity, ignored their unique needs, and positioned them below practitioners in a practitioner-patient hierarchy. How, Joan W wondered, could a decontextualized one-size-fits-all medical approach help fulfill women’s needs when their lives and decisions were so complex? She asked: “How can you provide [quality] services if you didn’t learn more about what the experience of women was?”³⁷⁵

Joan W ultimately felt that the structure of in-hospital abortion services and its medicalizing approach to women and their health was flawed and, moreover, that as a nurse she did not hold enough power there to change it. She found it difficult to balance her competing responsibilities in that rigidly structured system. She explained, “you have a huge responsibility to the institution, you have a responsibility to your profession, and you have a huge responsibility to

³⁷³ JW 887.

³⁷⁴ JW 1971–1973.

³⁷⁵ JW 306.

the women.”³⁷⁶ She felt that “working against [that system] was tremendous,” adding, “trying to break that was really difficult.”³⁷⁷ Echoing arguments put forward by women’s health advocates, Joan W perceived hospital-based abortion services as hierarchical and physician- and institution-driven, which she found both oppressive to women and detrimental to her ability to practice autonomously. Indeed, Joan W eventually left the hospital to work in the freestanding Ottawa abortion clinic, anticipating that alternative perspectives and practices could thrive there.

Certainly, the pre-op counselling office stood out as a place where nurses could learn about the range of women’s experiences and their abortion needs through conversation (instead of labeling women without hearing their stories or learning anything about them). They could help share the medical or professional knowledge around pregnancy, contraception, and the abortion procedure for women rather than safeguard or gatekeep it. Through pre-op conversations, nurses also had the opportunity to acknowledge women’s authority over their own lives by hearing their abortion decisions and passing those expectations on to the Operating Room staff (rather than telling women what was ‘good for them’). This role could help nurses attempt to uphold an overarching key tenet of de-medicalization—namely, that women “should be seen [and treated] as active agents in their own health rather than merely as passive patients [or recipients] of the medical system.”³⁷⁸ In this way, Joan W demonstrated that she perceived a chief problem of abortion provision in the established hospital system was its medicalization. By contrast, she articulated

³⁷⁶ JW 667.

³⁷⁷ JW 893.

³⁷⁸ Morrow, “Our Bodies”: 41.

the belief that in practicing from a freestanding clinic, she could help implement more de-medicalizing practices.

However, while it provided a good opportunity to shift focus to a range of women's unique wants and needs and to include women as active and knowledgeable agents in abortion provision, the pre-op interview at the freestanding clinic was by no means a 'level playing field' between women patients and nurses. In fact, the pre-op nurse held a significant level of authority in the freestanding clinic given that she was partially responsible for assessing and determining whether a woman was an appropriate candidate for an abortion in the clinic on the scheduled day of surgery. In their roles of assessing women before their abortions, pre-op nurses were on the lookout for a number of physical and emotional factors that could put women's overall safety in jeopardy should the abortion procedure go ahead. Both autonomously and in collaboration with patients and physicians, pre-op nurses were key-decision makers here: they could (and sometimes did) prevent the procedure from happening if they deemed it unsafe.

In terms of biomedical risk factors, pre-op nurses were primarily concerned with the potential exacerbation of women's pre-existing conditions that could cause harm during or as a result of the procedure. By identifying contraindications and assessing the associated risk for women seeking abortions, clinic nurses aimed to promote their safety. Based on their clinical knowledge and experiences, these nurses understood the potential poor outcomes associated with what was ultimately a surgical procedure. Given their knowledge and experience, clinic nurses wanted to screen women in pre-op for physical conditions or contraindications. In so doing, nurses

intended to avoid scenarios for which women and practitioners were unprepared or unable to manage. Lisa E explained:

I was really worried about taking care of people that had problems that they could actually die from: if they had a known cardiac problem or blood disorder, uncontrollable asthma, something where they could throw a [blood] clot [which could create a medical emergency]. It happened while we were doing surgery. There were some people that did pass away [but not at the clinic] shortly after we took care of them. You *don't* want that to happen at the clinic.³⁷⁹

Lisa E remembered two women in particular who, after their abortions, had died later in hospital from complications associated with medical conditions that had not been discovered in the pre-op assessment. With regret, she questioned whether these conditions could have been identified in the pre-op interview, if the nurses could have stopped the procedure from going forward, and if they could have done more to help these women obtain safer abortions. Lisa E noted that their alternative option was to direct or refer women to hospital for further assessment and a different method of abortion there. Although these cases happened early in her position at the abortion clinic, they stood out as significant events in Lisa E's career overall, and she found that they helped shape her work. Preventing clinic emergencies and poor (and even grave) medical outcomes for women, and thus the promotion of women's bodily safety, emerged as one of Lisa

³⁷⁹ LE 430.

E's key priorities as an abortion clinic nurse. Prevention work, she believed, ought to begin in pre-op while practitioners reviewed and documented women's medical histories. Nurses framed this process as 'screening.' Following her difficult experiences, Lisa E herself began to develop formal pre-op screening tools, carving out and taking up a leadership role in refining the safe operation of the clinic. She remembered:

I wrote up the policy and I wrote up the protocol and I made it [...] so it was really usable. [...]. I decided I was going to do what I always do. I talked to all the doctors. I talked to all the nurses. [...]. And I wrote up almost all those forms for our screening tool, the ways we screen for high-risk people with medical problems coming in. I came up with that idea way back when. I always wanted people to be screened and moved into another type of facility if there was going to be a tough time. [...] Those sorts of things made me really, really big on screening.³⁸⁰

Lisa E concluded poignantly, "the idea is not to take care of them [at the clinic] at all. [...]" The idea, rather, is to refer women to hospitals for abortions. She emphasized: "No one is allowed to die in an abortion clinic. It is a *bad* place to die."³⁸¹

³⁸⁰ LE 409–469.

³⁸¹ LE 461.

Through a range of work, abortion clinic nurses became well acquainted with the biomedical realities and risks of the abortion procedure in the clinic. In addition to their in-clinic experiences, they also drew from their theoretical nursing knowledge and hospital roles to anticipate and identify women's biomedical risk factors. In response, they wanted screening to begin early and expected it to be performed effectively in the pre-op phase of women's abortion appointments. As such, abortion clinic nurses prioritized screening and took on the task of developing useful guiding tools.³⁸² Screening tools helped nurses and their physician colleagues decide if an abortion procedure posed too great a risk such that it ought to be halted and a woman referred to hospital. For these nurses, medical screening and advocating for women's interests, and their safety in particular, went hand in hand.

In addition to those biomedical contraindications, abortion clinic nurses were also aware of and concerned about the ways that women's emotional or psychosocial conditions could similarly negatively affect their surgical experiences and put their overall safety at risk. In this context, pre-op nurses were on the lookout for women in emotional crisis, women who expressed they did not feel confident about their decision to terminate, or women who were experiencing distressing memories of past traumas such as sexual violence. Clinic nurses explained that for these women, the physical abortion procedure could amplify these memories, thoughts, and emotions, which could in turn jeopardize their emotional safety.

Lisa E explained:

³⁸² For an example of a screening form that includes these conditions, *see* Everywoman's, "Medical Protocol".

It can be quite catastrophic. [...]. They go into a story or memory thing and they begin to really cry out and it's more than just the abortion. The abortion is like a trigger for it. It's a different way of almost living in a memory or rape. And they're screaming at you. And you're *right there*. [...]. They're screaming, and you, as the nurse, need to calm them down.³⁸³

Lisa R similarly remembered:

You have a woman with all her history, and you have them naked from the waist down and you put their legs up and you give them a bunch of drugs, and all their, sometimes all their traumas come up and you're the one sitting right next to them. She's going to re-live that trauma. [...]. That's not a good thing for the women that are, that have a lot of history with sexual abuse because the abortion can create a dissociative state and it can take them to that place that they were and where they had no power and then [they can] have a total panic.³⁸⁴

In addition to these significant emotional reactions, nurses also experienced that heightened negative emotions could cascade into (bio)medical complications and full-blown medical

³⁸³ LE 617–629.

³⁸⁴ Lisa R [LR] 656–696. Interview by author, January 2016.

emergencies. For example, women who panicked or broke down during the procedure could (among other reactions) become short of breath, their heart rate and/or blood pressure could rise or fall dangerously, they could experience heart palpitations, suffer an asthma attack, or lose consciousness. Here, too, nurses knew that it was their responsibility to manage these outcomes during the abortion, which could be a difficult undertaking.

In order to reduce the risk of these outcomes, clinic nurses began to make decisions about who was safe to have an abortion with them at the clinic on a given day, who ought to be rescheduled for her abortion, and who ought to be referred to another facility (i.e., the hospital). Women who were very anxious, for example, could have their abortions under general anesthesia at the hospital rather than remain awake for the procedure as they necessarily did in the freestanding clinic. Joan W remembered some difficult cases when she felt it was her responsibility as the pre-op nurse to delay women's abortions owing to their emotional distress. She recounted:

[One woman] came in for an abortion to be done and when I counselled her, it was so hard on her and she was in so much distress with it, that I wouldn't do it [that day]. I really wanted her to take the time she needed [to become comfortable with her decision]. [...]. [For these women in crisis], you sort of said, 'Not today. I'll do you tomorrow, but I won't do you today. This is too hard for you to do it today.' [...]. It's not easy. You said, 'Come tomorrow or come next week.' Because if they're under that much stress, you kind of know there's a whole lot of other things

operating there. [...]. It would be much safer for me to bring her back the next day than to do her on a day when she's in that much distress. And that's the way I judged it. [...]. I couldn't let [these women] go [for the procedure] because *you don't know if the outcome will be safe or not*. So, sometimes those were really hard because patients would really get in distress [and they would sometimes be angry]. But they needed more control of the procedure than you could give them. And that was left to nursing to decide in many instances.³⁸⁵

Other abortion clinic nurses such as Lisa E, Sharon B, and Lisa R echoed Joan W's account, sharing that nurses were, at times, central actors in making the decision to accept or turn away a woman for a clinic abortion based on their assessment of women's emotional safety. Lisa R clarified: "It is not an emergency procedure. We will not create any harm if she goes home today and comes back tomorrow. But we're *so* not talking her into having an abortion today."³⁸⁶ As with dangerous biomedical factors, clinic nurses relied on appropriate pre-operative assessments of women's emotional states to help nurses and women decide whether they were safe to undergo an abortion at the clinic.

In taking on the pre-op work of assessing women for abortions, many of these nurses demonstrated a steadfast dedication to promoting women's safety in abortion clinics even when

³⁸⁵ JW 2485–2518.

³⁸⁶ LR 797–799.

their actions diminished women's capacity to determine where, when, and how they would terminate their pregnancies. Owing to their clinical expertise, then, pre-op nurses landed in a powerful and somewhat autonomous 'expert' position, which was in some ways liberating for them as women practitioners but simultaneously eroded women patients' opportunity for self-determination.

Supporting Women During the Procedure

Following the pre-op assessment, a second nurse, known as the "procedure room" nurse, guided the woman into the Operating Room, where she remained for the duration of the abortion. In this room, women quickly encountered abortion as a bodily phenomenon. This room was where their abortions became visceral and sometimes painful. Here was where abortion became unavoidably bloody.³⁸⁷ Procedure room nurses articulated the understanding that some of the women who entered the Operating Room were "really scared." In response, some nurses tried to prioritize the immediate promotion of women's comfort and safety and attempted to develop a trusting rapport while further assessing her patients' wants and needs (i.e., the ways that women wanted to experience the abortion or how they wanted to feel during it). At this time, before the abortion began, the procedure room nurse typically performed an additional safety check for any biomedical and emotional risk factors by reviewing the woman's medical history and other pre-op documentation and confirming her willingness to go ahead with the abortion. Here some

³⁸⁷ Here, I am pointing out the literal aspect of writer Anne Collins' phrase: "abortion is the bloody side of feminism," which is an interpretation of abortion provision that was taken up by some abortion clinic nurses. *See* Collins, "Considering Abortion": 114.

clinic nurses quickly attempted to get to know women as individuals and to offer women a sense of security through communication and acknowledgement. As Lisa R explained:

I worked really hard with connecting with the woman before [the procedure began]. While I'm doing the medical history, I work really hard at making eye contact and just getting a real sense of kind of what's going to work with this woman and what's not.³⁸⁸

Procedure room nurses—who were themselves newly encountering and developing the real side of abortion provision from the new freestanding clinics in the 1990s—came to know intimately that the in-clinic vacuum aspiration procedure could prove significantly challenging for some women physically and emotionally. In an effort to support women overall, these nurses addressed and tried to alleviate women’s psychological anxiety and physical pain. These elements were crucial factors in facilitating the ways that women experienced their abortions. Procedure room nurses drew from, implemented, and worked to refine a variety of techniques, both pharmacological and non-pharmacological, to do so. As with their other clinic roles, in developing and negotiating this work, procedure room nurses engaged in potentially medicalizing practices while also working towards promoting de-medicalizing ones. While doing so, they continued to demonstrate a deep professional commitment to helping women have safe abortions in freestanding clinics.

³⁸⁸ LR 696–700.

Non-Pharmacological Support

One way that procedure room nurses tried to promote women's emotional wellbeing was by monitoring and addressing their fear and anxiety. As they stood beside women at the 'head of the bed,' these nurses (i.e., the hand-holding nurses) claimed to pay careful attention to women's reactions by watching and engaging with them. Nurse Sallie Tisdale described this work in an article as follows:³⁸⁹

I stand beside the table. I hold the woman's hands in mine, resting them just below her ribs. I watch her eyes, finger her necklace, stroke her hair. I ask about her job, her family; in the haze she answers me; we chatter, faces close, eyes meeting [...]. I watch the shadows that creep up unnoticed and suddenly darken her face as she screws up her features and pushes a tear out each side to slide down her cheeks. I have learned to anticipate the quiver of the chin, the rapid intake of breath.³⁹⁰

If anxiety and fear reactions were noted, clinic nurses like Tisdale understood that some women found it helpful to turn to non-pharmacological techniques. In order to help allay women's fear,

³⁸⁹ Tisdale was a nurse from the USA writing in 1970 from a legal abortion clinic. Even though she wrote from an earlier time, her experiences then match the descriptions of Canadian participants following decriminalization after 1988. Tisdale's article was published in *Harper's Magazine*, a fairly mainstream publication.

³⁹⁰ Tisdale, "We Do Abortions": 67.

anxiety, and pain, procedure room, nurses elected, as Tisdale had, to talk (or not talk) with women and hold their hands. They mentioned they also sometimes led women in breathing techniques and listened to music with them. Procedure room nurses noted that these techniques were meant to be tailored to women individually in accordance with women's vocalized needs and nurses' own assessments. Lisa E, for example, explained her practice, remembering:

There's also a huge layer of their emotional, psychological wellbeing, which also feeds into their pain management. And so it's my story-telling I like to do, and the music, and my way of actually zeroing in on exactly what that woman needs right now by the quick history that I've taken and the way I can look at them [throughout the abortion] and get a quick assessment about what I need to do or say to them, to bring them, to talk to them or not, to use silence or chat, to get them through this psychological—whatever is going on with them.³⁹¹

Lisa R similarly explained:

I use my voice a lot, just the tone of my voice and being very gentle and that's what [one Vancouver Gynecologist] calls the 'Vocal Local.' So, I really work hard on distraction and you [...] just try and get them through it and safe. [...]. It's easier for the

³⁹¹ LE 1670.

ones that you can connect with a little bit. They're mentally distracted and things go just nice and smooth.³⁹²

These non-pharmacological approaches, I suggest, can be interpreted as de-medicalizing. With these practices, nurses drew from a range of de-medicalizing strategies advocated by critics of the medicalization of abortion. They tried to acknowledge and come to know women as individuals who arrived in the procedure room with complex physical, emotional, and social experiences that affected their health and surgical experiences. At times women were encouraged to participate in directing and managing their own abortion experiences by communicating to nurses what they wanted and needed and by engaging (or not) in non-pharmacological strategies. In describing their procedure room work, these abortion clinic nurses demonstrated that they valued these contextualized strategies, attempted to implement them, and tried to create space for women to make decisions about how they experienced their abortions.

Pharmacological Support and IV Therapy

Not only did procedure room nurses reflect that they valued non-pharmacological techniques for supporting women through their abortions, but many also said that they relied on pharmacological interventions. For example, in keeping with their scope of practice, nurses could offer women oral or intravenous sedatives, anxiolytics, and analgesia to help them manage

³⁹² LR 699–705. The “vocal local” here is analogous to numbing local anesthetics that are injected into tissues that will be manipulated in surgery (e.g., the cervix).

their physical pain and emotional anxiety (and typically both in combination).³⁹³ Moreover, using appropriate medications, nurses could help manage other complications such as allergic reactions or significant changes in blood pressure, among others. Nurses' use of pharmacological pain management through intravenous (IV) measures proved a notable site at which the ostensible clash between medicalizing and de-medicalizing approaches to abortion provision played out.³⁹⁴

Before or during the abortion, the procedure room nurse considered whether she ought to insert an IV into the woman's arm. Intravenous access allows for the infusion of fluids and medications directly into the bloodstream, which facilitates their rapid and effective administration and uptake. With an IV in place, procedure room nurses could quickly induce conscious sedation and provide analgesia for women.³⁹⁵ Women who accepted conscious sedation remained awake, or

³⁹³ All participants spoke about pharmacological interventions. For a non-medical source, *see* Gilbert, "Clients". Also of note: only nurses and physicians were licensed to administer oral or intravenous medications. Other workers in the clinics, such as non-nurse counsellors, were not licenced to do so. This regulation proved significant, for, according to some nurses, counsellors had been dispensing oral medications, which nurses perceived to be a dangerous and unauthorized practice.

³⁹⁴ For more on the history and meaning of IV therapy for nursing, *see* Sandelowski, "Venous Envy".

³⁹⁵ Conscious sedation is a method of anesthesia commonly used in short medical procedures, such as colonoscopies. The aim is to keep patients awake but relaxed. By contrast, the administration of general anesthesia renders a patient unconscious and paralyzed. General

conscious, for the procedure. It was intended that they felt relaxed or drowsy and experienced little or lesser pain than they might have felt with oral or no pharmacological analgesia at all.³⁹⁶ These medications thus had the potential to reduce or alleviate women's emotional and physical discomfort, which many clinic nurses deemed an important element of their work. In some clinics, nurses automatically inserted an IV for each woman.³⁹⁷ Yet at the self-identified feminist abortion clinic in Vancouver (i.e., Everywoman's), IV insertion was not automatic. In fact, when Everywoman's first opened, nurses were discouraged and even prevented through clinic policies from inserting IVs before the procedure.³⁹⁸

Why did Everywoman's resist automatic IV insertion for each patient? Whereas some staff at other abortion clinics perceived IV therapy as attending to a range of women-focused options, nurses' stories and clinic records indicate that some staff at Everywoman's framed IV sedation and analgesia as unnecessarily medicalizing and detrimental to women. It should be noted that the perspective that Everywoman's framed IV therapy as medicalized was also constructed, in part, by other people who did not work there. I am not making an argument about the 'truth' of

anesthesia is commonly used in hospitals for major surgery and is not available at freestanding clinics given its associated physiological risks and the need for additional clinical personnel to administer it and monitor patients. The other method of anesthesia used in the abortion clinic is local anesthesia, which is injected by the physician into the tissue of the cervix for numbing.

³⁹⁶ Wiebe, "Abortion".

³⁹⁷ Note that classified ads seeking nurses for the Morgentaler Clinic in Toronto called for nurses with IV skills. *See*, for example, "Morgentaler clinic requires".

³⁹⁸ LR noted this condition.

that perspective in this section but rather am pointing out that different approaches to IV analgesia (whether or not they were fully espoused) illustrate that the boundary between medicalization and de-medicalization could be blurry for nurses. To wit: some staff at Everywoman's put forward that IV insertion was an invasive and painful procedure and that IV medications were unnecessary for managing women's pain. Moreover, they suggested that IV medications dulled women's ability to experience their abortions at the time of the procedure, hindered their capacity for memory making, and potentially impeded future reflection on and developing understandings of their abortions. For some feminist women-centered health advocates, IV therapy contributed to the ongoing conceptualization and practice of abortion as a medical procedure that treated a pathology or illness rather than an event that could hold alternative meanings for women.

Christena M, a nurse who worked at Everywoman's clearly articulated some of the ideological tensions that manifested in IV therapy across the freestanding abortion clinics, while also articulating a sense of ambivalence about it herself. She remembered:

The people I talked to who worked at [other abortion clinics] seemed to think that things that went on at Everywoman's was somehow backward or punishing women. God, I don't think so! Everywoman's didn't get into using IV pain medicine and that seemed to be a big deal. But at the other clinics, everybody got an IV. Everybody got IV Meds! And supporting women through the procedure, I'd say about one out of ten had a tough time, but it was

like for less than a minute. So, you've got an IV, and that hurts, and its medicalizing, and like making its own trauma and trouble and then some of the IV drugs affect your memory. So [some clinic nurses'] take on that was, 'That's Good!' But I was thinking, 'Really? Do you want to have holes in your memory about something that was so powerful?' I thought both places had interesting arguments and I didn't have the answer. [...]. The staff in the other places thought Everywoman's was punishing women. It was like: 'Oh God! You don't want to go there! You're not going to get proper pain management!' But yet, women didn't seem to have much pain. It seemed pretty easy. I don't know.³⁹⁹

Indeed, some nurses fully supported and even insisted on establishing IV access for every woman before the abortion began. They expressed very little ambivalence. Not only did they believe that IV access was useful for providing adequate analgesia for women and supporting their emotional wellbeing, but nurses also expressed that it helped prepare them to manage adverse reactions and medical emergencies, which in turn helped them to provide safe abortions in the clinic. As Lisa E put it, "I thought it was a matter of safety for them to have IVs in case there was an allergic reaction or anything untoward. I always thought they should have an IV."⁴⁰⁰ In supporting IV insertion, Lisa E and other nurses advocated for their ability to administer fast-

³⁹⁹ CM 678–704.

⁴⁰⁰ LE 515.

acting supportive and resuscitative medications. They saw it as an essential element for the successful provision of safe abortion services.

Lisa R expressed her concern with supporting women in the procedure room who did not have an established IV yet did suffer something “untoward.” She explained:

You know, as a nurse you always have one or two clients that you're sweating [worried about], and you're cursing that [no-IV] policy because you'd like to get an IV in them fast—they needed atropine [an emergency cardiac medication] or, you know, you just need an IV!⁴⁰¹

Yet while nurses valued the medical benefits of IVs, they recognized that insertion could be frightening for women and that, as Christena M had described, could hurt, could be medicalizing, and could create additional trauma and trouble for women. Rene W suggested that nurses could and ought to support women throughout that IV insertion procedure as well, again by acting as a bridge between potentially medicalizing practices and women-focused strategies. She clarified:

A lot of them are really nervous and a lot of them are fixated on the whole IV thing. They're just terrified. [...]. But it's all about, a lot of it is just establishing rapport and trust and that can be hard, especially when [...] they're terrified of the IV because they've had

⁴⁰¹ LR 475–481.

problems in the past ... because they don't have good veins or whatever. We've made them fast; they're pregnant; they've been throwing up and then they're terrified [...]. That can be challenging. Sometimes it's easy but sometimes that can take time.⁴⁰²

Some abortion clinic nurses believed that it was worthwhile to take the time to insert an IV before the abortion (well before any complications arose) when she had the opportunity to establish trust and could offer support to women throughout the insertion process. For these nurses, IV access was vital for promoting women's safety in the clinic, and some were willing to perform a potentially medicalizing procedure on every woman in preparation for an unforeseen harmful outcome. At the same time, IV access opened space for women to make choices about *how* they could experience their abortions and manage their pain. For many procedure-room nurses, however, IV therapeutics did not usurp their non-pharmacological techniques. In valuing and combining this range of practices, these abortion clinic nurses demonstrated their commitment to promoting women's overall safety and a willingness or desire to bridge or blur the two approaches.

Through this work, clinic nurses further developed their knowledge and expert practice and continued to carve out growing professional autonomy and leadership roles in the procedure room. Many nurses reported that physicians generally trusted their clinical judgement in

⁴⁰² Rene W [RW] 1292–1296. Interview by author, February 2016.

administering IV therapies. In a sense, physicians shared their authority with nurses, using standard orders as a somewhat flexible tool to do so.⁴⁰³ Vancouver nurse Jeanette B explained:

There were standard orders. But the doctors trust us to sort of do whatever we need to do for the best patient outcome. We don't have to go 'Excuse me, Dr. Smith, do you think I can start an IV, I think maybe ... what do you think?' It's more like 'Oh, [the patient's] blood pressure is low, you need a little hydration, let's just start this [IV].' It's up to us.⁴⁰⁴

Sharon B similarly remembered:

It was the nurses' responsibility to put in the IV and instill the fentanyl ... but by doctor's order. We would say, 'I want to give her 100 of fentanyl' or 'I want to start with 50.' You would go and tell him what you wanted to do, and he would agree. And you would do it.⁴⁰⁵

⁴⁰³ Standard or standing orders were sets of pre-determined interventions that were available to nurses by physicians' order. They typically accounted for the most common problems or needs of the patient. Orders could include, for example, peripheral IV insertion or medication administration (including the dosage and route).

⁴⁰⁴ JB [JB] 329–333. Interview by author, November 2015.

⁴⁰⁵ SB 427–440.

Officially, it was outside abortion clinic nurses' scope of practice to initiate these procedures independently. The above examples highlight, however, the independence that abortion clinic nurses took up within this formal physician-nurse practice hierarchy. With growing autonomy, developing expertise, and increased confidence, procedure room nurses seemed to take ownership of this work.

Historian Julie Fairman made a similar argument in her analysis of the development of the Nurse Practitioner role in the USA that emerged in the 1960s and 1970s. She suggested that nurses who were expanding their scope of practice into traditionally physician-occupied territory negotiated similar tensions while building collaborative practice strategies with physicians.⁴⁰⁶ In an earlier article, she explicitly argued that in taking on such responsibility in new contexts, nurses demonstrated their [...] decision to use their clinical judgment when the rationality of physicians' orders was in question," and that nurses thus "made choices about technology that deeply influenced patient care."⁴⁰⁷ In this case, I would suggest that abortion clinic nurses constantly made decisions around the 'technology' of pain management, including when they perceived that the rationality of physicians' practices were in question. Their ability to do so, I put forward, is related to their theoretical knowledge and experiential know-how about women's pain (with knowledge and know-how comprising the hallmarks of technological ownership). They demonstrated that they also made similar decisions within the wide-ranging parameters of physicians' standard orders, seemingly with physicians' token (but legally necessary) approval. Readers will see a similar example of abortion clinic nurses' uptake of new technology in the

⁴⁰⁶ See Fairman, "The Roots".

⁴⁰⁷ Fairman, "Alternative Visions": 142.

context of the ostensible nurse-physician hierarchy in their use of ultrasound during the abortion procedure.

Some nurses, such as Lisa E in Vancouver, indeed demonstrated a sense of professional responsibility for offering and providing women with pharmacological and non-pharmacological support, reflecting:

I argued quite vehemently with some doctors that they needed to wait [before they started the abortion]. I said, '*Let me nurse these people!* I need to give them medicine and let them calm down a lot before you begin to operate!' And I think in the course of things doctors figure it out when they work with me. [...]. If I give women medication, some fentanyl, 5 or 10 minutes before they actually start the procedure, then that really gets [women] to calm down. [...]. And if I sing to them and I get the music going, get them calm, get them to trust me, they do way better than the very common practice of racing them through. [...]. [If they are raced through] they're going to crash. Or they'll have an overdose because everything is happening too fast.

I said [to the physicians], 'Listen you guys, listen to what is happening. You have to slow down.' So, I'm teaching the doctors. They can do their assessment, they can talk to [the woman], and

then I want them to *go away* for 3 or 4 minutes. And then it's like *'I will let you know when you can touch this woman! [...]. You just wait. And I will tell you when you can touch her.'* And then they follow me. [... I want nurses to] trust [their] judgement and tell those doctors, 'I get to be a good nurse here, and I'm not taking your orders. I get to be a good nurse, and I'm the one that's the conscious sedation expert, and I need to do this, and you're going to be good at doing the surgery, but first you need a calm patient. Well, that's my job.'⁴⁰⁸

This scenario coheres with scholar Margarete Sandelowski's argument that nurses have long been integrating medical procedures and equipment with patient comfort. To wit: she stated that "from the earliest days of trained nursing, nurses have shown their inclinations and talents for altering the material world of practice [through the use of different artifacts or 'technologies'] to enhance patient comfort."⁴⁰⁹ Moreover, she has argued that "by assisting reluctant and fearful patients to accept and accommodate to new technologies [... nurses have sought] to repair the damage to human dignity and autonomy that often accompanied technological change."⁴¹⁰ Similarly, throughout the abortion procedure, these nurses demonstrated the goal of offering emotional and physical comfort measures to women while they also watched for, prepared for, and managed complications or emergencies. These emergencies manifested in emotional and

⁴⁰⁸ LE 1524–1553.

⁴⁰⁹ Sandelowski, "Exploring Gender": 224

⁴¹⁰ Ibid.

physical ways, and often in combination. Subsequently, nurses tackled this work in multiple ways, incorporating and valuing a range of strategies for supporting women, which, as with their other clinic roles, drew from both the bio-medically driven and women-focused de-medicalizing approaches to abortion provision. They learned these strategies and refined them in the new context of freestanding abortion provision as they discovered what actions were and were not effective and then shared that new knowledge and know-how with their colleagues. They suggested that nurses could offer women a full complement of emotional and medical support, which they thought was necessary to fully support women and to promote their safety overall.

Surgical Support for Women

This section addresses the ways that nurses also participated in the actual abortion procedure or the more surgical aspects of it. For this work, they used the terms “procedure room nurse” and “scrub nurse” interchangeably.⁴¹¹ These nurses did not perform the direct surgical aspect of an

⁴¹¹ The number of practitioners and the roles that they played in the abortion clinic procedure room varied. In some clinics (typically in the very early years of their operation), non-nurse counsellors stayed with women ‘at the head of the bed,’ as it were, to support them emotionally. A “scrub” nurse at the time was responsible for managing equipment, assisting the operating physician, and providing medical intervention if necessary. This role echoes the in-hospital role of an Operating Room “scrub nurse,” who is part of the sterile team that is performing the actual operation, as opposed to the “circulating nurse,” who handles the non-sterile aspects of it. In time, the two roles in the procedure room were combined, which I discuss toward the end of this chapter. Once combined, one nurse performed both roles simultaneously. Counsellors did not enter the procedure room thereafter.

abortion. It was a physician who actually dilated the cervix and removed the uterine contents via manual curette and suction aspiration. Rather, nurses partnered with physicians to perform key roles in completing the procedure together. Their duties primarily included preparing and managing medical equipment, such as sterile surgical instruments, sampling apparatus (e.g., swabs and kits for sexually transmitted disease testing), the vacuum aspiration machine and its tubing, and in some cases an ultrasound machine. In some clinics, nurses also examined and handled fetal and uterine material (commonly termed the ‘products of conception’) that had been removed during abortion. In doing this range of work, nurses became intimately familiar with and helped refine the vacuum aspiration procedure, and they developed significant clinical expertise and know-how for helping to provide it in freestanding clinics. At the same time, and as they worked closely with operating physicians, nurses continued to re-negotiate their professional relationships with them, again disrupting the ostensible physician-nurse hierarchy that has been attributed to medicalized systems of practice. As with their other areas of abortion clinic work, evidence suggested that these nurses engaged in both potentially medicalizing practices and feminist or de-medicalizing ones ultimately in the pursuit of helping women have safe abortions. In this section I closely examine the ways that nurses took up two major tasks in the procedure room: managing the ultrasound and handling the products of conception.⁴¹²

⁴¹² These are but two foci among many. It is important to acknowledge, however, the value of the procedure room nurse or scrub nurse role overall given that without properly managed equipment, appropriate monitoring of uterine material, and effective STI testing, a woman’s health would have been seriously undermined. This was a vital role in supporting women’s health and safety, particularly physiologically, during the procedure and going forward by preventing abortion-related infection and promoting sexual health overall, for example.

Ultrasound: Medical and Medicalizing?

One way that abortion clinic nurses worked toward providing women with the safest abortions possible was to become experienced with the new vacuum aspiration procedure and to help refine the technique. They identified ultrasound as a particularly important method for fostering women's safety. In general, ultrasound harnesses the body's inaudible sound frequencies, which vary according to tissue density and elasticity. The information captured by ultrasound can then be translated into images of the body's inner structures and physiological processes.⁴¹³ The purpose of using ultrasound in abortion provision is to visualize the uterus and its contents, including the fetus. An ultrasound can be performed before, during, and following an abortion procedure, and can be done externally (through the abdominal wall)⁴¹⁴ or internally (through the vagina). The resultant images are dynamic, displayed on a television-like screen. In the freestanding clinics, ultrasound functioned as a diagnostic and procedural tool that proved useful

⁴¹³ See Venes, "Ultrasound": 2268.

⁴¹⁴ A very clear demonstration of the use of ultrasound in the vacuum aspiration procedure was given by physician Bernard Nathanson in the 1984 film *The Silent Scream*. Nathanson, a physician abortionist turned anti-abortionist filmed the ultrasound screen throughout an abortion. He showed these images in his film while narrating the process of the abortion throughout. His goal was to demonstrate the experience of the fetus. His major claim was that the ultrasound showed that as the fetus was approached by the suction cannula, it jerked away from the instrument and emitted a 'silent scream,' allegedly indicating its pain and fear. Nathanson's interpretations of the ultrasound have been supported and discounted by activists and other physicians alike. For one pro-choice feminist reaction to the film, see Fugh-Berman, "The Making and Faking of 'The Silent Scream'".

in multiple scenarios. Clinic nurses supported its use as a valuable tool for promoting safety for women.

One important feature of learning to use the ultrasound, nurses told me, was that they could then use it externally to guide the actual procedure in real-time, which was helpful to women and practitioners in many cases and vital in complicated ones.⁴¹⁵ In the image produced on the screen, practitioners could see the cervix, the size, shape, and position of the uterus, where the fetus or fetal tissue was located, where the suction cannula was in relation to those structures, and, subsequently, where the suction cannula needed to go. Partnering with the operating physician who was handling the surgery internally, some clinic nurses quickly learned how and elected to “drive,” as Sharon B put it, or perform the external ultrasound by passing the wand over the abdomen in search of and then holding steady on the pertinent areas. Abortion clinic nurses reported that they employed this technique particularly when the procedure proved unexpectedly difficult for physicians, such as in cases when they could not ‘find’ or reach the fetal tissue or when they found it difficult to pass the canula through the cervix at all. By using ultrasound, nurses could provide visual support and make suggestions as to how to proceed, thereby helping to reduce the risk of uterine perforation, retained fetal tissue, or other complications. In so doing, clinic nurses developed a collaborative and sometimes directive role with physicians while expanding, refining, and reinforcing their own scope of practice and clinical expertise. Clinic nurse Lisa E, for example, articulated this experience, noting:

⁴¹⁵ LE, RW, SB. *See also* Tisdale, “We Do abortions”.

[I was] sometimes helping [physicians] through the abortion by doing ultrasound. When they're having difficulty, I guide physicians, and I tell them 'Well, try this or maybe you should try that. [...].' Because I'm really good at this, right? Especially with newer physicians. And so, all those things go into your role when you're actually working in the Operating Room. [...]. It can be tricky.⁴¹⁶

Becoming “really good” at interpreting the ultrasound image and operating the machine in a meaningful way was new work for abortion clinic nurses. In her article describing her experience in a US American freestanding abortion clinic, nurse Sally Tisdale commented vividly, “It takes practice to read an ultrasound picture, which is grainy and etches as though in strokes of charcoal.”⁴¹⁷ It is a technology, she wrote, that merely “paints a faint, gray picture of the fetus.” Many abortion clinic nurses told me that they were willing and eager to learn and practice the complicated ultrasound techniques because they perceived ultrasound-guided abortions as vital to promoting or protecting women’s safety in difficult cases.

Clinic nurses and physicians worked together to become proficient with this technique. Many nurses commented on the increasingly collaborative professional relationships built between physicians and nurses in the clinics as both groups sought to develop expertise with an unfamiliar procedure. Sharon B, who had gained early experience with the method, noted that

⁴¹⁶ LE 1674–1692. RW remembered her experience similarly.

⁴¹⁷ Tisdale, “We Do Abortions”: 70.

physicians who were new to the procedure trusted her clinical knowledge and skills. She remembered:

The doctor would come to rely on you because you've been there for a hundred years and they haven't. And they're not used to doing this every day. So, they just go by what you say. We [experienced nurses] were the ones who knew how. I don't mean to brag or anything, it's like, that's just the way it is.⁴¹⁸

Similarly, clinic nurses noted that when they were the inexperienced practitioners themselves, they looked to veteran physicians for leadership. One nurse remembered that at the beginning of her career, when she possessed very little experience with the vacuum aspiration method, she learned a great deal from her physician colleagues. She explained that, in the procedure room:

I had lot to do with doctors, even more than I did with nurses [...]. We [the nurses] are all sort of doing our own thing [in the different areas of the clinic], so the person I'm working most directly with [in the procedure room] is almost always usually a doctor.⁴¹⁹

⁴¹⁸ SB 494-497.

⁴¹⁹ LE 398-401.

As a result of this arrangement, she said, “who I learned the most from was really the doctors.”⁴²⁰

Vancouver nurse Rene W articulated a similar perspective and commented that this close partnership disrupted some of the physician-nurse tension she felt in other areas of practice. She noted:

One of the things that was interesting for me was I had ... there was always this sort of anti, slightly anti-doctor sentiment, right? And when I got to know doctors and worked closely with them [in the procedure room], especially the OB/GYNs [obstetrician/gynecologists], the specialists, [I realized] these are just people and they want the best for their patients, too. And I got to know who they were and that gave me some respect for them and the responsibility they carry, and I would have never had that if I'd just been from the outside. You get to know them as people. You see them all the time. You're like 'Okay!'⁴²¹

In the context of this collaborative working relationship, many nurses noted that as they gained knowledge and experience in the procedure room, they were able to offer clinical support and, in some cases, direction to physicians. For example, drawing from her deepening knowledge and ever-increasing experience, Lisa E created an algorithm with ‘tips’ that could guide new or struggling physicians and nurses in the procedure room, demonstrating that she was gaining

⁴²⁰ LE 286.

⁴²¹ RW 763–771.

expert status in the Operating Room. She explained nonchalantly: “these are little tips that I know that the new doctors don't.”⁴²² Rene W summed up:

There was something exciting about doing it at this grassroots level when we were creating this job. We were actually working as a team with doctors. I was trained in the old hierarchy model of being the handmaid to the doctors. They were usually older. And they were men. I was sort of trained to be that way [in the hospital]. [...]. But this (abortion work in the freestanding clinic) was different [...]. We were creating something from the grassroots, and we could make it different.⁴²³

In learning ultrasound techniques, some clinic nurses demonstrated that they were able to disrupt the physician-nurse hierarchy in the freestanding clinics. Though they were performing a medicalized and arguably medicalizing task, as I will discuss in the following section, ultrasound offered nurses the opportunity to share power and clinical knowledge with physicians. As such, they illustrated that they could retain respect and autonomy as women-practitioners in freestanding abortion clinics, thus contributing to the renegotiation of practitioner-practitioner hierarchies to the benefit of women.

⁴²² LE 927

⁴²³ RW 663–672.

These remarks echo Julie Fairman's argument for the increased agency of nurses who negotiated their expanding scope of practice within the nurse-physician hierarchy. Fairman's analysis is a gendered one that positions nurses as women and physicians as men in the Nurse Practitioner context. Sandelowski puts forward a similar framework in the general context of hospital nursing. It is noteworthy here that RW and some other nurses framed their physician colleagues as mainly men, yet not all of the nurses that I interviewed did so. Moreover, it was not always the case that the physicians in freestanding clinics were men. Notably, Sandelowski points out an alternative view that 'technology' "has expanded the influence of medicine over nursing, by maintaining control over access to technologies and by *using nursing labour* to achieve medical goals."⁴²⁴ Indeed, these abortion clinic nurses were participating in the new labour of 'driving the ultrasound' in order to aid and improve physician practice. Though there is perhaps an argument to be made for the interpretation of reinforced control via the delegation of labour via ultrasound, participant nurses did not perceive or, it seems, develop their knowledge about it or enact it as such.⁴²⁵

In addition to guiding the procedure, in terms of promoting women's safety, one of the most important reasons for using ultrasound in the clinic, nurses reported, was to help determine the gestational age and the corresponding size of the pregnancy. As pregnancy advances, fetal growth and anatomical development follow an expected pattern or timeline.⁴²⁶ In the absence of

⁴²⁴ Sandelowski, "Exploring Gender": 223 (my emphasis).

⁴²⁵ Fairman, "The Roots"; Sandelowski "Exploring Gender".

⁴²⁶ For photographs of fetal development by gestational age, *see* for example, the groundbreaking pictorial published in *Life Magazine* in 1965 in Nilsson and Rosenfeld, "Drama".

ultrasound, practitioners can attempt to predict the size of the fetus based on the woman's reported length of pregnancy and by measuring and palpating the abdomen. However, clinic nurses explained that a more reliable way of obtaining that information is through ultrasound. Many nurses fully supported and implemented ultrasound into their work as a trustworthy diagnostic tool. They experienced that this technology facilitated improved decision-making about who was safe to undergo an in-clinic abortion based on the length of pregnancy, size of the fetus, and attendant surgical risk for women.

For abortion clinic nurses, it was important to adhere to gestational limits in vacuum aspiration abortions in order to diminish the risks associated with terminating larger, more developed pregnancies. They recognized and, in some cases, had experienced that nurses and physicians could not manage such cases or complications in the clinics in a fully safe manner. The chief problem with attempting to terminate an undiagnosed or unanticipated large or later-term pregnancy, they explained, was in trying to pass the fetus through an under-dilated cervix using a suction canula designed for earlier pregnancies. Unlike the softer, more malleable and smaller volume of tissue present in earlier pregnancies, larger, more developed, and solid fetal structures of later gestations could not fit through a small cervical opening or into the narrow suction catheter and tubing. In these cases, either the cervix had to be dilated quickly or the fetal tissue had to be dismantled manually. In some cases, both methods had to be implemented to complete the abortion. Aborting a large pregnancy through a hastily dilated cervix was very painful for women and it carried increased risks of cervical damage and retained fetal tissue. In other words, it was an unsafe maneuver. Moreover, dismantling the fetus manually and handling it thereafter was distressing for physicians and nurses. Some nurses found that they, their colleagues, and the

clinics were poorly equipped to handle these cases. For them, such procedures were unsafe but could be avoided through ultrasound facilitated assessment.

One Vancouver abortion clinic nurse remembered an experience she had in the pre-ultrasound days and the ensuing difficulties experienced by herself and the physician. She explained that this event had been a particularly significant one that stood out in and went on to shape her long career in abortion clinic nursing. She remembered:

One time there was, and it has actually stayed in my mind for a long time. We didn't have ultrasound, and one of the [gynecologists] had this patient who had been pregnant quite a few times. She came in and we started doing the procedure and - Whoosh! A big gush of amniotic fluid came out. What does that mean? That means [the fetus is] big. It was 18 weeks, but [us] being ill-prepared, the cervix was not dilated [enough]. Well, then there were all these little pieces [of the fetus that had to come out]. Really horrific to watch. Horrible, horrible. And that traumatized me for a long time.⁴²⁷

Jeanette B's colleague, Lisa E, reported similarly poor experiences when ultrasound was unavailable and gestational age was thus difficult to determine. True to her long-standing approach to abortion nursing, she loudly advocated for the implementation of ultrasound and was

⁴²⁷ JB 832–839.

relieved and excited when it finally became available at the clinic in the late 1990s. In her interview, she said:

Oh! The other thing is we didn't have ultrasound machines at the time, so we got ourselves into all kinds of trouble. There were some big mess ups that happened because of the fact that we didn't have ultrasounds. You had to have a good history [including of gestational age]. But we had times when less experienced doctors started an abortion, haven't done an ultrasound ... instead, just feeling [the woman's] abdomen [to determine fetal size through palpation], and they're presenting that way at 7 or 8 weeks, but they actually end up being 14 or 15 weeks! And we've actually had times when they've put the suction in and then out would come just a digit or something like that, and [that meant the pregnancy] was way too far along for that doctor, and so we were scrambling. At times I'd be scrambling, trying to track down doctors from someplace else to come in and kind of help us through that. So that was a big thing: assessing the dating of the pregnancies and coping when one was out. That was like a big clinic thing. But for me, as a nurse, it was trying to figure out how we were going to screen all this with a good history and not let it happen sort of thing. So that was, yeah, that's been a long process. Getting the ultrasound machines was a big piece to kind of sort that out. We got those in

regular use in the late '90's somewhere [...]. That was really cool
when we finally got that!⁴²⁸

Nurses' stories about ultrasound emphasize their commitment to promoting women's safety during their abortions. Further, they reveal nurses' ability to develop collaborative relationships with physicians and to help refine the vacuum aspiration procedure itself. As such, clinic nurses created and stepped into new medically focused roles that they perceived improved their ability to help women have safe abortions, which they continued to articulate was their primary goal. However, as with their other practices that more closely aligned nurses with physicians, ultrasound was perhaps a tool that promoted the medicalization of women's bodies and of abortion services in the freestanding clinics.

There were indeed other implications of nurses' use of ultrasound imaging in freestanding clinics. Science and Technology Scholars argue that neither scientific images nor the practices of producing them are neutral.⁴²⁹ Burri and Dumit, for example, explain that "scientific images are produced and interpreted by certain people and used in particular ways that reinforce certain kinds of knowledge."⁴³⁰ By this perspective, ultrasound can logically be understood as a medicalized, and perhaps medicalizing, process. Like the vaginal speculum, which the women's health movement took up as an iconic symbol of medicalization, ultrasound is a tool for

⁴²⁸ LE 325–346.

⁴²⁹ There is a wide-ranging sub-field of STS dedicated to scientific imaging. Burri and Dumit provide a thorough review of this body of literature in "The Handbook".

⁴³⁰ Ibid.

accessing and peering into women's bodies. It is controlled by practitioners (in this case physicians *and* nurses) who are trained to read or interpret images that are likely unfamiliar and un-readable by patients. Ultrasound renders women's real bodies into two-dimensional images, which is arguably de-humanizing and de-contextualizing. Moreover, when performing an ultrasound, the practitioner's gaze and attention are fixed on the screen: they are looking away from the woman in front of them. All of these points, taken alone or in combination can point to ultrasound imaging as a medicalizing phenomenon for women in abortion clinics over which clinic nurses hold authority. In the previous section, I highlighted the ways that nurses framed ultrasound imaging as a reliable and useful diagnostic and surgical tool and that for nurses, taking an active role in ultrasound use translated to an increased scope of practice, increased collaboration with physicians, a way to take a leading role in abortion provision, and a useful tool for promoting women's safety.

However, like compulsory IV insertion, ultrasound could be perceived of as medicalizing. It seemingly reinforced nurses' authority and expert status, closely aligned them with the medical establishment, and decontextualized women and their bodies in the procedure room. As these stories reveal, clinic nurses held fast to the idea that ultrasound was a crucial tool for promoting women's bodily safety. They took ownership of this technology, advocated for and then helped developed its material applications to women's bodies, and negotiated collaborative interdisciplinary relationships and clinical expertise in doing so. Ultrasound technology, then, proved a key aspect of Canadian nurses' work in freestanding abortion clinics. However, it was

not necessarily a tool with which they could straightforwardly blur the boundaries of medicalizing and de-medicalizing approaches to practice.⁴³¹

Handling the Products of Conception

Though they did not necessarily articulate ultrasound as such, scrub nurses took up other bridging roles in the final stages of women's abortion surgeries in their efforts to promote women's physical safety and emotional wellbeing. In some of the freestanding clinics, such as the Toronto and Ottawa Morgentaler Clinics, when the surgery was finishing, one task of the nurse was to manage the 'products of conception.' Here, the nurse collected, examined, and disposed of the uterine contents, paying close attention to the fetal tissue. One of the major reasons for collecting and examining the products was to assess for whether the abortion was 'complete'—that is, that all fetal and uterine tissue had been removed. This determination was imperative to promoting women's bodily safety given that retained tissue significantly increased women's risk for infection and, moreover, necessitated a second procedure to remove it. With that in mind, the scrub nurse examined the tissue, considering whether it was of the appropriate

⁴³¹ This is not to argue that it was impossible for nurses to implement ultrasound in de-medicalizing ways. They could, and some did, for example, take the time to explain to women what they were seeing on the screen, thus illuminating or clarifying the practice and the abortion somewhat. LE and CM also noted that in-clinic ultrasound could be less judgemental than community procedures performed by anti-abortion technicians. These interpretations, however, were not fully articulated or explored by the of the participants or in the archival material. Further investigation is needed here.

amount and character expected of a particular gestational age and, more specifically, whether all expected fetal parts were accounted for.

Toronto clinic nurse Sharon B reported that when she performed this role, she communicated her assessment to the operating physician, who would either enter the uterus once again to capture additional tissue or conclude the procedure. According to her, the physicians she worked with usually trusted nurses' assessments, again indicating a strong collaborative relationship between them. She explained:

The nurse would say, 'Yeah, you got it all.' [...]. Or if you weren't happy that you got it all—that the doctor didn't—you said, 'There's not enough here.' And, you know, the doctor would come to rely on you. The doctors relied on us to let them know what was good.⁴³²

This nurse-physician partnership echoed the one established in other procedure room areas, such as when providing women with pharmacological pain control and performing the procedure under ultrasound guidance. In continuing to negotiate this relationship, abortion clinic nurses, were seemingly able to make a move toward disrupting established hierarchical structures. At this stage in of the procedure, practitioners were fixated on the pieces of tissue that had been pulled away from women's bodies, and, ultimately, on the success of the surgery. Managing the

⁴³² SB 500.

products of conception offered nurses another opportunity to promote the bodily safety of women and to help them have safe abortions.

Some scrub nurses also demonstrated that in managing the products of conception, they were able to engage in poignant women-focused, contextualizing practices. US American nurse, Sally Tisdale, for example, noted that when she contemplated those tissues more deeply at the sink, she began to ‘remember’ the complex woman (and not merely the passive patient) behind her. “When I am struck in the moment by the contents in the basin,” she wrote, “I am careful to remember the context, to note the tearful teenager and the woman sighing with something more than relief”.⁴³³ In this description, Tisdale illustrates that handling the tissues and helping to declare the surgery complete provided an opportunity for her to reflect on the unique lives and social positions of her patients (teenagers and women alike), and to acknowledge that women brought unique meanings of their abortions to the procedure room, as evidenced by her observation that sometimes women “sighed with something more than relief.”

Some scrub nurses who handled the products of conception also perceived it as one avenue towards creating space for women to make choices about what they wanted to see of and learn about their abortions and ‘their products,’ as nurses termed it. Vancouver abortion clinic nurse Rene W, for example, articulated her strong support of helping women view the fetus, remembering:

⁴³³ Tisdale, “We Do Abortions”: 69

If people wanted to see the product, I would show them the product. For me, I was sort of one of the people that would [show them]. If you wanted to see it and it's like a big one, I would [show it]. 'There you go. See it?' I let them know that it's a fetus. [...]. If they wanted [to see it, I thought], 'It's your body! See what you want. Like, it's not for me to tell you whether that's right or wrong. That's your right. If you want to see it.'⁴³⁴

In addition to show it to women, clinic nurses wanted to make sure that women were fully supported in viewing the fetus and were helped to understand what they were seeing. They sought to work toward breaking down knowledge-guarding or gatekeeping about abortion by showing the fetus to women and explaining what they were seeing rather than dismissing women's wants and needs and reserving specialized knowledge (and language) for practitioners. At least one scrub nurse, Joan W, was willing to advocate strongly for a genuinely women-driven approach in the face of physicians' failure to do so. She remembered one particular instance:

There was always [a woman who said,] 'I'd like to see the fetus.'
So, one [time one] of my doctors gives her a smashed-up piece of tissue, and there's *maybe* some fetal tissue there. And I said to him, 'Don't you ever do that again if you're not [actually] going to

⁴³⁴ RW 1325–1342.

show it to her. If you're going to show her, then show her the fetus!⁴³⁵

My interpretation here is that in declining to show women their products or failing to explain them in a supportive way (if at all) to women, some practitioners reinforced the medicalization of abortion. Perhaps most noticeably, as in the situation above, physicians could rely on their professional knowledge and their ability to control this (non-surgical) aspect of the abortion, which reinforced their privileged status as clinical experts and as the most appropriate drivers of abortion provision. Abortion clinic nurses, too, this chapter shows, could take this approach. However, some of their stories demonstrate that in managing the products of conception, they did aim to de-medicalize women's experiences in the Operating Room. The role compelled some scrub nurses to reflect on the connections between individual women and their products of conception and it offered them the opportunity show and explain the products to women.

Going further, some of these nurses gave women their products to take home if they requested them. Vancouver nurse Rene W presented that action as a straightforward one, saying, "back in the day, we'd give people [the products]. If you want to take your products—go and take your products, they're yours."⁴³⁶ Ottawa nurse Joan W told a more complicated story, which highlighted both the ambivalence she felt in 'releasing' the products and her desire to respect women's decisions. She told me:

⁴³⁵ JW 1077–1982.

⁴³⁶ RW 1348. Perhaps this quotation reads as flippant or terse. RW recounted these memories in a soft and emphatic and, seemingly (to my ear), empathetic manner.

I can remember a patient saying to me, ‘I want to take this fetus home,’ and I wasn’t easy with that. That was my bias, right. I did give [it to her]. We discussed it. And discussed it with the physician. It was a particular patient, and it was for a definite reason. I said, [to the woman], ‘Now I have to think about this, and this is what I’m worried about,’ and then they would answer, ‘Oh, you don’t have to worry because this is what I want to do.’ [...] And, I don’t want to question and say to her ‘I need you to explain to me why you want to do this.’ [...]. She doesn’t need to explain it to me, it’s her fetus!

“Anyway,” she concluded, “they decided they would take it home.”⁴³⁷

These stories reveal that nurses could help to share their range of knowledge about the fetus, women’s bodies, and the abortion for women, that is to help ‘demystify’ abortion provision, or share it beyond the realm of practitioners. They could partner with women as active participants and helped to facilitate their decision making around how they experienced their abortions. Although procedure room nursing could in many ways be seen and experienced as medicalizing, it also became clear that while many nurses fully recognized the need to privilege the medical aspects of abortion in order to maintain women’s bodily safety and emotional wellbeing, they also attempted to integrate de-medicalizing practices as well. I put forward that their developing roles in the procedure room continued to provide abortion clinic nurses a measure of clinical

⁴³⁷ JW 1053–1706.

leadership and autonomy, which allowed them to collaborate with women, with each other, and with physicians in wide-ranging ways that informed and were informed by multiple approaches to women's health. A quotation from Joan W, I think, well captures the unique position that nurses held in freestanding abortion clinics as they negotiated their own work in ways that they thought would help women have the safest abortions. "Nurses," she said, "stand between the procedural protocols and the experience of the clinic."⁴³⁸

Feminist Abortion Services: An Interdisciplinary Tension?

Just as nurses developed and negotiated new roles in freestanding abortion clinics with physicians and women-patients, they similarly did so with counsellors. The general term 'counsellor' was taken up by women of various backgrounds, including social workers, otherwise credentialed counsellors, and uncredentialed lay-women,⁴³⁹ who wanted to support women having abortions. In some cases, counsellors identified as feminist health advocates (or simply feminists) who had perceived that existing abortion services were medicalizing and oppressive.⁴⁴⁰ In response, they joined with others in aiming to "build on the experience of the women's health care movement of the last two decades"⁴⁴¹ to help re-imagine, re-organize, and

⁴³⁸ JW 1192.

⁴³⁹ LR explained: "a lot of the counsellors had some sexual health training and counselling background, but they weren't social workers. They didn't have to have any kind of certification of any kind": 86–88. *See also* Ann Thompson, "Winning Choice".

⁴⁴⁰ I discussed these perspectives more fully in the Introduction. *See also* Shanahan, "Exciting Developments".

⁴⁴¹ *Ibid.*

offer abortion services to women in de-medicalizing ways. They took up counselling and support work inside the clinics in order to do so. In the evolving context of decriminalization and the strengthening women's health movement, clinic roles thus had to be negotiated between nurses and counsellors. Perhaps unsurprisingly, tensions arose in these negotiations.⁴⁴²

Indeed, clinic nurses remembered a feeling of tension between themselves and their counsellor colleagues as they created and divided new and familiar work. For nurses, the tension centered around their belief that they possessed the range of knowledge and skills necessary to fully support women both physically and emotionally throughout their abortion appointments (that is, to promote their overall safety). Nurses remembered feeling dismissed by counsellors, who wanted to fulfill the pre-op counselling role and provide 'head-of-the-bed' support to women inside the procedure room themselves. Clinic nurses suggested that counsellors sometimes treated them merely as "medical people,"⁴⁴³ questioning nurses' abilities to do the emotionally supportive side of counselling work.⁴⁴⁴ Nurses believed that they were labelled as being *only*

⁴⁴² STS scholars Bijker et al. theorized that during the processes of a system's re-stabilization, "tensions are likely to arise in a number of areas [...] as social actors' power and participation in the organization and management of the system are negotiated." See "Social Construction": xlii.

⁴⁴³ LE 683.

⁴⁴⁴ This perception was also embedded in Thomson's "Winning". She noted that nurses began to feel pushed out of the early development of the clinic by their feminist collaborators. Nurse Bettie Scheffer explained to Thomson that it was "very much a challenge to feel part of that group. I certainly felt shut out lots of times": 181. Her feelings owed in part, she explained, to "the group's rejection of the 'medical model'—a clinic controlled by its doctors—and the 'clear

concerned with, or indeed capable of, addressing women's physical needs, and that counsellors believed that "nurses couldn't cope with anything emotional that might come up with women."⁴⁴⁵ This perspective was frustrating for nurses, who argued that they possessed a unique ability and opportunity to bridge the two components of care, which they in fact saw, and some experienced, as inextricable.

Lisa E reflected on her experience with non-nurse counsellors:

I wanted to be diplomatic about it when I started. When I saw the [counselling] role, I just didn't think there was anything [that they were doing] that a nurse couldn't do. When I talked to one of the counsellors, who was a social worker, [and found out what she did], I tried to explain to the administration that I took all the same

mistrust of anyone (including nurses) who was a health professional": 181. Scheffer, along with two other nurses, Mary Stolk (the spokeswoman for the Vancouver AIS) and Lucille Wood, left the clinic's Steering Committee in June of 1988. Thomson does not linger on this topic.

Sandelowski in "Exploring Gender" has argued that this nurse-feminist tension generally existed outside of abortion services as well, referring to "a mutual disdain nurses and feminist have felt for each other, the suspicion some nurses feel towards theories outside of nursing to resolve problems in nursing, and the cultural devaluation of the feminine that affects them both. Nursing is too female for many feminists, while feminism is not female enough for some nurses": 219–228.

⁴⁴⁵ LR 766.

courses she did. I used the same theoretical models that she did, this was what we used at University! [...]. I said nurses are just as capable of obtaining consent and working through [women's] emotional issues and doing all that sort of stuff in a counselling role. At the same time, I could take a [medical] history and be a little bit more efficient. But that got struck down. They really wanted to divide it so that we were kind of seen as just these 'medical' people and they are the 'counselling' people. And I just thought: 'Nonsense!'⁴⁴⁶

Lisa E argued that as a nurse she could draw from a range of knowledge and experience in order to fully support women in the counselling and procedure rooms. She explained:

I just felt like nursing is applied science, and you get to apply some of these best things of being female – like, the thing about nursing is we do this nurturing aspect, which is very intuitive, instinctual. Plus, you have to know the science to know what you're doing. We can be all feely and all those things—motherly, sisterly, whatever—but we also have to have some science behind what we're doing. It's not just a feeling. You have to have evidence. I saw both sides and I wasn't anti-medicine. [... It was about] knowing how to approach people in a way that they still feel

⁴⁴⁶ LE 663–684.

supported as women and to talk to them not in a condescending way but in a supportive way, which meets them where they're at.⁴⁴⁷

Here, Lisa E connected her *abortion* nursing practice with nursing practice at-large and with the profession's broader consideration of and debate around its theoretical underpinnings. By theoretical underpinnings, I mean nursing's epistemological and ontological commitments,⁴⁴⁸

⁴⁴⁷ LE 591–603.

⁴⁴⁸ I have explored nursing ontology and epistemology elsewhere. In an unpublished paper, I noted that ontology is a branch of metaphysics that is concerned with, as philosopher Lowe in "Ontology" put it, "*being* in general, embracing such issues as the nature of existence and the categorial structure of reality": 634 (my emphasis). I take up nursing ontology as relating to the category of nurse. I embrace the principal issue of the nature of nursing in addition to sub-questions around what it means to *be* a nurse, what it is that nurses do, and what differentiates nursing from other health care professions. On the other hand, the philosophical branch of epistemology considers questions related to knowing and knowledge. Nurses interested in nursing epistemology might ask questions such as: what do nurses know? How do they know it? And how should they come to know it? These questions address both the content of nursing knowledge and the processes for its dissemination and uptake, including through formal nursing education and informal experiential learning. *See*, Haney, "They Were Confused". For more on the nature of nursing knowledge, *see* Johnson and Ratner, "The Nature of Knowledge" and Thorne and Sawatzky, "Particularizing the General". For more on epistemology in general, *see* Hamlyn, 1995. I posit that professional nursing identity comprises both ontology and

which had long been contemplated by nursing leaders and were increasing made explicit in the 1980s—this, when nursing education at the university level was being expanded and as Lisa E was earning her baccalaureate degree. Lisa E appears to be commenting on holistic models of nursing, which arguably provided a theoretical foundation in the combined bio-psycho-social care and understanding of human behaviour, which she perceived were meaningfully applicable to this work.⁴⁴⁹ In that perspective, biomedical knowledge was but one, albeit necessary, domain of nursing knowledge. Lisa E argued that she ought to be able to draw from her full well of education, knowledge, experience, and know-how to support women in all aspects of their abortion experiences at the clinic. She saw that role as a nursing one that was supported by nursing theory and deeper disciplinary commitments that were looking beyond the physical to the domains of nursing that integrated science, art, and social context.⁴⁵⁰ Of people's lives and experiences of health as relevant for health care. Although many nurses like Lisa E indicated that they wanted to perform the primary counselling role, the work was largely undertaken by counsellors.

Counsellors, however, were dissuaded from performing the support-role in the procedure room. Nurses claimed that role, arguing that they could enact multiple approaches to supporting

epistemology (and ethics), accounting as they do for the combined ideologies and practices that are permitted and expected of members of a professional group. For more on professional identity, *see* Fagermoen, “Professional Identity” or Phillips and Hardy, “Discourse Analysis”.

⁴⁴⁹ For an analysis of the history of the concept of holism in nursing, *see* Boschma, “Holism” and Boschma, “Ambivalence”.

⁴⁵⁰ Andrist et al., “History of Ideas”.

women's bodily safety and emotional wellbeing, which I have already discussed. Significantly, nurses valued their well-practiced ability to understand women's complex experiences in the Operating Room, which they reasoned, non-nurse counsellors were less able to do. As the manager of her clinic, Sharon B transitioned the procedure room role into a nurse-staffed one, and the other clinics adopted the same practice. Sharon B remarked:

I think I had an impact on changing that role and turning it into a nursing job because I didn't like the fact that the person at the head of the bed who could see the colour of the patient and see what was going on with her was not a nurse. I didn't like that. It didn't take much to push Henry to change that role.⁴⁵¹

In many cases, abortion clinic nurses eventually combined the supportive (head-of-bed) and procedural roles into one position, again highlighting their commitment and ability to engage with multiple and complex approaches to abortion provision. Lisa E summarized:

And then I'm also assisting the physician. [...]. You're monitoring the patient, you have a hand on their pulse, you're watching kind of what's going on and you're dealing with their story and then whatever potential agony or pain they're suffering through, and the

⁴⁵¹ SB 523–527.

doctor wants this instrument, then that instrument, and then you're supposed to be doing the swabs, getting them this or that.⁴⁵²

Of this role, Jeanette B aptly noted, It's a lot of work in there!"⁴⁵³

While developing the decriminalized abortion clinics, nurses demonstrated that they held on to the medical meaning of abortion while also acknowledging and valuing its emotional and social implications. Lisa R articulated this point well when she reflected, "I think, the nature of the work. [...]. It's unique. It's not like we're doing laser eye surgery or colonoscopies. We are doing abortion procedures. And it's very politically charged and fraught with lots of emotions."⁴⁵⁴ "But," she later underscored, "it's still a medical procedure." Lisa E similarly commented that abortion was more than medical, it was, after all "going to fit with [her] feminist activism." Yet she also emphasized the (bio)medical nature of abortion. "Abortion was surgery," she said. As such, Lisa E argued, abortion provision ought to be practiced from a combined "medical-feminist" model.⁴⁵⁵ It is my interpretation that in negotiating new work and new professional relationships in the context of the women's health movement, nurses in these clinics understood and experienced the medical and social aspects of abortion as inextricable. In their

⁴⁵² LE 1674.

⁴⁵³ JB 578.

⁴⁵⁴ LR 316–320.

⁴⁵⁵ LE 247/1183.

nursing roles, perhaps in quite a unique way, they were well able to understand and experience abortion provision as, indeed, “the bloody side of feminism.”⁴⁵⁶

In this chapter, I have argued that following decriminalization of abortion provision in 1988, abortion clinic nurses meaningfully engaged with the medicalizing facets of abortion work, an increasingly vocal feminist critique of abortion’s medicalization, and de-medicalizing strategies put forward as alternative ways of thinking about and providing abortions. My analysis reveals that, collectively, abortion clinic nurses neither perceived those systems as diametrically opposed nor sought to adopt one over the other in an *a priori* manner. Rather, they brought multiple perspectives to their work and demonstrated a willingness to bridge the two ostensibly competing systems of medicalization and de-medicalized (sometimes termed feminist) reimaginings of abortion by incorporating elements from each, typically on a case-by-case basis. Some clinic nurses explicitly framed this merged approach as a ‘medical-feminist’ one that allowed and indeed compelled them to draw from and contribute to developing a wealth of clinical know-how and theoretical knowledge, new interdisciplinary relationships, and a strong professional culture committed to promoting women’s overall safety and helping them to have safe abortions. Lisa E encapsulated this perspective quite well when she explained that she saw her work at the freestanding clinic as an “opportunity to do something real,” which she ultimately conceptualized as one ‘real’ way to make “the *world* a safer place for women.”⁴⁵⁷

⁴⁵⁶ As writer Anne Collins so strikingly put it in “Considering Abortion”: 114.

⁴⁵⁷ LE 247–1183.

CHAPTER 3: Abortion Nursing in Freestanding Clinics Amid Anti-Abortion Activism

I was working that day! I was in the Operating Room. [...]. I was the Head Nurse. It was very weird. It was very exciting. We knew the decision was coming that day and we had patients booked. [...]. We knew this was happening. And we were waiting and waiting [...]. Everybody was outside. All the protesters were outside and everybody's yelling and waving placards and we [the nurses and staff] were all hanging out the window looking at things as we had our breaks. The place was crazy. And [...] you're thinking to yourself, "*Wow!*" [...]. You think everything is just going to change with a snap of a finger because now there's this decision.⁴⁵⁸

This energetic recollection is Toronto abortion clinic nurse Sharon B's memory of January 28, 1988—the day of abortion's decriminalization in Canada.⁴⁵⁹ Clearly, she remembered this day as an exciting one and, like many abortion supporters, was optimistic about the future of decriminalized abortion provision. In some ways she was right to be hopeful particularly given that following decriminalization, as I have shown in Chapter Two, nurses and their colleagues were able to establish freestanding abortion clinics across the country and help develop and

⁴⁵⁸ SB 611.

⁴⁵⁹ For more on the process of decriminalization, *see* my Introduction; Day and Persky, "Supreme Court"; or Jenson "Getting to Morgentaler".

refine the services that they provided there. However, when Sharon B and other abortion clinic nurses later reflected on their experiences outside of the strictly clinical context, they indicated that not everything had changed “with a snap of the finger.” Rather, their stories and other evidence suggested that as the politics of reproductive health continued to rage, as public debate about abortion provision heated up, and as anti-abortion activism that was targeted against freestanding abortion clinics intensified, abortion clinic nurses continued to face considerable cultural resistance to their work. As a result, abortion clinic nurses found that they were, in fact, still challenged to “just get on with it.”⁴⁶⁰

As the state’s withdrawal from criminal abortion regulation ostensibly rendered abortion more legally and socially ‘allowed,’ the cultural uptake of abortion provision and abortion nursing proved not fully positive. Rather, a pre-decriminalization anti-abortion response neither stopped nor stagnated: it intensified. Following decriminalization, citizens who opposed abortion provision feared that they were losing ground in the shifting legal and clinical contexts (i.e., both as abortion was decriminalized and as new clinics were opened and operated successfully). Laura McArthur, the president of the *Toronto Right to Life Association* (an anti-abortion organization), reportedly articulated this perspective in 1988 when she claimed, “the Supreme Court of Canada’s decision [to decriminalize abortion] shook pro-lifers to their roots.”⁴⁶¹ Anti-abortionists were thus compelled to act with increasing dedication, she said. Even as legal and clinical restrictions were loosening, then, wider cultural space for anti-abortion activism was opening

⁴⁶⁰ SB 655.

⁴⁶¹ “Do good things?”

up.⁴⁶² In the following chapter I consider some of the resultant cultural challenges (as opposed to the legal and clinical ones that I discussed in Chapter One and Two) that abortion clinic nurses encountered in the lead up to and following decriminalization. Drawing from their oral histories and archival material such as newspaper reports, professional nursing literature, pro-choice and anti-abortion literature, and abortion clinic records, I highlight the ways that abortion clinic nurses were exposed to and remembered anti-abortionism, including by other (so-called ‘pro-life’) nurses. I pay particular attention to those nurses’ construction of and legitimization of an anti-abortion professional nursing identity (and the necessary de-legitimization of an abortion-supportive one).⁴⁶³ Finally, I analyze some of the strategies that abortion clinic nurses developed

⁴⁶² The un-named author of “Do good things” argued that decriminalization and the opening up of this cultural space was a “blessing” for the anti-abortion cause insofar as it brought additional attention to the issue and motivated members to develop and enact additional activism strategies.

⁴⁶³ Nurses’ resistance to early abortion work after liberalization in the Canadian context has yet to be fully examined. In “Nursing and Hospital,” Karissa Haugeberg argued that in the shifting legal and clinical context in the United States circa the 1970s, many in-hospital nurses were clinically unprepared to take on increasing abortion work, were frustrated by labour conditions for nurses-as-women (which were highlighted in abortion provision) and were resistant to shifting cultural attitudes toward sex and reproduction. She argued that these factors translated into nurses’ frustration with women patients and the uptake of an anti-abortionist conscientious objection to abortion work. Nurses’ conscientious objection was explicitly rooted in religious discourse, which, Haugeberg suggested, had the effect of obscuring their other work-related perspectives. By contrast, through a brief historical discourse analysis of abortion-and-nursing in the *American Journal of Nursing*, I included nurses’ abortion-supportive work, concluding that

in order to manage anti-abortionism in their efforts to keeping their patients, colleagues, and themselves safe in a decidedly unsafe social and physical environment. Ultimately, this chapter demonstrates that the work of abortion nurses was informed by direct cultural resistance to abortion and abortion nursing.

Not Talking About It

A most intriguing pattern arose in nurses' oral history interviews when I asked them if, in the 1980s and 1990s, they talked about their work outside of clinics. Many of the nurses indicated that they had been reluctant to do so. Jeanette B explained, "We downplayed it. We were always trying to invent what we said."⁴⁶⁴ I noted that many of the nurses who downplayed their work or tried to invent what to say did so in similar ways. They told me that when asked by strangers in their daily lives, "what do you do," for example, these nurses typically answered broadly and vaguely. Some couched their abortion work in euphemism or provided real examples of the other (ostensibly less taboo) work that they performed at their otherwise un-specified nursing jobs. Sometimes abortion clinic nurses merely hinted at where they worked but skirted around the clinical aspects of it altogether. They recounted these conversations as follows:

I wouldn't tell people where I worked at all. [If someone asked],

'Where do you work?' [I would say], 'Oh, I work in a clinic.' [...].

through their new and increasing abortion work, some nurses were able to articulate and take up more autonomous practice roles while participating in the ongoing negotiation and strengthening of nursing identity for themselves. *See* Haney, "Professional Discourse".

⁴⁶⁴ JB 736.

‘What kind of clinic?’ I danced around it a lot. [I said], ‘Women’s health, women’s reproductive health, birth control, STD exams, that kind of stuff.’⁴⁶⁵

I will often be like: ‘Well, I work in women’s health care,’ or ‘I work with women from the waist down,’ [or] I provide ‘reproductive choices’—if they really want to know.⁴⁶⁶

I didn’t say, ‘We’re an abortion clinic.’ I said, ‘I work in an ambulatory care clinic in women’s reproductive health. And that we do gynie [gynecological] procedures under moderate sedation. We have IUD clinics. We do paps and birth control counselling. We write prescriptions. We even do endometrial biopsies.’⁴⁶⁷

[I said to one woman], ‘It’s a bit controversial.’ And she said ‘Oh! Really?’ And I said, ‘Yeah I worked in a bit of a conflict.’ She said, ‘Oh, that sounds interesting!’ and I said, ‘Well the person who I worked with just died this year.’⁴⁶⁸

⁴⁶⁵ LR 1003–1008.

⁴⁶⁶ RW 469–471.

⁴⁶⁷ JB 737–738.

⁴⁶⁸ SB 1687. Here SB was referring to Henry Morgentaler who died May 29, 2013.

In addition to these vague responses, a few clinic nurses decided that in some circumstances they preferred not to talk about their work at all. Lisa E quipped: “It’s not something I talk about at a dinner party,”⁴⁶⁹ while Joan W confided, “I didn’t tell the neighbours [...]. I had no idea what to say so I didn’t tell anyone.”⁴⁷⁰ Jeanette B explained that she felt that she and her colleagues “really had to be sort of selective about who [they’d] tell. Back then,” she said, “things were a bit more careful. You didn’t just sort of blurt it out.”⁴⁷¹

Though many of their retrospective descriptions were articulated in a light-hearted way and often with some laughter, it is clear that many of these abortion clinics nurses had in the past been wary about disclosing where they worked. They had perceived a need to be a bit careful about it. But why, even after abortion’s decriminalization, did they feel that need? Jeanette B’s account of how she broached the issue with her children pointed towards an answer to that question, which drives the rest of this chapter. It was, she explained, an issue of safety. She reflected:

I said to [my children], “Don’t tell them what Mummy does because there’s a lot of people who don’t agree with what I do, and they *hurt* us.” So, they never [did tell. ... They just said], “My Mom’s a nurse.” “Where?” “I don’t know.” And people let it go.⁴⁷²

⁴⁶⁹ LE 1286.

⁴⁷⁰ JW 2163.

⁴⁷¹ JB 171.

⁴⁷² JB 862–866.

She further reflected:

It's weird the things that you have to do. No one else in whatever profession has to tell their children to lie about where they work for safety reasons, right? That is sort of so strange, I think, in this day and age when you feel [...] safety is an issue.⁴⁷³

Indeed, as this chapter will show, the safety of abortion clinic nurses (and their families, colleagues, and the women for whom they cared) was in many ways at risk in the lead up to and following decriminalization. In what follows, I elaborate on the connections between anti-abortion activism and abortion clinic nurses.

Anti-Abortionism and Professional Nursing Identity After 1969

I do not believe in lending my services to this slaughter-house butchery of human life.

[...]. Personally, I would sooner turn my back and sling hash for a living.⁴⁷⁴

The politics, ideologies, and activism of the Canadian anti-abortion movement at large have been considered by a number of scholars.⁴⁷⁵ For the purposes of this study, I briefly outline some of those elements in order to position nursing within the context of the wider anti-abortion

⁴⁷³ JB 866–869.

⁴⁷⁴ Schibild, “Letter”: 6.

⁴⁷⁵ Ackerman, “A Region at Odds”; Cuneo, “Catholics”; Johnstone, “After Morgentaler”; Lochwin, “Blinded”; Saurette and Gordon, “Changing Voice”; Stettner, “Without Apology”.

movement. Political theorists Paul Saurette and Kelly Gordon have argued that the Canadian anti-abortion movement began to take hold in the early 1970s in response to abortion's liberalization in 1969.⁴⁷⁶ Immediate public anti-abortionist responses came primarily from Catholic organizations such as the Canadian Conference of Catholic Bishops, the Knights of Columbus, and the Catholic Women's League.⁴⁷⁷ Other grassroots anti-abortion coalitions, notably The Alliance for Life and the Toronto Right to Life, quickly followed suit. Though rooted in Christian ideology, many members of these early organizations reportedly articulated their public arguments by way of secular "medicalized and scientific rationales" as opposed to deeply religious ones.⁴⁷⁸ They claimed to draw from advances in obstetric and fetal medicine to argue that abortion was unduly harmful to the fetus and the pregnant woman.⁴⁷⁹ For one example, anti-abortionists offered that through ultrasound they could see that the procedure caused pain to the fetus.⁴⁸⁰ As a result, they espoused that abortion ought to be prevented or limited.

⁴⁷⁶ Saurette and Gordon, "Changing Voice". For more on liberalization, *see* my Introduction. Remember that liberalization rendered in-hospital abortion legal only if a woman's pregnancy threatened her life or health, among many other restrictions.

⁴⁷⁷ Saurette and Gordon, "Changing Voice": 108 onward.

⁴⁷⁸ *Ibid*: 110.

⁴⁷⁹ Van and Gerner, "High tech".

⁴⁸⁰ UK nurse Joanne Timpson outlines these UK arguments well in her article, "Abortion: The Antithesis of Womanhood".

Other more explicitly religious arms of the anti-abortion movement, which were reportedly motivated by the perception of an increasingly (and, for them, untenable) secularized society emerged in the late 1970s and early 1980s. Unlike their earlier counterparts, these anti-abortionists loudly put forward moral or Christian religious arguments against abortion provision. They argued, for example, that abortion, given that it destroyed the living and ensouled fetus, violated the sanctity of life, and was therefore a sin and ought to be prevented. By the mid-1980s and beyond, Saurette and Gordon have claimed, these Christian perspectives, which united both Catholics and Protestants, came to dominate anti-abortion discourse and activism in Canada overall. Scientific arguments continued to be invoked but were reportedly relegated to the background as the anti-abortion movement gained traction.⁴⁸¹ In the course of my research, I found that some nurses who held anti-abortion beliefs similarly took up (and, significantly, often combined) scientific and Christian religious discourses to articulate their resistance to abortion work immediately following abortion's liberalization. In the following section I outline some of these articulations and activities in the liberalized era, which provides foundational context for my interpretation of anti-abortionist nurses' resistance to freestanding clinics.

Liberalization, Discourse, and Anti-Abortion Nursing Identity

As with members of the wider anti-abortion movement, much resistance to abortion and its provision on the part of nurses immediately arose following abortion's liberalization in 1969. The suggestion here is that hospital nurses reacted against legislative and practice changes that

⁴⁸¹ See, Ackerman, "Defence of Reason". She has argued for the ongoing use of science and reason in combination with religious arguments.

saw them increasingly expected to take on abortion work when hospitals developed their abortion-service programs and provided higher volumes of ‘therapeutic abortions’ there.⁴⁸² Some hospital nurses reported in the major print media in the early 1970s that they had indeed been expected to take on new abortion related work (which I will discuss further in a forthcoming section), which they found burdensome owing to their anti-abortion perspectives.⁴⁸³ Insight into nurses’ anti-abortion convictions in the 1970s can be found in the public news media and within the pages of *Canadian Nurse*, the latter of which published a flurry of nurses’ abortion-related Letters to the Editor between 1970 and 1974.⁴⁸⁴ In these letters, some nurses explicitly and firmly articulated their anti-abortion perspectives, thus jointly creating a body of discourse around abortion, nursing, and abortion nursing that resolutely rejected the latter. A fuller analysis of nurses’ anti-abortion and abortion-supportive letters in *Canadian Nurse* at this time and

⁴⁸² Badgley et al., “Operation”.

⁴⁸³ See, for example, “Nurses drop protest”.

⁴⁸⁴ I have analyzed these letters in previous research, see Haney “Nursing Identity”. I counted 44 explicitly abortion-related Letters to the Editor published in *Canadian Nurse* between January 1968 and 1974. They were both supportive of and resistant to abortion provision. Letters included reactions to abortion-supportive editorials by editor in chief V.A. Lindabury, nurses’ original Letters to the Editor, and feature articles. One particularly inflammatory article was “Abortion and Morality” by a USA Professor of Biology at Stanford University (Paul, R. Ehrlich) and a physicist from the California Institute of Technology in Pasadena California (J. P. Holdren). Interestingly, *Canadian Nurse* stopped printing reactions to that article in December of 1972, warning would-be letter writers that, “This is the last month in which correspondence regarding the article [...] will appear.” See Lindabury, “Editorial”: 8.

beyond is still needed. I offer a brief but important portrait here as it pertains to my historical inquiry aims.

In February 1971, Sister Marie Simone Roach, identifying herself as the Acting Chairman of the Nursing Department of St. Francis Xavier University in Nova Scotia, wrote to *Canadian Nurse* readers:

Are we for life or death? [...]. In this present controversy, is it possible that the profession of nursing, with its life-long tradition of reverence for the dignity of the human person, will opt for a decision that makes pre-natal euthanasia legally and culturally acceptable? [...]. *The Code of Ethics of the International Council of Nurses* begins by asserting that the fundamental responsibility of the nurse is threefold: '[...] to conserve life, to alleviate suffering and to promote health.' Under the guise of alleviating [women's] suffering, it would seem that some of us assent to the destruction of [fetal] life. Perhaps we need to reflect more on our ethical responsibilities.

She concluded, rhetorically: "Shall we opt for professional ideals or decadence?"⁴⁸⁵

In August 1972, Emma Lenzmann, who identified herself as an "Operating Room Nurse at Burnaby General Hospital in British Columbia," wrote:

⁴⁸⁵ Roach, "Are we for life?": 5.

I regard a fetus as a developing life rather than a potential life. Just as an infant needs care and protection to survive and develop into mature adulthood, so a fetus requires the nurturing and protective uterine environment to develop and mature. The embryo and fetus are in the first stages in the development of a human being [...]

There are still some nurses (and I believe their numbers are many) who are thoroughly disgusted with the abortions performed in their hospitals today, and who find themselves in the undesirable situation of assisting with these operations because they have no other option—other than to resign. We still believe in the sanctity of life and deplore the fact that we are called upon to assist in its destruction.⁴⁸⁶

Throughout the early to mid 1970s, nurses' anti-abortion letters and articulations elsewhere continued in a similar vein. It is important to note that throughout her career, Sister Roach was a prominent leader, educator, and theorist of nursing. Of particular relevance to her perspectives on abortion-and-nursing is her influential and long-used "Theory of Caring." There, she conceptualized the practice of nursing as creating and existing within a "sacred scene," which elevated both the nurse and the patient on a spiritual level."⁴⁸⁷ Also notable is that Roach earned

⁴⁸⁶ Lenzmann, "Disagree": 5.

⁴⁸⁷ Roach "Reflections on the Theme": 8. *See also* Roach, "Caring"; and Roach and Canadian Hospital Association, "Human Act".

a Doctor of Education degree in 1970, was the director of the CNA Code of Ethics project in the 1980s and was awarded the Order of Canada in 2010. She was and remains a well-respected nursing scholar and remains a well-respected nurse, nursing scholar, and Canadian citizen.⁴⁸⁸ Given the range of self-identified credentials of letter writing nurses such as Roach, Lenzmann (“simply” an Operating Room nurse), and others, it is evident that nurses in multiple professional spheres continued to discursively construct anti-abortion professional nursing identities that were grounded in Christian values and claimed some ownership of scientific knowledge. Ultimately, many of these nurses argued that given that nursing itself was (as they saw it) founded in the Christian tradition and developed in parallel with advances in scientific knowledge, to participate in abortion provision contravened essential nursing values or professional commitments. ‘Abortion practitioner,’ for these nurses, was not a legitimate professional identity, and abortion work was not a legitimate undertaking.

Notably, these writers applied their Christian perspectives to the profession at large. Yet many historians have noted that early nursing in Canada (that is, nursing by white women beginning in the 16th century) was established in both religious and secular traditions. The history of French Catholic nursing sisters who arrived “on the shores of the St. Lawrence in 1693”⁴⁸⁹ with the aim of caring for European settlers and ‘ministering’ to Indigenous peoples alike has been well documented and dominated early narratives of nursing historiography.⁴⁹⁰ However, scholarly attention has increasingly been paid to their more secular counterparts and those nurses’ trek

⁴⁸⁸ See Lawlor, “Nursing pioneer”.

⁴⁸⁹ Gibbon and Mathewson, “Three Centuries”: 3.

⁴⁹⁰ Ibid. For a more recent and nuanced analysis, see Violette, “Healing”.

towards Western Canada.⁴⁹¹ Canadian historian Kristin Burnett has argued that modern nursing practice, in addition to religious European approaches also developed out of Indigenous women's work (and the appropriation of it).⁴⁹² Additionally, other scholars have identified the ways that professional nursing work developed out of lay women's traditional domestic or household roles.⁴⁹³ Herein lies an example of nursing's long-standing professional engagement with questions around the nature of nursing itself. That is to say, this discourse indicates that nursing's ongoing broader considerations of its vocational, spiritual, and secular underpinnings, were echoed in their uptake of (or rather in their resistance to) abortion practice for nurses. Despite this range of nursing's roots and development, Christian perspectives certainly prevailed for nurses who held anti-abortion beliefs (hereafter referred to as anti-abortion nurses),⁴⁹⁴ which,

⁴⁹¹ *See*, for example, Young and Rousseau, "Lay Nursing".

⁴⁹² Burnett, "Taking Medicine".

⁴⁹³ *See* D'Antonio, "Legacy" for the USA context. *See also* the (by now) grand narrative of Sarah Gamp—Charles Dickens' portrayal of the nurse as an un-trained, uneducated, and un-trustworthy (often drunk) woman who was tasked with minding the sick, primarily as a domestic helper (in McPherson, "Bedside Matters," for example).

⁴⁹⁴ The use of this term 'anti-abortion nurses' is not to not pitch two groups of actual nurses (i.e., anti-abortion nurse activists and nurses who worked in freestanding clinics) against each other. Rather, I use it more generally to focus on the cultural constructions of these ideological stances and of nursing to examine how nurses played roles in both of them, which demonstrates that nurses may take up a range of (competing) positions within the overall debates and emerging discourses around abortion nursing.

their language indicated, contributed to their (anti-abortion) conceptualization of nursing identity after liberalization and in the lead up to and following decriminalization.

Ultimately, in the 1970s anti-abortion nurses implicitly argued that nurses could not take up abortion work as legitimate practice even in hospitals under legal conditions. I suggest that in so doing, they constructed a social environment in which anti-abortionism in nursing was normalized and thus legitimized, which provided a foundation for their continued anti-abortionism into the 1980s and 1990s.⁴⁹⁵ As a final example from the post-liberalization era, a 1971 letter from Jocelyn Schibild, a Registered Nurse from British Columbia, brings this discursive or social normalization into focus. To the readers of *Canadian Nurse*, using colloquial language, she emphatically proclaimed: “I do not believe in lending my services to this slaughter-house butchery of human life. [...]. Personally, I would sooner turn my back and sling hash for a living.”⁴⁹⁶ Though nurses’ letters and other sources of discourse in the 1970s require further investigation, I put forward that this beginning analysis suggests that some nurses participated in constructing an anti-abortion professional identity for nurses. Further, I suggest that doing so seemingly supported and was supported by their actual enactment of anti-

⁴⁹⁵ This is not to say that it was not contested or even that it was the *only* social environment constructed through discourse. I am focused here on the anti-abortion context.

⁴⁹⁶ Schibild, “Letter”: 6.

abortionism.⁴⁹⁷ To illustrate, I briefly discuss nurses' early enactment of anti-abortionism in the next section.

Nurses' Resistance to Hospital Abortion Work

Through archival research I found that after liberalization, hospital nurses claimed that they were expected to integrate new and more abortion work into their long-held nursing positions—as opposed to voluntarily moving into abortion-specific areas if they desired to do that work. Their familiar places of work included, for example, The Operating Room (where surgical abortions were performed) and Perinatal or Maternity Units (where women were prepared for and recovered from surgical abortions and, moreover, where non-surgical abortions, such as saline instillation, were induced and completed with major nursing management).⁴⁹⁸ For some anti-

⁴⁹⁷ I do not aim to provide a full analysis of anti-abortionism in nursing in this era. Rather, my aim is to provide an account of the foundation from which nurses later enacted anti-abortionism in and around freestanding clinics.

⁴⁹⁸ Saline instillation and prostaglandin administration were intended to induce fetal demise and stimulate uterine contractions which would result in the spontaneous vaginal delivery of the fetus and placenta (akin to the labour and delivery of a live infant). In rare cases, such as when those methods failed, hospital practitioners resorted to the hysterotomy method, wherein they emptied the uterus through abdominal surgery (akin to the Caesarean Section). The saline and prostaglandin procedures were typically induced by physicians and then managed (sometimes independently) by nurses to completion on the hospital wards. Hysterotomies were performed by physicians in the Operating Room with nursing assistance. These women recovered from that

abortion nurses, this work was ultimately unwanted. For them, abortion work contravened their moral and clinical conceptualizations of what a nurse ought to be and do, from which they were unwilling to waver. Subsequently, some nurses who held these anti-abortion perspectives began to resist hospital abortion work in a variety of ways.

Some nurses, for example, refused to participate in hospital abortion provision outright. In 1971, Ontario Nurse Ita Venner explained to *The Globe and Mail* that she and her colleagues objected to and refused to prepare women for abortion surgery or to administer abortifacient medications (such as saline infusions or prostaglandins), which were indeed nursing duties.⁴⁹⁹ At Venner's Ontario hospital, sixty-seven nurses reportedly voiced their objections by signing a petition outlining that position.⁵⁰⁰ I suggest that in addition to refusing to do abortion work, signing a petition was a voluble act of resistance to abortion work by these nurses. Additionally, some nurses voluntarily transferred themselves out of their familiar departments where they might have encountered abortion, choosing instead to work in areas where abortions and their related tasks were not done.⁵⁰¹ Reportedly some hospital administrators readily agreed to these departmental transfers seemingly in an effort "to arrange a [mutually satisfactory] situation so

surgery on the hospital nursing wards. See Neubardt and Schulman, "Techniques" for more detail on those procedures.

⁴⁹⁹ See "Care of patient". For more on Ita Venner, see Appendix.

⁵⁰⁰ Ibid.

⁵⁰¹ The Badgley et al., "Operation" report noted: "1 out of 13 nurses from whom information had been obtained said they knew of one or more colleagues who had left their positions because of assignments involving the abortion procedure": 21.

that a nurse who [was] strongly against abortion [was] not placed in the situation of having to refuse service.”⁵⁰² Here, I suggest, nurses were developing a professional identity in which explicit anti-abortion perspectives and actual employment-changing actions were framed by nurses as normal or legitimate nursing values and behaviours. Moreover, they were accepted and reinforced as such by hospital employers as well.

Some anti-abortion nurses were not satisfied with their employers’ response, however. They indicated that they were not ‘permitted’ by hospitals to transfer into new departments but rather were expected and even forced to take up new positions (or quit). Perceiving these changes as reprimands and demotions, anti-abortion nurses expressed the belief that they were being treated unfairly by the employer. Nurse Frances Jean Martin, for example, claimed to *The Globe and Mail* reporter that she was forced by the hospital into a lesser paid and less specialized position after she refused to participate in abortions. She said she had been working as the head nurse of the labour and delivery ward but, because she refused to do abortion work, was “demoted to a regular duty nurse in the surgical ward. The demotion meant a drop of about [\$80 to] \$100 a month in pay.”⁵⁰³ Dismayed by these conditions within hospital structures, I suggest, anti-abortion nurses in the 1970s expanded their resistance strategies.

⁵⁰² Kirkwood, “Demotion”: 1.

⁵⁰³ Ibid.

Outside of hospitals, anti-abortion nurses published their perspectives in the mainstream media (e.g., *The Globe and Mail*), in which they were specifically cited as nurses.⁵⁰⁴ They began to picket outside their hospitals protesting abortion provision, and, rather significantly, they joined anti-abortion protests with non-nurses against legal in-hospital abortion provision.⁵⁰⁵ According to *The Globe and Mail*, in May 1971, ten nurses joined some four hundred activists in Ottawa to protest. Strikingly, the nurse-activists appeared *in uniform*, and were said to have, in fact, led the event. *The Globe* reported: “Uniformed nurses carrying wreaths led an orderly crowd of about 400 men, women and children onto [Parliament Hill].”⁵⁰⁶ Ontario nurse Ita Venner claimed that their ultimate aim was to “call for legislation to protect the right of nurses to refuse to participate in abortion procedures.”⁵⁰⁷ Significantly, Venner was not speaking or representing herself as an individual nurse as such. Rather, she made her remarks as the spokeswoman and Chairwoman of a new formal anti-abortion-nurse organization called *Nurses for Life*.⁵⁰⁸ As with their previous

⁵⁰⁴ See, for example, “30 protestors”; “Care of patient”; Kirkwood, “Demotion” or “Nurses drop protest”.

⁵⁰⁵ “Ottawa march protests”.

⁵⁰⁶ Ibid: 13.

⁵⁰⁷ Ibid: 13.

⁵⁰⁸ The early history of *Nurses for Life* remains largely unknown, and a fuller investigation into it overall is still needed. Preliminary research reveals that nurses from this organization later participated with other anti-abortion professional groups (including *Teachers for Life* and *Physicians for Life*) in joining forces to create broader coalitions such as *Manitoba’s League for Life* (first chaired by a retired Registered Nurse) and *Action Life*. See Murawsky “Rita Curley”; “Nurses for Life”; Nurses for Life, “Abortion”; Nurses for Life, “About Us”; or Riley, et al. “The

activities, this time by bringing their perspectives and activism to a wider public audience and doing so under the banner of *nursing*, I suggest, anti-abortion nurses continued to cultivate and normalize an anti-abortion professional identity for nurses in general.⁵⁰⁹ They put forward—to nurses, hospital employers, law makers, and the general public—the idea that nurses could and should hold anti-abortion views and enact them. Ultimately, anti-abortionism was framed by them as a permitted and even preferred set of beliefs and actions for nurses, that is, as a legitimate nursing identity to hold. I suggest that this early activity provided a foundation for nurses’ ongoing and intensifying anti-abortionism in the 1980s in and around freestanding clinics.

Nation’s New Agony”. For more on Venner’s involvement in initiating the organization, *see* Petrsek, “Silhouettes”. Note that well known anti-abortion activist, nurse Cissy Von Dehn, became the head of *Nurses for Life* in Vancouver.

⁵⁰⁹ An earlier investigation into pre-1960s abortion-related nursing discourse suggested that nurses, owing to their ostensible professional obligations, were expected to safeguard the moral and legal regulation of criminalized abortion. As early as the 1950s *Canadian Nurse* readers were reminded of their duty to report abortion-providing physicians, to elicit incriminating information from women about their abolitionist ‘conspirators’ (by way of witnessing women’s dying declarations), and to testify in court. *See* Haney, “Nursing Identity”. For more on nurses’ earlier participation in dying declarations, *see* Klausen, “Doctors”, who briefly mentioned nurses’ roles in her analysis of physicians’ and women’s experiences. For an analysis of women’s dying declarations in the USA, *see* Leavitt, “Brought to Bed”.

Anti-Abortionism and Freestanding Abortion Clinics

As freestanding clinics began to open and gain traction, nurses and others who resisted abortion widened their foci of opposition. In addition to continuing to contest in-hospital policies and abortion provision,⁵¹⁰ they added freestanding clinics and the people who worked in them (including nurses) to their list of targets. In the following sections, I similarly shift my focus to anti-abortion perspectives and activities that centred around freestanding clinics. It is important to note that I have chosen to not fully distinguish between the pre- and post-decriminalization eras vis-à-vis the clinics given that the anti-abortion beliefs and strategies at play were similar over time and across clinics. That is to say that some of the anti-abortion strategies developed and enacted in opposition to the illegal Morgentaler clinics in the 1970s and mid-1980s continued there and were then echoed at new legal clinics after 1988. I attribute this continuity to the common reactions of anti-abortionists to the establishment and successful operation of freestanding abortion clinics at all.

Before I examine the anti-abortion activism enacted in and around freestanding clinics and abortion clinic nurses' responses to it, I will briefly outline some of the ways that anti-abortionists, and here I focus primarily on nurses, constructed and reinforced an anti-abortion social reality vis-à-vis abortion and freestanding clinics.⁵¹¹ Generally, I suggest that the language

⁵¹⁰ For post-decriminalization examples of in-hospital abortion provision, *see* Bolan, “300 protest” or Keyser, “Warring”.

⁵¹¹ Saurette and Gordon in “Arguing Abortion” have analyzed anti-abortion discourse more fully. Here I am highlighting the ongoing anti-abortion discourse of nurses and positioning it into the nursing context and the construction of nursing identity more specifically.

used by anti-abortionist nurses and others helped them to continue to conceptualize the fetus, the procedure, abortion practitioners (including nurses), and now the abortion clinic itself in ways that simultaneously supported and were reinforced by their anti-abortion perspectives and ongoing activism. I will examine this language next, arguing that this discourse-making helped to further construct, legitimize and normalize both a general anti-abortion social reality (in which freestanding clinic nurses then had to function) and an anti-abortion nursing identity (that challenged other nurses to take up abortion work). Though primarily focused on that of nurses, the following brief analysis is of combined anti-abortion discourse of nurses and their allies in both nursing and non-nursing literature.

The Pre-Born Human, the Act of Murder, the Murderer, and the Abortuary

Beginning with the fetus, in the 1980s and 1990s, some anti-abortionist nurses and their allies continued to speak and write about it in Christian terms as being a fully-fledged living human. They did so by referring to it as a *life*, specifically a “pre-born life,”⁵¹² an “innocent human life,”⁵¹³ a “tiny human being,”⁵¹⁴ a “pre-born child,”⁵¹⁵ the “youngest member of the human family,”⁵¹⁶ a “little baby in the womb,”⁵¹⁷ and, finally, a “child”⁵¹⁸ The fetus, they suggested,

⁵¹² Otis, “Nurses fight”.

⁵¹³ Nurses for Life, “Abortion”.

⁵¹⁴ Mably, “Husband”: 11. He was supporting his wife’s Letter to the Editor, *see* Mably, “Caregivers”.

⁵¹⁵ “Do good things?”

⁵¹⁶ Nurses for Life, “Abortion”.

⁵¹⁷ Gosgnach, “Day of infamy”.

comprised not only the material, or physical, contents of the pregnant uterus but also held an additional, primarily spiritual, meaning. For them, the fetus held an identity similar (if not identical) to ensouled people who were already born and living outside the womb. In describing the fetus this way, they offered the first premise of the anti-abortion nursing argument, namely, that the fetus *is* life. These articulations of the fetus echoed those nurses' earlier 1970s letters to the *Canadian Nurse* and further pointed to the Christian undercurrents of anti-abortionism by and for nurses that were seemingly shored up by claims to scientific knowledge by way of a professional understanding of fetal development.

Moving on to their discursive construction of the abortion procedure itself, some anti-abortionists continued to argue that in terminating the fetus, abortion extinguished or killed a valued life. Nurse Don Mably wrote in his letter to *Canadian Nurse* that abortion "resulted in the death of [the] tiny human being,"⁵¹⁹ which for anti-abortionists thus comprised the "deliberate extinction of preborn life."⁵²⁰ Another nurse asserted in her letter that the act of abortion was 'violent' and 'abusive,' explaining that abortion practitioners "violently dispose of, tear apart, burn or mutilate our own offspring [...], neglecting any thought of the total and ultimate abuse of our preborn infants."⁵²¹ Notably, this nurse implied that she, in the course of her work, has witnessed these physical and spiritual aspects of abortion. Taking this discourse of violence, abuse, and killing further, anti-abortion nurses and their allies continued to explicitly equate the

⁵¹⁸ Morgan, "Obituaries".

⁵¹⁹ Mably, "Husband": 11.

⁵²⁰ Otis, "Nurses fight".

⁵²¹ McCready, "Abortion": 5.

abortion procedure with the act of “murder.”⁵²² Yet, murder, the argument went, was an act in which nurses-as-such necessarily could not participate.

Here anti-abortion nurses turned to their professional values and commitments to argue that abortion was antithetical to nursing. For them, participating in abortion provision did not cohere with legitimate professional nursing identity. Some nurses articulated that killing or destroying fetal life went against their essential nursing values and ethics.⁵²³ They claimed, rather, that they were professionally obligated to preserve and advocate for all life, especially fetal life. Ita Venner, the nurse from Ontario, for example told a reporter for the anti-abortion newsletter, *The Interim*, in 1990, “I’m a nurse, and a nurse is supposed to save lives.”⁵²⁴ Another noted abortion activist nurse, Rita Burnie, similarly proclaimed, ‘I went into nursing to save lives.’⁵²⁵ Echoing the language of Sister Simone Roach in 1971, one nurse made the point especially clear in her letter to the editor in *Canadian Nurse*. Nurse Carlo Lawson, a pediatric nursing instructor, wrote: “Under the rather weak excuse of wanting ‘to help women in trouble,’ we as nurses are contradicting a basic, deep principle in our philosophy of care, which is to preserve life.”^{526,527}

⁵²² Pawluk, “More”: 54.

⁵²³ Lamb, “Nurses”.

⁵²⁴ Otis, “Fines”.

⁵²⁵ Tuns, “Rita Burnie”. For more on Rita Burnie and her sister Helen, *see* Appendix.

⁵²⁶ Lawson, “Professional challenge”: 8.

⁵²⁷ Significantly, this kind of discourse works to obscure or decontextualize and dismiss women’s abortion needs over and above fetal considerations. Some anti-abortionists, including nurses, as indicated here, continued to make a moral distinction between the actual lives of

Finally, just as some anti-abortionists extended the language of preserving life to refraining from murder, so too did Rita Burnie's sister. Helen Burnie, also a nurse, claimed that, as a nurse, she did not "believe in murder, especially the murder of babies [not yet born]."⁵²⁸

women and the fetus to uphold their perspectives. In her seminal article, "A defense of abortion," philosopher Judith Jarvis Thomson outlined the familiar anti-abortion argument which holds that to perform an abortion to save the life of a woman is to actively (or directly) kill the similarly living, yet fully innocent fetus, whereas to decline the abortion is merely an indirect act of 'letting' a woman (and quite possibly the fetus) die. The most relevant premises that lead to the fetus-focused moral conclusion that abortion ought to be prohibited in such cases are as follows: 1) directly killing an innocent person is murder and murder is not permissible (therefore the abortion itself is not permissible) and 2) 'letting die' is, morally speaking, preferable to directly killing a person (and therefore the abortion ought not to be performed). In the case where a woman's life is not in danger, the parallel argument against abortion is thus rather straightforward. Notably, in this moral paradigm, 'the woman' is seemingly more obscured than in the medical or secular social ones. In other, arguably more women-focused, anti-abortion moral arguments, women remain similarly decontextualized, conceptualized on the whole as natural mothers who ought to fulfil their moral (and, in the case of women of the appropriate 'breeding,' nationalist) duty as such regardless of the circumstances surrounding their pregnancies (including rape or otherwise gendered violence, for example). For an article on abortion, womanhood, and nationalism by a nurse, *see* Timpson, "Antithesis".

⁵²⁸ "Abortuary picket line".

In *Canadian Nurse* some anti-abortion nurses rejected the identity, as they saw it, of ‘nurse-murderer’ for themselves individually and also resisted it for all other nurses. Connie Pawluk, for example, wrote to explain: “When an ‘operator’ [i.e., a physician] in an operating facility hands you, the nurse, the ‘products of conception’ to put in the garbage, you have now become an accessory to murder.”⁵²⁹ Some anti-abortion nurses concluded that as practitioners who necessarily were committed to conserving life, nurses were logically prohibited from participating in abortion. Abortion supportive ideals and abortion supportive work contravened the *being* of a nurse and the *doing* of nursing work for *all* nurses. Nurse Beverly Mably (the wife of Don Mably) concluded: “as registered nurses we have a responsibility to speak out on behalf of the sanctity of life. We are caregivers, not killers.”⁵³⁰ Again, some of these anti-abortion nurses espoused that they were professionally committed and obligated to saving or preserving life—a maxim that clearly rested on religious Christian belief which demanded they respect the sanctity of life. They explained that participation in abortion provision as (ultimately Christian) nurses was thus professionally prohibited.

Finally, anti-abortion nurses and their allies turned their attention to the concept of the freestanding abortion clinic itself. If abortion was killing and its practitioners were killers, they suggested, then the space where abortion was carried out could not qualify as a medical (or healing) facility. Instead, some (perhaps radical) anti-abortionists renamed the clinic *the*

⁵²⁹ Pawluk, “More”: 54.

⁵³⁰ Mably, “Caregivers”: 5. For a similar perspective, see Whitemann, “Prevention”. Notice also Mably’s use of the word ‘care,’ which echoes Sister Roach’s perspective in her *Theory of Caring* that nursing is or ought to be in essence a caring endeavour. See Lawlor, “Nursing Pioneer”.

'abortuary,' a word that intentionally evokes the mortuary, or the place where dead bodies are interred.⁵³¹ In a letter to Vancouver's mayor in 1989, one anti-abortionist wrote of the new Everywoman's Health Center: "This is not a Medical Clinic. It is an abortuary."⁵³² Betty Green, the president of Vancouver anti-abortionist group, the *Right to Life Society*, similarly called Everywoman's a "killing centre."⁵³³ An anti-abortionist group in Toronto labelled the Morgentaler clinic there "the house of death."⁵³⁴ For anti-abortionists, the freestanding clinics were especially egregious over and above hospital facilities. They noted that freestanding clinics provided 'elective' abortions to women "on demand," as nurse McCready put it in her letter to *Canadian Nurse*.⁵³⁵ Abortions performed at women's discretion, they believed, typically lacked any medical justification, and thus always facilitated unnecessary killing or murdering. For them, this kind of abortion provision went beyond in-hospital, ostensibly therapeutic, services. Freestanding clinic practitioners, they suggested, did not possess the power to heal but rather,

⁵³¹ For example, see "Abortuary picket line"; Orsini, "Bringing home"; or the words of infamous anti-abortionist Don Spratt, as quoted in Rees, "Premier".

⁵³² Wright, "Letter". She and her co-authors, "Nineteen women at Lakeside Correctional Centre," identified themselves as "rescuers" who aimed to "save the lives of babies in the womb [...] acting as good neighbours to the youngest in society".

⁵³³ Betty Green, "Letter". See also Green's quotation: "I don't think the general population of BC wants to see children killed and I don't think anyone wants a killing centre in their neighbourhood" in Grindlay, "New abortion clinic".

⁵³⁴ Lee, "I'm no criminal".

⁵³⁵ McCready. "Abortion": 5. By contrast, securing "abortion on demand" was argued by second wave feminists as imperative to supporting women's social and medical autonomy.

“the license to kill.”⁵³⁶ Commenting on the establishment of Vancouver’s second freestanding clinic (The Elizabeth Bagshaw clinic), Betty Green remarked: “Apparently, it’s open season on unborn children.”⁵³⁷

The letter of one anti-abortionist nurse to the Minister of Health in 1985, two years after the illegal Toronto and Winnipeg Morgentaler clinics were established, particularly illustrates her deep resistance to freestanding clinics as a god-abiding nurse. It also highlights anti-abortion nurses’ desire to reach a wide-ranging and, in this case ostensibly powerful, audience. With her husband Rev. Alvin Pinno, Registered Nurse Dorothy C. Pinno wrote to Jake Epp as follows:

[..] As a registered nurse and a minister of the Gospel of Jesus Christ [...] we are gravely concerned about a number of social and moral issues facing our nation today [including abortion. ...]. We expect our federal government to ensure that the [abortion] law will be enforced and that no abortion clinics will be established across our nation. Although the evil of abortion as brought in and institutionalized under the formal Liberal government, for which God will hold them accountable, the ball is now in your park, and we watch with hope that you will curtail this wholesale slaughter of the innocent. You, too, are accountable to God, and God’s will is that justice will be a reality in our nation, and not just a pious

⁵³⁶ Kines, “Abortion foe”: B8.

⁵³⁷ Ibid.

phrase. We call upon you to act now and save the lives of unborn children!⁵³⁸

Firmly ensconced in this discursive reality, I suggest, anti-abortion nurses and other activists subsequently targeted the freestanding abortion clinics and the nurses and others who worked there in material ways. They had, in many ways, constructed a social atmosphere that drove and supported resistance to nurses' abortion work in freestanding clinics that was primarily founded in the idea that abortion-supportive work was necessarily prohibited for nurses given the profession's broader, and according to them, seemingly universal, Christian-based, but science-supported, professional identity.

Anti-Abortion Activism in and Around Freestanding Abortion Clinics

In the following sections, I outline some of the activism strategies devised by anti-abortionists and clinic nurses' management of them.⁵³⁹ I include the activities of all members of the anti-abortion movement (both men and women), yet I particularly highlight the work of anti-

⁵³⁸ Pinno, "Letter to Epp".

⁵³⁹ I mention but a few examples below. There is much more documentation regarding anti-abortion activism against freestanding clinics in various sources. For additional Vancouver accounts, for example, *see* the Everywoman's Records in CoVA, especially in Prochoice Records AM 1486 576-E-1-14; AM 1486 576 E-2-10; AM 1486 E-3-10; AM 1486 E-3-2-11. Other rich documentation about anti-abortionism in Vancouver can be found in the legal papers related to the R. v. Lewis case of 1996, wherein Maurice Lewis was charged in relation to his activism (especially, "Reasons for Judgement").

abortionist nurses within it. Similarly, though I include anti-abortionism activism lobbied against all clinic workers, I particularly highlight that which was explicitly targeted against abortion clinic nurses. Moreover, I bring forward clinic nurses' responses to anti-abortionism in general. As such, there are three 'streams,' if you will, of anti-abortionism-and-nursing considered here: anti-abortionism *by* nurses (as part of the general anti-abortion movement), anti-abortionism *against* nurses (amid anti-abortionism against all clinic workers), and clinic nurses' *responses* to anti-abortionism in general (but not necessarily their responses to anti-abortionism on the part of their nurse-counterparts). With this analysis, I do not aim to focus on direct or explicit nurse-to-nurse confrontations (though there are some examples of those activities), but rather to illuminate the social and material environments constructed in and around freestanding clinics in the context of nursing in general. In so doing, I shed light on various 'nursing-specific' elements of anti-abortion activism and provide an interpretation of the implications of those elements on professional nursing identity more broadly.⁵⁴⁰

⁵⁴⁰ Non-nursing-specific anti-abortionism has been analyzed in greater detail elsewhere. *See* Ackerman, "Dark Secret"; Ackerman, "Not in the Atlantic"; Ackerman and Stettner, "Public Not Ready"; Cueno "Catholics"; Saurette and Gordon, "Changing Voice"; and Stettner and Douville, "Image". For a table of anti-abortion statistics on violence against providers and clinic-targeted activism in the USA and Canada (ranging from 1990–2109), *see* National Abortion Federation, "Violence and Disruption Statistics".

*Alternative Places “Everywoman’s Abortion ‘Clinic’ has a new neighbour!”*⁵⁴¹

A striking project that some anti-abortion nurses and their activist allies undertook to resist freestanding clinics was the establishment of alternative places from which they could counsel and support women in choosing *not* to have abortions. That is, a few anti-abortion activists were compelled to offer a different physical place (other than the abortion clinic) for pregnant women to go. Because they perceived abortion clinics as “abortuaries” and “killing centres,” as they put it, from the perspectives of these anti-abortionists, alternative spaces arguably comprised legitimate ‘treatment’ or health facilities. Perhaps owing to their training and the experience with offering counseling and treatment in their hospital nursing work,⁵⁴² anti-abortion nurses took up leadership roles in establishing and operating alternative spaces. One significant example of such a place and such a nurse lies at Vancouver’s Gianna House. In 1990, retired nurse Cecilia Von Dehn (then the president of the Vancouver chapter of *Nurses for Life*) purchased a small bungalow “directly behind” Everywoman’s Health Centre.⁵⁴³ Emphasizing the religious undercurrents of Von Dehn’s activism, she named it, *Gianna House*, choosing the name in homage to an Italian physician, Gianna Beretta Molla.⁵⁴⁴ Von Dehn apparently determined that the physician embodied the anti-abortion perspectives that she so valued. The story goes that in 1961, upon discovering that she had a uterine tumor, the pregnant Gianna chose to continue her

⁵⁴¹ Hansard, “British Columbia”.

⁵⁴² Interestingly, this perspective echoes abortion clinic nurses’ suggestion that they were fully qualified to provide abortion-supportive counselling in freestanding abortion clinics, as discussed in Chapter Two.

⁵⁴³ For more on Von Dehn, *see* Appendix.

⁵⁴⁴ Horwood, “Love”.

pregnancy (rather than terminate and treat her own condition instead).⁵⁴⁵ Reportedly, in so doing, the physician held fast to her “political activ(ism) and ardent pro-life [ideals].”⁵⁴⁶ Gianna died of complications one week later. Yet because she “chose the life of her [unborn] child over her own,”⁵⁴⁷ anti-abortionists in Canada later proclaimed her to be a “modern day Christian heroine.”⁵⁴⁸ Thus inspired, Von Dehn named the new house *Gianna House*.⁵⁴⁹ She did not intend to live there.

⁵⁴⁵ It is unclear if in 1961 in Italy, when abortion was illegal, whether Gianna would actually have been able to choose to terminate this pregnancy.

⁵⁴⁶ Horwood, “Love”

⁵⁴⁷ Ibid.

⁵⁴⁸ Hansard, “British Columbia”. Here, perhaps, is a good example of the anti-choice “direct killing” vs. “letting die” moral argument in action. The argument applies as follows: rather than killing the innocent and ensouled fetus directly, which—owing to the sanctity of life maxim—is not permitted in this paradigm, Gianna was allowed to die (letting die being the morally preferable option). For this argument, *see again*: Judith Jarvis Thomson, “In Defense of Abortion.” Additionally, this example could perhaps illustrate the outcome of the argument that women were expected to (want to) carry out their ‘inherent’ capacity for motherhood. For one nurse’s articulation of this argument in the context of nursing and abortion specifically, *see* Kay Eliason’s Letter to the Editor in *Canadian Nurse*. She wrote: “Young nurses have chosen a noble (excuse the old-fashioned word) profession because they are normal, healthy young women and nursing is something women traditionally have done well. These girls also have the same dreams and aspirations my colleagues and I had 30 years ago. They want love and motherhood, not empty arms and an aching heart”: 4. For more on the connection between religious beliefs and

Von Dehn reported that she and her associates acquired the house in order to operate it as a place to provide counselling services primarily to the women coming and going from the neighbouring Everywoman's clinic. Volunteer "staff" at Gianna House claimed that they also wanted to help women with "housing, food, financial aid, clothing, telling loved ones [about their pregnancies], and working out school arrangements"⁵⁵⁰ if needed. It is unclear from the sources that I consulted who it was that partnered with Gianna House staff in order to actually arrange or provide these resources. One report indicated that the Anglican Catholic Church might have been involved given that they helped with developing the facility itself. According to one report, a 'Father Gale' of that diocese, for example, helped furnish the house with a prayer room.⁵⁵¹ Perhaps members of this church, then, were involved with operating Gianna House and its services in other (as yet uncovered by my investigation) ways. What becomes clearer, I suggest, is that with this new space, nurse Von Dehn and her allies combined ostensibly clinical counselling services with their deeply held religious perspectives in a physical space that ultimately supported anti-abortion activism by and towards nurses and others.

The actual counselling services that Von Dehn reportedly offered from Gianna House remain unclear. I put forward, however, that they likely resembled earlier anti-abortion services established or operated by nurses (and others) prior to decriminalization. Anti-abortion nurse Ita

women's duty for motherhood, *see* Rauhala. "Religion is key". The explicit justification given by Gianna Beretta Molla is unclear from the sources I consulted.

⁵⁴⁹ For a photo of Gianna House, *see*: Horwood, "Love".

⁵⁵⁰ Hansard, "British Columbia".

⁵⁵¹ *Ibid.*

Venner, for example, set up a telephone call-in line in the early 1970s by which to offer anti-abortion counselling to women.⁵⁵² Specifically, when women called in, she asked them questions such as:

Why do you want to abort your baby? When did you become pregnant? How old is your baby now? Do you know how big your baby is? Do you know that your baby's heart is already beating, and that the baby already looks like you?⁵⁵³

Throughout these conversations, Venner was said to provide the caller with “facts and truth”⁵⁵⁴ about pregnancy, fetal development, and abortion (which she was theoretically able to do owing to her previous nursing training and experience) while “painting a picture of the beautiful child.”⁵⁵⁵ She assured women that “all the help they needed [to support their pregnancies] was available [to] them.”⁵⁵⁶ Perhaps the staff at Vancouver's Gianna House employed similar ‘counselling’ techniques that combined ‘facts and truth’ with more spiritual conceptualizations of the fetus as a ‘baby.’ The ultimate goal for these anti-abortionists was to discourage women

⁵⁵² See “Crusaders” or Morgan, “Obituaries”.

⁵⁵³ Morgan, “Obituaries”.

⁵⁵⁴ *Ibid.*

⁵⁵⁵ *Ibid.*

⁵⁵⁶ *Ibid.*

from having abortions, and, in the words of Von Dehn, to also provide a physical “safe house where [they could] invite the girls in for coffee and offer them a last resort.”⁵⁵⁷

Similar to Gianna House, anti-abortionists opened a physical space next to the illegal Morgentaler Clinic in Toronto in 1985. They named it *The Way Inn*, and similarly framed it as a “pro-life coffee-house.”⁵⁵⁸ From the beginning, retired nurse Joanne Dieleman, originally a “Dutch midwife” who thereafter worked in Ontario as a nurse, was the co-ordinator of this space. She herself had refused to undergo an abortion in 1970 after contracting rubella while pregnant, which can result in fetal anomaly and thus was considered by many at that time a legitimate justification for obtaining a therapeutic abortion.⁵⁵⁹ With that experience in mind, she committed herself to “counselling dubious [women],”⁵⁶⁰ as she perceived them, at the Inn. One biographical report notes that Dieleman “follow[ed] God’s agenda” there and “saw this presence as [...] a ministry for Christ.”⁵⁶¹ Articulating the somewhat paradoxical philosophy of the “cafe,” a spokesman from *The Way Inn* reported that it “is designed to be a place where women considering an abortion can discuss the issue in ‘a non-judgmental environment and a loving way’ without forgetting that they must face their responsibilities.”⁵⁶²

⁵⁵⁷ Horwood, “Love”.

⁵⁵⁸ Petrasek, “Silhouettes”: 159

⁵⁵⁹ See Roulston, “Causes”.

⁵⁶⁰ Petrasek, “Silhouettes”: 162

⁵⁶¹ Ibid.

⁵⁶² Cernetig, “Picketing”: M5.

The Gianna House and The Way Inn examples also highlight the expansion and intensification of anti-abortion activism by nurses and others leading up to and following decriminalization.

Unlike Venner's 1970s telephone line, Gianna House and The Way Inn were physical spaces (that literally neighbored the abortion clinics), which allowed them to function in new ways beyond anti-abortion counselling. Gianna House in particular positioned itself as a physical headquarters for anti-abortionists that supported the development of their ideologies and real-world activism. Von Dehn remarked that, at Gianna House, "we now have a base for pro-life support groups. It will be a place for us to have coffee *and* prayer."⁵⁶³ In order to 'facilitate prayer,' they appropriately designated one room as the "prayer room."⁵⁶⁴ Yet, rather tellingly, one *Vancouver Province* reporter who toured the house revealed that the prayer room included more than just "pictures of Jesus on the walls." It also boasted "a corner window that look[ed] across a back lane at the rear of the Everywoman's Health Centre."⁵⁶⁵ One Gianna House member remarked that the prayer room, in his opinion, had "the best view." From that room, anti-abortionists could monitor the clinic and facilitate mobilization in order to physically protest against it and the nurses and others who worked or went there. Von Dehn explicitly articulated her hope that the space would support anti-abortion activism beyond counselling women. She told the *Vancouver Province*: "'We hope it will draw more picketers."⁵⁶⁶

⁵⁶³ Horwood, "Love".

⁵⁶⁴ This is the room that Father Gale 'furnished'.

⁵⁶⁵ Kines, "Abortion foe": B8.

⁵⁶⁶ Horwood, "Love".

Making Noise

Indeed, picketers were drawn to the freestanding abortion clinics across Canada both before and after decriminalization. Picketing meant that anti-abortion activists gathered outside freestanding clinics carrying signs and placards (the likes of which Sharon B remembered outside of the Toronto Morgentaler Clinic) that decried abortion and its ‘elective’ provision from the clinics. A newspaper photograph of Gianna House (which also featured its owner, nurse Von Dehn, and her daughter) pictured two men holding picket signs. One read: “Killing babies is barbaric.”⁵⁶⁷ The other read: “Equal rights for unborn women.”⁵⁶⁸ Vancouver anti-abortionists reported that picketing the freestanding clinics had become imperative given that previous tactics had not succeeded in preventing clinics from opening or in shutting them down. They claimed that they began to picket in-person “after years of letter writing” in order “to put a stop to the killing of a person.”⁵⁶⁹

Some nurses regularly took part in carrying out—if not organizing—these demonstrations. Cecilia Von Dehn’s Gianna House, for example, functioned as a pre-picketing meeting place where anti-abortionists could plan their protests, take refreshments, and energize each other to

⁵⁶⁷ Ibid.

⁵⁶⁸ Ibid. Here again is an example of the relegation of living adult women into the background via anti-abortion discourse. For more on this strategy, *see* Thomson, “A Defense of Abortion”.

⁵⁶⁹ “Vancouver defendants speak”. It is worth noting that anti-abortionists had been picketing hospitals and demonstrating on Parliament Hill already. It is unclear if this author is thus referring to abortion clinics as new sites of picketing. For an example of nurses’ letter-writing, *see* Dorothy Pino’s “Letter to Jake Epp”.

carry out their plans as a group (instead of as disjointed individuals, for example).⁵⁷⁰ One clinic nurse I interviewed reported that protesters gathered outside of Everywoman's to pray and sing *O Canada* before moving on to actually marching around it.⁵⁷¹ In Toronto, sisters and retired nurses Helen and Rita Burnie similarly picketed the Morgentaler clinic, demonstrating a strong commitment to their activism. Helen reportedly picketed the clinic "five days a week"⁵⁷² while Rita appeared "three days a week for about four hours each day."⁵⁷³ Anti-abortion activist allies of Von Dehn and the Burnie sisters claimed that through picketing they opposed the normalization of abortion that was engendered by the clinics. One spokesman for *Campaign Life BC* explained that they aimed to "demonstrate opposition to [Everywoman's] clinic [because it] normalizes the act of abortion [and] makes abortion more commonplace."⁵⁷⁴

⁵⁷⁰ Gianna House was also an easily accessible storage space for the cumbersome signs and other demonstration materials.

⁵⁷¹ JF. The nurse did not indicate which prayer was chanted. I suspect it was The Lord's Prayer (from personal experience). In Toronto, anti-abortion nurse Helen Burnie was reported to have "pray[ed] in front of a casket, a symbol for aborted babies outside the Morgentaler clinic". See, "Praying": A6. The singing of *O Canada* points to a unification of religion, nationalism (i.e., Christian nationalism), and anti-abortionism, which is not analyzed in this study. For more on that topic: see Ackerman, "Not in the Atlantic" or Ackerman, "A Region at Odds" in which she tackled geographical identity in her work on the anti-abortion movement in the Maritimes.

⁵⁷² "Pickets' credo": A10.

⁵⁷³ "Abortuary picket".

⁵⁷⁴ Walter Szetela of Campaign Life BC as quoted in Bolan, "300 Protest": A3.

In picketing the clinic, I argue, anti-abortionists (including nurses and others) aimed for more than merely de-normalizing or de-legitimizing clinic operation. Namely, I suggest that they aimed to normalize anti-abortion activism in general and, perhaps less directly, normalize and make common-place anti-abortion activism on the part of nurses-as-such. Regular and increasingly familiar in-person picketing that was widely reported in the media, I suggest, helped to construct, normalize, and legitimize a physical and social anti-abortion atmosphere around the clinics. Moreover, this atmosphere allowed for (and was in turn reinforced by) increasingly elaborate and forceful resistance to the in-clinic abortion work of nurses by anti-abortion nurses and their allies, which I will discuss next. This environment, evidence suggests, in many ways created an unpredictable, hostile, and sometimes unsafe social and physical reality for abortion clinic nurses, both at their workplaces and beyond, which, I argue, they then had to manage.

With an anti-abortion atmosphere steadfastly developing, anti-abortion nurses and their allies continued their protests and escalated their efforts around the freestanding clinics. One developing tactic was to present and focus on detailed imagery of the fetus.⁵⁷⁵ It was reported, for example, that:

Pro-lifers [including members of *Nurses for Life* and its sister organization *Campaign for Life Coalition*, which also included nurses] now [felt] that they [had] to display more graphic pictures

⁵⁷⁵ For more on fetal imagery and anti-abortionism, see Casper, “Making Unborn”; Hartouni, “Cultural Conceptions”; Mitchell and Georges, “Baby’s First”; Rapp, “Real Time”; and Stabile, “Shooting the Mother”.

of the death of our unborn [...] in order to bring the full impact of the horrors of abortion to the attention of the public.⁵⁷⁶

In our interview, Ottawa abortion clinic nurse Joan W articulated her perspective of those actions. She perceived that with this graphic imagery, anti-abortionists were not only interested in demonstrating that abortion comprised the barbaric killing of an unborn person, but that they also aimed to educate women about fetal development, which they believed could sway women's decisions. She explained her belief that anti-abortionists at that time:

Were in the middle of a fetus fetish. They thought or assumed that [women] made a decision [to abort] based on the size of a fetus or age of the fetus. That's what the anti-abortion people kept saying: 'If you just show them the fetus, women wouldn't have aborted.'⁵⁷⁷

She concluded, "Those years were really a pain because all the discussion about abortion had nothing to do with women."⁵⁷⁸ Regardless of the intended surface-level messaging, increasing

⁵⁷⁶ "Caplan sit-in".

⁵⁷⁷ JW 2090–2093.

⁵⁷⁸ JW 1919. Here JW points to and rejects the erasure of women in this kind of anti-abortion discourse. It is notable that her remark that "[anti-abortionism] had nothing to do with women" in this context echoed her dismay at the legal in-hospital and ostensibly abortion-supportive system, which she perceived dismissed the unique experiences, wants, and needs of women

use of fetal imagery suggests that anti-abortionists perceived that their longstanding style of everyday picketing or verbal counselling, complete with vocal descriptions of fetal development (such as that which nurses Ita Venner and Cecilia Von Dehn provided over the phone and in person at Gianna House, respectively), was not influential enough. Those strategies, according to them, did not deliver a full-enough impact to prevent abortion provision or shut down freestanding clinics.

Adding to graphic fetal imagery, large numbers of Christian protesters created even more anti-abortion ‘noise’ outside the clinics, which clinic nurses encountered. These anti-abortionists prayed aloud, played religious music through loudspeakers, dressed up as Jesus and circled the clinics in other religious costumes, and they constructed physical anti-abortion displays. This kind of activism, I suggest, helped anti-abortionists reinforce the abortion-resistant social and physical environments that they had been developing in and around freestanding clinics, which ultimately affected clinic nurses. Outside the Kensington Clinic in Calgary, for example, anti-abortionists “set up a painted plaster statue of Jesus, [and] a sound system filled the air with Gregorian chant.”⁵⁷⁹ Similarly, outside Vancouver’s Everywoman’s clinic:

About 300 protesters paraded with picket signs and gaudy pictures of aborted fetuses. Two men leaned against the outside wall, heads

seeking abortions there (*see* Chapter Two). An analysis of this parallel, though striking and thought-provoking, falls beyond the scope of this dissertation.

⁵⁷⁹ Gilbert, “Clients”: A1.

bowed, mumbling prayers. “Dear Jesus, let no blood be shed on this ground today. Lord help the little babies.”⁵⁸⁰

Going further, at Gianna House in Vancouver, anti-abortionists set up ever-changing displays on their lawn, which gave the nurses working at Everywoman’s clinic pause. One clinic nurse explained:

We were right next door to a house that was owned by the anti-choice [... and they created] tombstones to the unborn children, and they had crosses that they would put out, every once in a while, in the front yard. They had fetuses in little baby carriages. Not only we as workers had to walk past [them] but all the women coming in to access our services had to walk past too, which really kind of heightened anxiety and made it difficult.⁵⁸¹

She elaborated:

There were two men that did a lot of protesting as well. They kind of made us feel a bit more vulnerable. The old ladies saying their rosaries, you know, you could knock them over with a single blow. You didn’t feel that they weren’t physically threatening or

⁵⁸⁰ Miller, “Everywoman’s”: n.p.

⁵⁸¹ LR 94–100.

intimidating. They are annoying [... but] it was a lot harder, I think, with the men.⁵⁸²

Here, Lisa R's comment points to clinic nurses' consideration for their own safety or vulnerability. Significantly, it also acknowledges the concern for women-patients that she and her colleagues continue to hold outside of the legal and clinical contexts of abortion provision that I discussed in Chapter One and Two, respectively. In cementing anti-abortionism even deeper into social consciousness and physical reality, I suggest, anti-abortionists around the clinics, in addition to being 'annoying' and 'threatening,' were supported in carrying out even more explicit and implicit intents to harass clinic nurses (and their co-workers and women-patients) by targeting them directly and more forcefully through both on- and off-site strategies.

Clinic Attacks

One on-site strategy that anti-abortionists turned to was violent clinic attacks.⁵⁸³ General attacks on the clinics, which commonly (but not always) took place after-hours, undoubtedly affected clinic nurses and contributed to unsafe and hostile work environments for them. These attacks included, for but a few examples, firebombing the Toronto Morgentaler Clinic, attempting arson on the Edmonton Morgentaler Clinic, releasing poison gas into the Edmonton clinic's ventilation system, making bomb-threats to the Calgary Kensington Clinic, and breaking into Everywoman's clinic (using a tire iron) in order to damage the ultrasound machine and suction

⁵⁸² LR 127–133.

⁵⁸³ See Todd, "Secrecy" for more on attacks.

aspirator there.⁵⁸⁴ Presumably, finding out about and managing these threats and attacks were difficult tasks for many clinic nurses.

Indeed, nurse Cory Bennett, the director of Calgary's Kensington Clinic, was said to show signs of uneasiness during a bomb threat on her clinic. Tom Keyser of *The Calgary Herald* reported:

Five cops from the bomb unit made a last sweep across the roof and through the building. They went away satisfied. All clear. Crank call. Probably just the Pro-Life Death Squad—I didn't make that up—tossing off a little cut-rate terrorism from the cheap seats. Cory Bennett was all nerves. She lit a fidgety cigarette [...]. Bennett's only 29, but she's tough and focused. A Registered Nurse and straight-ahead feminist, she's worked for similar clinics in

⁵⁸⁴ I discussed the significance of the ultrasound and suction aspiration machines in Chapter Two. Also of note: a nurse in Calgary (Don Mably, who readers may remember from his letters to the editor of *Canadian Nurse*) similarly attacked a Calgary hospital day-surgery clinic (i.e., not a freestanding clinic) where abortions were performed. Mably reportedly “lock(ed) himself to a suction machine in the (Peter) Lougheed (Hospital) abortion clinic. The cops twisted his ankles out of their chains and drove him downtown, where Mably was booked on a minor trespassing charge.” See Keyser, “Warring”: B1. For the freestanding clinic attacks, see for example, “Edmonton Morgentaler clinic”; Ramsey, “Abortion clinic vandalized”; and Watt, “Thug smashes”.

Toronto and Vancouver. [...]. She never had to deal with bomb scares [there]. This one shook her.⁵⁸⁵

Little is known about other clinic nurses' immediate reactions to such violent clinic attacks at the time. Yet multiple nurses who worked at Everywoman's shared their memories of one (ostensibly) less violent, but no less poignant, act of anti-abortion vandalism against their clinic.

Lisa R explained:

We had this beautiful [...] mural painted on the outside [of the clinic]. And they'd come and butt their cigarettes on the flowers on the mural. One time they painted it all. The mural and the flowers were gone. It was a really unhealthy environment.⁵⁸⁶

Some of Lisa R's colleagues described the vandalism similarly.⁵⁸⁷ Jackie F remembered that, as head nurse, she had been made aware of the event when clinic security:

... called me at about 6 O'clock in the morning, saying, "your whole front door of the clinic has been blocked by mud." At that

⁵⁸⁵ Keyser, "Warring".

⁵⁸⁶ LR 233–240.

⁵⁸⁷ JF; CM; RW.

point we had a nice mural on the front of the building, they had put [black paint] all over it.”⁵⁸⁸

I interpret nurses’ numerous memories of the destruction of the welcoming mural at Everywoman’s (i.e., a seemingly simple physical act that was in fact deeply symbolic) as an event that distressed them in some ways and that perhaps even shook them to some degree. These kinds of building-focused attacks, including the more extreme events that nurses like Cory Bennett experienced, contributed to a chaotic and at times violent environment for clinic nurses. These anti-abortion activities, I suggest, highlight the ongoing construction and maintenance, and thus the normalization, of an anti-abortion atmosphere built around and literally *on* the walls of freestanding clinics. By this analysis, it appears as though anti-abortion activism was creeping towards targeting clinic nurses and their colleagues directly. In the next sections I examine the ways that clinic nurses were indeed targeted by anti-activists at the clinics and beyond.

Violence Against Nurses at the Clinics

Anti-abortion activists continued to develop methods of resistance that focused on the staff who worked in freestanding clinics. In these cases, in addition to focusing on their own prayers, walking in circles around the clinics, waving picket signs, making threats, and attacking clinics in general ways, anti-abortion activists also addressed clinic nurses and their colleagues directly. For example, anti-abortionists sometimes took pictures of or threatened to take pictures of nurses (and others) entering and leaving the clinic, thus threatening them with wider public exposure and potential for more harassment. According to the *Toronto Star*, “picture-taking is one method

⁵⁸⁸ JF 627–630.

used by anti-abortionist demonstrators [including nurse Helen Burnie] to discourage people from going into the building”.⁵⁸⁹ While Helen Burnie admitted to actual picture-taking at the Toronto Morgentaler Clinic,⁵⁹⁰ some other anti-abortionists merely pretended to take photographs.

Toronto clinic nurse Sharon B remembered this anti-abortion strategy on the day she applied for her job in 1986. She recounted:

The day I dropped off my resume [to apply to work at the Morgentaler Clinic] was a day I was working [at a hospital], so I had my uniform on. I drove up, stopped, and went through these protestors. I don't remember if they said anything to me or not. They must have. They did. They pretended to be taking my picture. I was just flabbergasted. [...]. I got pulled over by the police. 'What?!' And the guy said, 'I want you to know that there was no film in those cameras.' And then I realized he was the guy that was sitting on the side of the clinic and he had come to reassure me that there was no film in the camera and that they wouldn't be putting my picture all over the paper.⁵⁹¹

⁵⁸⁹ “Assault charge”.

⁵⁹⁰ *Ibid.*

⁵⁹¹ SB 169–173. This action by the officer is perhaps remarkable in that it took place before decriminalization and thus during the time of ongoing police raids on the clinics (as discussed in Chapter One). By contrast, JB remembered anti-abortion police following clinic staff home in an act of intimidation after decriminalization.

In addition to picture-taking, as Sharon B noted, anti-abortion activists in fact did ‘say something’ to nurses at the clinics. They sometimes shouted disparaging remarks at them. She vividly remembered their scorn. Sharon B said:

On pay day the regular protesters would come. And we always went to the bank [to deposit our pay cheques. ...]. So, every Monday at lunch time, we’d all go [to the bank] and they knew it. ‘Aw going with your blood money?!’ They would yell at us. They were always calling after us!⁵⁹²

These activities were also reported in major print media at the time. According to *The Windsor Star*, Toronto anti-abortionists sometimes “engaged in shouting matches with nurses and doctors trying to enter the clinic.”⁵⁹³ Similarly, the *Vancouver Province* reported: “Employees at Everywoman’s health centre in Vancouver are used to running a gauntlet of shouting [and] placard-waving anti-abortionists who throw animal blood and call nurses ‘murderers.’”⁵⁹⁴ In Calgary, *The Herald* reported that picketer “Stella Attrell yelled at two clinic employees [...], saying to the head nurse, ‘Dear Lord, save this woman, she has no shame!’”⁵⁹⁵

⁵⁹² SB 768–772.

⁵⁹³ “Both sides”.

⁵⁹⁴ Fournier, “Lives”: A14 (my emphasis). *See* this source for more on escalating violence.

⁵⁹⁵ Dolik, “Anti-abortion”: B1.

This vocal harassment of nurses by anti-abortionists also developed into closer physical altercations at times. According to the anti-abortion newsletter, *The Interim*, for example, anti-abortion nurse Rita Burnie was involved in “a verbal exchange between picketers [i.e., herself] and abortuary workers [i.e., nurses and others at the Toronto Morgentaler clinic, which] began as the workers were leaving for the day.”⁵⁹⁶ This confrontation apparently resulted in “some shoving,” and the police were called to intervene. The police then charged Burnie and other anti-abortionists for their actions. Burnie herself was charged with “assault with a weapon.”⁵⁹⁷ Anti-abortionists were incredulous given that the weapon that was “allegedly involved [was] her picket sign.”⁵⁹⁸ Yet, despite anti-abortionists’ incredulity, picket signs were likely harmful to clinic nurses and others. In perhaps a similar incident at the Winnipeg clinic in 1989, for example, it was reported that “a clinic nurse was hit in the face by a picket sign.”⁵⁹⁹

Physical violence or the threat of physical violence against staff outside the clinics was apparently commonplace at this time. In addition to the nurse-focused stories above, consider but a few newspaper headlines from 1989: “Protester charged with assault in abortion clinic

⁵⁹⁶ Walker, “Metro Cops”.

⁵⁹⁷ Ibid. She was released on bail. Of note here is that before decriminalization it was not only abortion-supportive nurses who faced criminal charges but also anti-abortion nurses. Though significant, a fuller examination of their apparent legal plight falls beyond the scope of this dissertation.

⁵⁹⁸ Ibid.

⁵⁹⁹ “New clashes”: A8.

demonstration;”⁶⁰⁰ New clashes outside clinic in Winnipeg;”⁶⁰¹ and “5 arrested in scuffle outside abortion clinic.”⁶⁰² These stories and headlines make it clear that clinic nurses, with their other colleagues, faced significant challenges in travelling to and from their workplaces—but what of actually entering the clinics to carry out their work?

Standing Firm

Increasing the challenge, anti-abortion protestors moved ever-forward towards the clinics and staff members. They began to set up clinic blockades in which they arranged their very bodies into human chains or human walls, infamously doing so at both the Toronto Morgentaler Clinic and Vancouver’s Everywoman’s Health Clinic.⁶⁰³ Together, they situated themselves in front of

⁶⁰⁰ Picard, “Protester charged”: A 11.

⁶⁰¹ “New clashes”: A8

⁶⁰² Picard, “5 arrested”: A15. Similar headlines continued into the 1990s. *See*, for example, “Keyser, “Death threats are common in the trenches”.

⁶⁰³ *See*, for example, Boei, “Wall.” These protestors, including some nurses, were mobilizing as part of the intensifying broader anti-abortion movement. Nurse Helen Burnie was explicitly involved with the notoriously violent fundamentalist Christian group *Operation Rescue*.

According to Saurette and Gordon in “Changing Voice,” Operation Rescue was established in 1986 and “has largely been credited with pioneering and popularizing highly confrontational social protest and direct action in the anti-abortion movement”: 379. Members of this group endeavoured to “rescue” pregnant women and fetuses from outside of abortion clinics. *See* Saurette and Gordon’s “Appendix A” for a glossary of similar organizations and individuals and key legal and political events.

clinic doors in order to “stand immobile [... when] staff tried to approach.”⁶⁰⁴ These demonstrators, it was reported, were “prepared to stop clinic staff and supporters or clients from entering the building.”⁶⁰⁵ Toronto Morgentaler Clinic nurse Sharon B remembered the familiar scene at her clinic well, explaining:

The place was surrounded with a gate, and the gate was always locked [by us]. And they used to put glue in the lock, and then we had to have bolt cutters inside the door if they did that [in order to open the gate]. But then they started to put those kryptonite bike locks on—they would put that around their neck. And then put it into a bucket of cement and let it harden so that the guy was attached to the chain link fence so you couldn't open it. You couldn't open the thing and move them. You just couldn't do that. So, you had to climb a fence to get in and then get started on your work until the police could come and take them away. Because the patients can't come in, because the chains are locked, and you can't unlock the chain because the guy has kryptonite-ed himself to it.⁶⁰⁶

⁶⁰⁴ Boei, “Clinic lawyer”: A10. For Toronto, *see* “Both sides”. Everywoman’s also kept security logs detailing various incidents. *See*, for example, Everywoman’s, “Excerpts.”

⁶⁰⁵ Ward, “Abortion”: A1.

⁶⁰⁶ SB 786–800. SB remarked that she “hated climbing the fences.”

True to their aims, once in place, anti-abortion protesters, including some nurses, refused to relent or to leave the clinics.⁶⁰⁷ A common strategy for anti-abortionists attempting to stand their ground when police requested that they move away was to “go limp,” lay or sit down, and refuse to walk. These protesters were subsequently physically carried away by police (sometimes dramatically on stretchers), which was photographed and published by mainstream newspapers.⁶⁰⁸

For those protesters who cemented or locked themselves in place, police had to get more creative. In one instance at Vancouver’s Everywoman’s clinic, for example, police called “city crews [to use] acetylene cutters [i.e., torches] to [...] sever bicycle locks connecting two demonstrators by their necks to a large block of concrete that had been placed outside the front door of the clinic.”⁶⁰⁹ Back in Toronto, when asked about her refusal to leave the clinic, nurse Ita Venner explained: “Well, I’m not guilty of any crime. *I’m a nurse*, and a nurse is supposed to save lives. That’s what I was doing.”⁶¹⁰ Here, anti-abortion nurses and their allies continued to build and defend an increasingly hostile, chaotic, and violent physical and social anti-abortion

⁶⁰⁷ For four Vancouver nurses who refused to leave and were detained by police, see “Vancouver defendants.” According to this article, one of the nurses (Wendy Muir) spent 27 days in jail rather than promise to remain away from the clinic. In Toronto, Ita Venner similarly refused to stop protesting. See Otis, “Fines”.

⁶⁰⁸ For a photo of police carrying a protester away from EHC on a stretcher, see Ward, “Abortion”: A1.

⁶⁰⁹ Ibid. For a photo of police cutting away a protester with torch, see Trask, “Protestors”.

⁶¹⁰ Otis, “Fines” (my emphasis).

environment at the clinics. They tried to prevent nurses from entering the clinics at all while they simultaneously attempted to degrade clinic nurses and de-legitimize abortion work for them in general. According to these protestors, abortion clinic nurses had rejected their professional obligations. They ‘had no shame,’ they were paid in ‘blood money’ and they participated in ‘murder,’ which were decidedly not nurse-like. For these speakers, clinic nurses had committed the cardinal professional sin of failing to save peoples’ (i.e., fetal) lives—a perspective that highlights and reinforces the anti-abortionist move to bring Christian perspectives to bear on their conceptualizations of nursing identity while, in turn, bringing the Christian roots of nursing to bear on their anti-abortionist identities.

Violence Against Nurses at Home

In some remarkable ways, anti-abortionists added to the growing context of cultural resistance to abortion provision by expanding their harassment of clinic nurses beyond their workplaces and into their homes. Vancouver abortion nurse Jackie F remembered that some anti-abortionists “watched [nurses’] cars and they would follow you home.”⁶¹¹ She said they “had to be careful because [we’re] kind of out there. And they knew who I was because the anti-choice would talk to me on the street.”⁶¹² And, once they knew who clinic nurses were and where they lived, committed anti-abortionists engaged in more picketing and further attacks at nurses’ private homes. In one instance in 1986, it was reported that:

⁶¹¹ JF 618.

⁶¹² JF 975–978.

Approximately 40 picketers appeared outside the home of Jane Berry, a senior nurse at [The Toronto Morgentaler Clinic]. Pamphlets on the unborn child were distributed to local residences along with the statement explaining the actions of the picketers. ‘She [Berry] has resisted all our pleas to reconsider what she is doing,’ the statement said. ‘Please talk to Jane, ask her to find other work.’ Ms. Berry, who was home at the time, was shocked to see the picketers, adding that ‘They’re stepping up their harassment antics.’”⁶¹³

Similar tactics were employed against physicians at their homes.⁶¹⁴ In Calgary, for example, some anti-abortion activists “shoved gruesome, full-colour anti-abortion pamphlets through the mail slots of a doctor’s neighbours.”⁶¹⁵ In terms of anti-abortion nurses’ participation and reactions to this harassment, Calgary nurse Beverley Mably claimed to support these schemes in her city, noting to the *Calgary Herald* that, “‘It didn’t bother me at all. To picket a doctor’s home is peaceful compared to what the doctors are doing.’”⁶¹⁶

⁶¹³ Orsini, “Bringing home”.

⁶¹⁴ See Welsh, “Protests”.

⁶¹⁵ Keyser, “Warring”.

⁶¹⁶ Ibid. Readers may remember Beverly Mably from her letters to *Canadian Nurse* (and as Don Mably’s wife). For her letters, see: Mably, “Dilemma” or Mably, “Caregivers”.

For one abortion clinic nurse, public recognition subsequently resulted in ostracism by her family and even the threat of excommunication from the Catholic Church. Newspaper reports indicated that Winnipeg nurse, Lynn Hilliard, was threatened with excommunication by the Roman Catholic Church owing to her work in the illegal Morgentaler clinic and the resultant criminal charges laid against her, which were publicised in major newspapers. A church spokesperson told one paper that Hilliard would “be automatically excommunicated under canon law if proven guilty of conspiracy charges to procure abortion.”⁶¹⁷ He went on to assert that “the only way out for her would be to renounce her job, to come back and be reconciled with the church through sacrament.”⁶¹⁸ It is somewhat unclear whether Hilliard was excommunicated as she was cleared of all charges. It was publicised that she was very much barred from marrying in the Catholic Church as she had planned. Some of Hilliard’s family seemed similarly resistant to her work. Reacting to the reports of the threatened excommunication, Hilliard’s aunt told the *Sunday Sun*: “None of us can understand why, as a good Roman Catholic, Lynn would work in such a clinic.”⁶¹⁹ As a result of anti-abortion perspectives, these reports suggest, abortion clinic nurse Lynn Hilliard faced a less than welcoming social environment outside of the clinic both in terms of (at least some) of her family members and her wider church community.

Contrary to nurse Beverly Mably’s assertion that acts against clinic nurses and physicians at home were relatively “peaceful,” acts of anti-abortionism certainly proved less so when some

⁶¹⁷ “Nurse barred”.

⁶¹⁸ Ibid.

⁶¹⁹ “Nurse must”. For more on this case, see Harpur, “Excommunication rare” or Davidson, “Abortion nurse”.

anti-abortionists incited attacks on clinic workers in their homes. Nurse Jackie F remembered that her house was attacked on numerous occasions. She said:

We've had a few incidents here. Especially around November.

We've had stuff thrown in our windows and, I don't know, one of those bombs they throw in the front yard and start a fire. We have gone through a few things like that. [...]. We found bullets outside one of the cars.⁶²⁰

In the historical record of violence against abortion clinic workers, this kind of harassment against nurses in their homes has been eclipsed by that against physicians. Violence against nurses is perhaps under-reported (both by newspapers and themselves) for a variety of reasons, likely including owing to the repeated, injurious, and symbolic nature of physicians' experiences. Three of the most publicised accounts of physician-targeted violence in Canada are the home-shootings of physicians Garson Romalis in Vancouver in 1994, Hugh Short in Ontario in 1995, and Jack Fainman in Winnipeg in 1997. These attacks are known as the "Remembrance Day Shootings," having taken place November 8th, 10th, and 11th, respectively. Each event resulted in injury, but none were fatal.⁶²¹

⁶²⁰ JF 610–116; 985.

⁶²¹ "Legacy." *See also*: Abortion Rights Coalition of Canada, "Position Paper". This list includes nurse Emily Lyons, who was wounded at an attack on a freestanding abortion clinic in Birmingham Alabama in January 1998.

Significantly for abortion clinic nurses, though there are little to no reports of similarly injurious experiences, it was within this broader and extraordinarily violent context that they were watched, photographed, spoken to on the street, followed home, picketed at home, exposed to their neighbours and church communities, and attacked. The veritable avalanche of stories of harassment and violence suggests that leading up to and following decriminalization abortion clinic nurses operated in a cultural space that included anti-abortionism as a legitimate if not normal standpoint. This environment, I suggest, provided a foundation for anti-abortion resistance to and de-legitimization of nurses' work in freestanding abortion clinics (both by anti-abortion nurses and others). I submit that as with the anti-abortion activism that took place at the clinics and hospitals, these 'off-site' attitudes and behaviours also challenged abortion clinic nurses in adopting, enacting, and disclosing a professional nursing identity that supported abortion work for them. It becomes clear from this analysis, then, that the work of abortion clinic nurses was not only related to legal, medical, and (liberalizing) social concerns around safety, but also to direct cultural resistance to abortion and abortion nursing. What follows from here is an exploration of the ways that abortion clinic nurses managed the challenges of anti-abortionism.

Abortion Clinic Nurses' Response to Anti-Abortionism

The previous discussion of the ongoing anti-abortionism targeted at nurses and freestanding clinics offers a vivid picture of the context in which clinic nurses approached the task of (not) talking about their work in public. I invite readers to recall that abortion clinic nurses remembered that when people asked them about their work, they said they "danced around" and "downplayed" it or "invented what to say" rather than reveal it immediately or explicitly. I

conceptualize this discursive move as ‘careful disclosure’ and argue that nurses employed it as a (counter)resistance strategy against the negative anti-abortion responses that they had previously experienced or otherwise anticipated. Further, I put forward that clinic nurses did so in order to construct or maintain safe social and physical spaces for themselves and their families, which, this evidence suggests, had been at risk to varying degrees. Indeed some, but certainly not all, of the nurses I interviewed articulated that they perceived or had reacted to this risk as such.⁶²²

Remember that Jeanette B warned her children that there were people who did not agree with what she did, and, if they found out that she worked in an abortion clinic, they might hurt her. Lisa R similarly remembered of the time, “You know, people were scared because there was violence that was happening, and not just with [the physicians].”⁶²³ And, Joan W admitted that she was sometimes “terrified because, of course I thought, “Oh God! We were on the news all

⁶²² It should be noted that not every nurse interviewed for this study articulated feeling unsafe at home or at the clinic. Some nurses stated that they never felt unsafe, while some put forward both feelings within their interviews (at different times). Additionally, although they used the language of ‘harm,’ ‘violence,’ and ‘terror,’ most of the nurses recounted their memories of anti-abortionism with outward expressions of exasperation, levity, and nonchalance rather than (to my eye) fear. These ambiguities are difficult (and perhaps unnecessary for this study) to parse. However, to offer a few preliminary interpretations. It could be that these ambiguities point to another strategy employed by clinic nurses in order to manage anti-abortionism. Or perhaps their light-hearted discursive approaches could indicate a measure of success for abortion clinic nurses in actually constructing, adopting, and enacting an abortion-supportive professional identity.

⁶²³ LR 233.

the time. I have newspaper clippings with huge pictures of me.”⁶²⁴ In a tangible display of her less-than-safe past, Jackie F showed me the bullet proof vest that she had worn to and from work in the 1990s, remarking, “Yeah, I still have my vest. We all had to have vests.”⁶²⁵ Jackie F went on to explain that she had to wear the vest in order to stay safe “in the anti-choice time.” Upon reflection she remarked further, “we did a lot of work to make sure we were safe.” It is this nursing work of trying to make sure they were safe that comprises the remainder of this chapter.

The main argument I offer here is that, with others, abortion clinic nurses aimed to create physical and social environments that helped them to avoid and reject anti-abortionism. At the same time, they also worked toward constructing abortion-supportive spaces, and, ultimately, a professional nursing identity that allowed them to do abortion work and to be abortion providers (i.e., abortion clinic nurses). In the following analysis I offer some of their strategies for doing so. In addition to the careful disclosure methods discussed above, I identified seeking secrecy

⁶²⁴ JW 2075–2077. This uneasiness, however, did not prevent JW from appearing in public forums in support of abortion provision. For one example, JW told me that on February 12, 1988, she participated with Henry Morgentaler in a televised debate with members of the anti-abortion movement. For more about this debate from the anti-abortion perspective, *see* Thompson, “Fraudulent”. In this debate, JW attempted to acknowledge women in the midst of a fetus-focused anti-abortion narrative. She is quoted by Thompson in “Fraudulent” as arguing: ““Most of us will never forget those young dead bodies [of women who died from unsafe abortions. ...]. It is my hope that women will be treated honourably, not greeted with a law that simply tells women what they must live with!””

⁶²⁵ JF 973.

and security, pushing back, and building collaborative professional relationships as some of the ways in which nurses attempted to promote the safety of their patients, families, colleagues, and themselves.

Secrecy and Security

Maintaining safety outside of the clinics proved a complex issue for abortion clinic nurses.

Under the threat of negative social reactions and harassment in their communities, some nurses indicated that they ought to try to conceal their work or themselves. At a minimum, participants explained, they sometimes declined to talk about or even hint at their abortion work at all, that is, they forewent the careful disclosure discussed above. Jeanette B remembered: “In the beginning I used to tell people where I worked. I’ve had the whole room go completely silent and stare at me. Well, that was the end of that!”⁶²⁶ When it was impossible to conceal the work that they did, some clinic nurses took up more severe preventative measures against potential harassment.

Ontario nurse Joan W remembered she “had to have an unlisted phone number.”⁶²⁷ Vancouver nurse Jeanette B said that she and her colleagues were advised by the Vancouver Police Department that they “should have unlisted numbers [...] and should never have anything—cars or anything—be registered under your name.”⁶²⁸ These few examples indicate that at times when they could not or would not engage in careful disclosure about where they worked, some abortion clinic nurses tried to conceal it or themselves in other ways. In other words, I suggest,

⁶²⁶ JB 229.

⁶²⁷ JW 2162.

⁶²⁸ JB 191–194.

they seemingly attempted to (or were encouraged to) seek anonymity in their personal lives as one strategy for managing anti-abortionism and the potential enactment of it.

Back at the clinics, nurses with other staff continued to manage anti-abortionism through similar careful disclosure and concealment strategies—this time in the form of creating and supporting clinic security. One strategy staff employed was to keep silent about their plans for opening clinics or to otherwise control the flow of information about them. Having witnessed the ongoing protests, attacks, and harassment of staff at existing clinics, some of the staff at new clinics opted to keep their upcoming locations and opening dates secret. By doing so, they seemingly aimed to keep the anti-abortion protestors away from the new clinics for as long as possible in order to avoid the unsafe conditions they created there. About the secrecy of opening Vancouver's second abortion clinic (Elizabeth Bagshaw) while anti-abortionism raged outside of its first (Everywoman's), a spokeswoman for the *BC Coalition for Abortion Clinics* commented to the *Vancouver Sun*:

'I think [clinic staff] want an opportunity to establish the new clinic with as little problems as possible. [...]. There's always the possibility of problems, so what they are being is very circumspect. [...]. They're making their own decisions and their own timing as to where, when and how to let the information out.'⁶²⁹

Joan W remembered employing a similar strategy when opening the clinic in Ottawa. She explained:

⁶²⁹ Kines, "Location".

It was interesting because they didn't tell anybody where the clinic was going to be. People were so fascinated by that and the reason that they couldn't do it. [...]. You [should] have a secure construction site, [...] which means that every single piece of equipment, every single human being all day long every single day, had to be clocked in and out. And it cost a fortune to do that, apparently [which we could not do at the clinic]. So, the way they coped with that was to not tell anybody where it was. So that's what they did. [...]. When I was working here, I said to people, 'Well...we're setting up the Clinic.' And they said, 'Everybody wants to know where!' It was very interesting.⁶³⁰

By keeping quiet about their plans, staff at developing abortion clinics arguably aimed to prevent hostile and violent anti-abortion environments from forming and becoming fully established (and thus normalized) around their new spaces. I suggest that they were working toward building an environment that positively supported abortion provision and thus nurses' work in freestanding clinics by implicitly rejecting anti-abortionism as unacceptable and unnecessary. In these acts of secrecy and security, abortion clinic nurses and other staff members again confronted anti-abortion resistance through mindful attention and careful (non)disclosure and concealment strategies while also creating abortion supportive ones. In this way, I suggest, they were working

⁶³⁰ JW 2143–2158.

towards keeping staff and patients both physically and socially safe, which was also a primary aim for nurses in challenging legal and clinical contexts.

Comparably, some abortion clinic developers attempted to attain a level of secrecy or security by opening their abortion clinics in multi-use professional medical buildings rather than as stand-alone structures. One *Vancouver Province* reporter explained that: “[The landlord of the building] said protesters have targeted ‘stand-alone’ clinics where the physicians, staff and clients have been easily identifiable as being associated with the clinic. [However, he said,] ‘in a multi-tenant building this identification is not possible.’”⁶³¹ This kind of concealment, then, could result in less harassment and more security for staff and patients. Indeed, although anti-abortion demonstrators still “picketed [the multi-use building that the Elizabeth Bagshaw Clinic was housed in] twice weekly,”⁶³² clinic nurse Jeanette B remembered that the strategy was somewhat successful. “Because we’ve always been in professional buildings,” she explained, “they [the protesters] didn’t actually come to the door like they did at Everywoman’s. For me it felt a lot more secure.”⁶³³ Though it occurred beyond the timeframe of this study, it is also worth noting that Everywoman’s clinic moved into a multi-use building (and away from *Gianna House*) in the early 2000s, which Lisa R remembered with relief. Of the stand-alone location, she said, “We tried for *so long* to get out of that building.”⁶³⁴ Readers may recall that it was Lisa R

⁶³¹ Austin, “Firm warning”: 5. I do not dwell on the stand-alone vs. multi-use building phenomenon here because the nurses in my sources did not do so.

⁶³² Horwood, “Love”: 3.

⁶³³ JB 225–227.

⁶³⁴ LR 239.

who remembered the original building and the anti-abortion activism surrounding it as comprising a “really unhealthy environment.”⁶³⁵ Of some significance here as well is that Henry Morgentaler elected to open the original illegal Toronto clinic in a stand-alone, non-professional building that was shared with a feminist bookstore. In that case, he purposefully aimed for the clinic to be seen, to be perceived as being aligned with feminist women’s liberation, to be made increasingly public, and to incur state intervention. For, prior to decriminalization, he used the clinic to make a political point and challenge the law.⁶³⁶ There, clinic staff were seemingly willing to risk some measure of security in order to work toward abortion law repeal.

Securing the Clinic

Yet, neither stand-alone clinics nor those housed in multi-use buildings—or their staff and patients—could be fully sheltered from anti-abortion resistance. As noted above, clinics and staff in both locations experienced violent attacks. In this context, many clinic nurses and their colleagues continued to resist anti-abortion activism by helping to increase physical security measures at the clinics. Ottawa nurse Joan W remembered that she was fully involved in this process, having been the one who “had to outfit the clinic”⁶³⁷ with new equipment and additional policies that were designed to prevent or deter clinic attacks. Other clinic nurses similarly recalled their roles, remembering that they met with police, other abortion-advocacy organizations, and independent security companies to help them determine the most appropriate policies, processes, and equipment to implement. Vancouver nurse Jeanette B explained that

⁶³⁵ LR 240.

⁶³⁶ See Chapter One for a discussion of this strategy.

⁶³⁷ JW 2677.

“security people” from the “Vancouver Police Department and the National Abortion Federation⁶³⁸ would come and do a sort of big risk assessment before the clinic was even open”⁶³⁹ to offer suggestions for how to secure the clinic. And in central and Eastern Canada, Sharon B similarly “met with the RCMP and the Chief of Police about security” for her clinics there.⁶⁴⁰

In consultation with those groups (and likely with each other), multiple clinics adopted identical security methods, which many nurses shared in their interviews. However, one retired clinic nurse—perhaps showing an unfading commitment to non-disclosure and concealment strategies—asked that I not reveal particular in-clinic security measures.⁶⁴¹ It is perhaps sufficient to note, then, one particularly poignant and visible (external) security strategy. According to *Calgary Herald* reporter Terry Gilbert, Calgary’s Kensington Clinic was designed such that there was “nothing an intruder [could] be chained to.”⁶⁴² Vancouver nurse Jackie F commented multiple times on clinic security, reflecting that it was an ever-present issue that

⁶³⁸ According to Saurette and Gordon in “Changing Voice,” the National Abortion Federation [NAF] is a “professional organization of abortion providers in North America. Established in the US in 1977 through the merger of the National Association of Abortion Facilities and the National Abortion Council, NAF offers training and services to abortion providers, as well as information about abortion and referral services to women”: 378.

⁶³⁹ JB 186. JF remembered these processes similarly.

⁶⁴⁰ SB 872.

⁶⁴¹ Details of security measures are available in other publications.

⁶⁴² Gilbert, “Clients”: A1.

abortion clinic nurses fully prioritized. “We were always dealing with security issues,” she said.⁶⁴³ These and other examples indicate that abortion clinic nurses aimed to prevent or reduce anti-abortion activism through increased clinic security. They intended to leave little opportunity for clinic attacks inside and outside the clinics during both on- and off-hours. As such, I suggest, they confronted and sought to manage anti-abortion resistance to their work by preventing the further construction of a physical anti-abortion environment that literally surrounded them. In so doing, clinic nurses also seemed to reject the idea (i.e., the corresponding social reality) that the near-ubiquitous anti-abortion perspectives and activities they encountered on a day-to-day basis were acceptable or normal. On the contrary, by helping to implement and strengthen security, abortion clinic nurses managed these conditions by working toward preventing or dismantling them, thus demonstrating that a safe clinic environment was, for them, an appropriate and necessary goal.

Pushing Back

Despite increasing security measures, outside of the abortion clinics, protests and harassment of clinic nurses raged on. In response, some clinic nurses elected to push back. In multiple ways, clinic nurses confronted protesters directly, including by talking or yelling with them, getting physical, and engaging the law. Jackie F, for example, remembered that, as head nurse, she sometimes “had to go out and talk to people—tell them to leave,” which, she reported, she did calmly.⁶⁴⁴ Sharon B, however, remembered sometimes reacting with more force by shouting back at protesters. She explained:

⁶⁴³ JF 699.

⁶⁴⁴ JF 1050.

My office was at the top of the house—it was a 3-story house [where the abortion clinic was], and my office was at the top of the house—looking out the back road where the protestors were, and it also had a little fire escape. We [nurses and staff] would sit on the fire escape. And we’d yell at the protestors. And they would yell at us.⁶⁴⁵

Pushing back even more forcefully against protestors at her clinic, Sharon B remembered a few physical altercations. In one instance, she recalled:

There were regulars so to speak. One of them used to shove pamphlets in your face, and I pushed him out of the way. I can’t remember what I did. [But I said,] ‘Back off! Back off!’ [He said to a nearby police officer], ‘Officer, officer, did you see what she did! Charge her with assault.’ And [the officer] said something to him about, ‘I’ve been watching you for a long time. You’re lucky she doesn’t charge *you* with assault.’⁶⁴⁶

Sharon B never took that suggestion. Lisa R experienced a similar altercation in Vancouver when a protester gained unauthorized entrance to the clinic. “I think I was the one that went in

⁶⁴⁵ SB 809–816.

⁶⁴⁶ SB 174–182.

there and shoved her out,” she recalled.⁶⁴⁷ Unlike Sharon B, the intruder did not threaten Lisa R with assault charges at the time. Yet in a later instance, Sharon B actually was charged with assault. “Oh man, I was mad,” she exclaimed, then elaborated:

There was a big protest [...] and we were helping take patients in [to the clinic] and [...] there was a bit of an alley and they had to go up the alley and I was trying to get a patient up, and I got pinned against the wall. And this woman kept shoving these pamphlets in my mouth, you know, with the bloody fetus and stuff like that. And she kept shoving them in my face, and I pushed her out of the way. I might have hit her hand. I don’t know. I thought I was just pushing the pamphlet out of the way because she was shoving it in my face, plus there was a patient right beside me [...], so I pushed [the protestor] out of the way. Well, lo and behold, I got busted! The police told me I was charged with assault. I was so mad I couldn’t believe it.⁶⁴⁸

With the help of Henry Morgentaler’s personal lawyer, the charges against Sharon B were eventually dropped. Sharon B’s and other clinic nurses’ willingness to confront anti-abortion protesters directly (whether verbally or physically), despite this legal threat, highlights their commitment to managing and dismantling anti-abortionism around the clinics. These clinic

⁶⁴⁷ LR 209.

⁶⁴⁸ SB 710–720.

nurses demonstrated that they continuously rejected anti-abortionism and the negative environments created by its activists—and that they did so by concealing the clinic, shoring up its security, and pushing back against protesters out in the open. Moreover, in so doing these nurses in particular helped construct and enact a professional identity as abortion clinic nurses wherein confronting and challenging anti-abortionism was accepted, encouraged, and valued.

Stretching their efforts even further, a few reports indicate that abortion clinic nurses also confronted and pushed back against anti-abortionism through legal channels themselves. In one instance in Edmonton in 1991, for example, staff at the Morgentaler clinic helped to urge lawmakers to legally bar anti-abortion protesters from approaching and blockading their clinic. Specifically, they helped petition the court to grant an injunction that would limit the distance allowed between protesters and the clinic. Adrienne Tanner of the *Edmonton Journal* reported that one Tuesday night, nurses and other staff of the Edmonton Morgentaler clinic “stayed up until 1 a.m. [...] preparing affidavits for [the] injunction.”⁶⁴⁹ According to Tanner, these staff members were motivated to challenge escalating on-site anti-abortion activism following a particularly violent protest in which “one nurse [...] harbored a patient in her car for three hours [...] while protesters waved plastic fetuses and pictures of babies in front of her window.”⁶⁵⁰ In this case, the request was successful. Tanner noted that the injunction was granted on Wednesday, that is:

⁶⁴⁹ Tanner, “Court order”: B1.

⁶⁵⁰ *Ibid.*

Only one day after the worst violence since the clinic opened in September. Security guards and protesters came to blows Tuesday afternoon after anti-abortion activists blocked patients and staff from entering the clinic that morning. [...]. [The new] injunction bars protesters from disturbing, interrupting and obstructing patients and staff at the clinic. [...]. Picket lines and demonstrations have also been outlawed within a specified zone surrounding the clinic.⁶⁵¹

At the behest of clinic staff and their pro-choice allies, other cities instituted similar legislation for their abortion clinics. The space that was mandated to be left free from protests came to be known as “bubble zones.”⁶⁵²

⁶⁵¹ Ibid.

⁶⁵² The history of the development of bubble zone laws across Canada is complex and not yet fully analyzed by legal scholars. I do not aim to provide a full account or analysis of these processes here. I did find that nurses *were there* and that they participated in meeting this anti-abortion challenge through legal channels. For an overview of injunctions and bubble zone laws across Canada in general, see Abortion Rights Coalition of Canada, “Court Decisions”. *The Prochoice Press Newsletter* is another excellent source for general pro-choice action in response to anti-abortion activism. It focuses especially on BC but also covers worldwide events. Of some note here is that in 1994 in Toronto, retired nurse Joanne Dieleman (the co-ordinator of Toronto’s anti-abortion drop-in café *The Way Inn*) was named as one of many defendants in an injunction case there. The case was successful, and Dieleman and her associates were ordered to

After multiple injunctions similar to the one in Edmonton were issued over time in BC, in September of 1995, the more permanent and far-reaching *Access to Abortion Services Act* came into effect there. According to the *Prochoice Press Newsletter*:

The Act creates “access” zones around facilities which provide abortion services, homes and offices of doctors who provide abortion services, and the homes of other abortion service providers [i.e., nurses and other staff]. [...]. Within those access zones, it is an offence to engage in any of the following activities: sidewalk interference; protesting; besetting; physical interference with, or attempted interference with a patient, doctor, or abortion service provider; [and] intimidation of a patient, doctor, or abortion service provider. [...]. Those who commit any of these offences may be arrested without warrant. [...]. If convicted, an offender will face a fine of up to \$5,000 for the first offence and up to \$10,000 for each additional offence. The Act also provides for imprisonment of offenders for up to six months for first offences and up to one year for subsequent offences.⁶⁵³

cease protesting abortion clinics. See “Ontario v. Dieleman”. Retired Vancouver nurse Cecelia Von Dehn has been involved in similar legal cases. In 2009, it was reported by anti-abortion newsletter *The Interim* that: “Two of Von Dehn’s most notable accomplishments have been *Gianna House* and fighting B.C.’s bubble zone against pro-life activists” (in Vere, “Cynthia”).

⁶⁵³ “The New Act”. For a similar earlier injunction in Vancouver, see: “Court injunction”.

Although securing bubble zone legislation was seen as a positive challenge to anti-abortion activism in general, abortion clinic nurses experienced that they were not fully protected by it. Jackie F noted that at Everywoman’s stand-alone clinic, many protesters simply “didn’t [obey the law], they walked right through it.”⁶⁵⁴

One Vancouver clinic nurse in particular was significantly involved in engaging with the law when she was called to confront a bubble zone offender (i.e., a man who ‘didn’t obey the law’ but rather ‘walked right through it’)—both in the moment outside of her clinic and subsequently later in court. Lisa R remembered she was working at the clinic when a well-known protester violated their bubble zone. She explained:

He was in the bubble zone with a large [nine-foot tall] cross and I think a sign as well, which was, to me, a very clear breach of [the law] even though he wasn’t handing [out information]. He was like, ‘I was never handing out information and I was silent the whole time.’ But he was really testing the boundaries, which a lot of them did. Testing the boundaries of that law.⁶⁵⁵

Because Lisa R believed he was testing, if not breaking, the law, she was compelled to manage the situation by calling the police (i.e., engaging law enforcement). She explained, “I was the acting Executive Director [of the clinic] at that time, and so I called the police and had to liaison

⁶⁵⁴ JF 983–985.

⁶⁵⁵ LR 1441–1448.

with them and get him out of there,” which she did. Yet, unconvinced that he had indeed broken the law, the offender appeared in court to argue his case. As a result, “about a year or so later,” Lisa R “had to go to court to testify to all of it,” primarily because she “was the one that called in the incident report.”⁶⁵⁶

Recalling the case, Lisa R indicated that in court (that is, in addition to at the clinic), this anti-abortionist tried to intimidate her and de-legitimize abortion work for nurses in general. She remembered:

He represented himself in court and had these really unusual questions, and I remember [that I was cross examined by him] for a long time. [...]. He was asking really silly questions, and he was like, ‘Oh, are you a nurse?’ [And I was] like, ‘Yeah.’ ‘Are you a union person?’ ‘Yeah.’ [...]. ‘Well, you know, you as a nurse are being paid for this and the wages of sin are death!’ all dramatic like.⁶⁵⁷

Lisa R indicated that throughout this nerve-wracking session, however, she exhibited fierce determination to defend the law, her colleagues, and the women visiting the clinic. She explained:

⁶⁵⁶ LR 146/164.

⁶⁵⁷ LR 152–159.

He had broken the law and the law was there to protect us, the clinic workers, and the women accessing the services. And I was pissed that he was challenging that and trying to get away with it, which I knew was wrong, and I was not going to let him get away with that, and I wanted to [stop him]. It was important for me, I felt, to do my best to make sure that he didn't get away with it and didn't open the door for other crazy people to come in and push those limits either.⁶⁵⁸

Although she had little choice in whether or not to attend court and undergo questioning by this anti-abortionist, Lisa R demonstrated a firm commitment to advocating for the safety and security of her co-workers and patients. She steeled herself and “faced it” with the support of her co-workers and lawyer. She said:

I faced it. The lawyer prepared me. There were others that had witnessed it and had been on the stand as well, but I had a more key role in that time. [...]. I was prepared and I was nervous. I can't say that I was scared but I was definitely nervous. And I had my co-workers, and I had my support. I breathed every time I got asked a question and I just went slow and steady and I tried not to get too riled up and I just, you know, answered the questions

⁶⁵⁸ LR 180–188.

because I knew he was trying to catch me in lies and misread my words.⁶⁵⁹

The work that some nurses undertook to secure injunctions for their clinics and, in Lisa R's case in particular, to formally defend the bubble zones highlights yet another strategy that some clinic nurses employed against the challenge of anti-abortionism: namely, engaging the law. By preparing affidavits, testifying in court, and partnering with law enforcement, some abortion clinic nurses continued to reject anti-abortion activism and thus resisted the physical and social anti-abortion environments that those activists intended to cultivate. Instead, I suggest, clinic nurses carved out roles that helped them to support each other in doing abortion work and being abortion providers in freestanding clinics. These activities thus emerge as one component of the range of work that they did to promote safety for workers and patients in and around freestanding clinics.

Professional Collaboration

In addition to resisting anti-abortion environments, evidence indicates that abortion clinic nurses worked toward actively building abortion-supportive ones. Through activities such as building nurse-to-nurse relationships within and across clinics and engaging with other colleagues nationally and internationally (activities that I conceptualize as *professional collaboration*), some abortion clinic nurses demonstrated that they aimed to construct safe and supportive physical and social environments. The terms that some nurses assigned to these relationships were striking. In Vancouver, Lisa R reported that she and some of her colleagues from the two freestanding

⁶⁵⁹ LR 164–175.

clinics in Vancouver perceived themselves to be part of an “underground nursing network.”⁶⁶⁰ Similarly, of the broader interdisciplinary collaborations she engaged in, Ontario nurse Sharon B reflected that she felt that she was part of “almost a secret society sometimes.”⁶⁶¹ In the following sections, I discuss the ways that some abortion clinic nurses experienced and perceived both the construction and enactment of these professional relationships. Ultimately, I offer that participating in so-named ‘underground networks’ and ‘secret societies’ with other abortion providers helped these nurses to construct and enact professional nursing identities and a relational network that normalized abortion clinic work as a legitimate and safe endeavour for them.

Clinic nurses outside of Vancouver may not have referred to their professional partnerships as the “underground nursing network,” yet oral history interviews and other reports indicated that nurses supported each other, both within and beyond their own cities. Nursing networks, if you will, seemed to extend over multiple freestanding clinics across Canada, including those that ostensibly operated from different theoretical approaches (such as the feminist and biomedical perspectives, as discussed in Chapter Two). Moreover, clinic nurses in Vancouver also had occasion to partner with staff at the hospital’s out-patient surgery department. In so doing, nurses shared the staff, equipment, and knowledge and training that were essential to the delivery of safe and effective abortion services.

⁶⁶⁰ LR 533.

⁶⁶¹ SB 1727.

In terms of knowledge and training, Sharon B reported that as an experienced abortion clinic nurse, she travelled throughout Canada to help prepare new nurses in establishing new clinics and learning various skills. This work, she said, included setting up their administrative procedures and helping them to learn the new vacuum aspiration abortion technique. Likewise, Lisa E reported that nurse Cory Bennet travelled from Calgary to Vancouver to help train nurses at the Elizabeth Bagshaw Clinic in its early days. Similarly, in terms of day-to-day staffing, some of the nurses I interviewed indicated that they worked in multiple clinics. Sharon B, for example, travelled to other clinics not only to train new nurses, but also to work in them if they were short of staff. In Fredericton, Halifax, Ottawa, and Edmonton, for example, she took on hands-on nursing roles such as working in the procedure or recovery rooms as required.⁶⁶² A few nurses in Vancouver also said they split their time between the two abortion clinics there, which many of their colleagues found helpful and supportive. Perhaps articulating a feminist perspective, Jackie F partly attributed nurses' willingness to do so owing to their identities as women. She recalled:

I think it's very interesting because women do it, and they don't have any questions about it. If you need help, they will be there. If you are running short [of staff], they'll figure out how to get to you or to get you the help you need.⁶⁶³

In a similar way, when physician Garson Romalis was shot and wounded at his house, Jackie F herself hoped she could help at either of the Vancouver clinics by offering support to the nurses

⁶⁶² For more on the details of these nursing roles, *see* Chapter Two.

⁶⁶³ JF 1236–1239.

and staff there in any way she could.⁶⁶⁴ She remembered she was willing to step into various clinic roles, including hands-on clinical or administrative positions in order to provide assistance amid the chaos. She remembered:

When Dr. Romalis was shot, I was actually on that day [...]. I was running between the two places [...] and I had just left the Bagshaw clinic. I was driving to Everywoman's and I heard he'd been shot so I went back [to Bagshaw] because I didn't know where their director was at the time, and I thought maybe I could help.⁶⁶⁵

Here Jackie F demonstrated a commitment to supporting nurses and other staff across the two clinics in Vancouver. She concluded: "You always have to make sure you're safe and if you need help, you'll get it."⁶⁶⁶

In addition to lending (literally) themselves and their knowledge amongst themselves, abortion clinic nurses in Vancouver also shared equipment when needed. As an example, Lisa R told me how she might react if her clinic ran out of syringes. "Shit," she would say to herself:

⁶⁶⁴ Garson Romalis was shot at his home in November in 1994.

⁶⁶⁵ JF 604–608.

⁶⁶⁶ JF 1049.

We're all out of syringes!' So, I went to [the other clinic to get some]. You know it doesn't matter really what the *politics* are [...]. Ultimately, we have to provide what we can for the women. [...]. I was, like: if you needed something and you got it [from another clinic you acted like] it never happened. [...]. I think that the nurses [from both clinics] have always gotten along that way.⁶⁶⁷

For another striking example, when anti-abortionists broke into Everywoman's and damaged their vacuum aspirator, nurses were able to borrow a replacement from nearby Vancouver General Hospital.⁶⁶⁸ Notably, it was Jackie F who was working in the hospital's day-surgery unit at the hospital (she had not yet been hired at Everywoman's or Bagshaw) as one of the head nurses. She helped organize the lending of the unit. She remembered:

Actually, when I was working Surgical Daycare [at the hospital], Everywoman's was open, and they had a break-in and actually [...] I got them one of our old machines because, with the break-in, [anti-abortionists] had damaged the suction machine. So, I'd gotten

⁶⁶⁷ LR 539–550.

⁶⁶⁸ JF shared this memory. The break-in happened on February 25, 1990. In the records of Everywoman's Annual General Meeting that year, it was noted that a second aspirator was borrowed from a clinic in the USA. The notes also state: "Thanks to 'heroic' staff response, all the patients for that day were re-scheduled." See Everywoman's Health Centre, "Annual General Meeting".

one of our machines. They came in their van or whatever and put our machine in their car and took it over to the Everywoman's. It was fine [with the other head nurse]. We were helping out.⁶⁶⁹

These stories demonstrate that some abortion clinic nurses built and reinforced nurse-to-nurse relationships across freestanding abortion clinics, and, in the Vancouver case, with the hospital as well. They worked together, I suggest, in order to provide safe abortion services and to support each other in doing so. It is in this way, then, that they contributed to abortion-supportive physical and social environments wherein they were able to do abortion work and safely take on the identity of abortion providers.

In addition to developing nurse-to-nurse relationships in Canada, abortion clinic nurses also engaged in building intra- and interdisciplinary ones more broadly. Many nurses identified that attending the yearly, abortion-focused professional conference (or Annual Meeting) organized by the National Abortion Federation [NAF] was a good opportunity to create those relationships. Unfortunately, little has been documented about the history of the NAF conferences. In 2021, the NAF website indicated that their “Annual Meeting is the primary venue for presentation of the latest research, innovations, and policies that affect abortion care provision around the world.”⁶⁷⁰ Presumably, their meetings were similar in the 1990s. Nurses remembered that they indeed learned about “all the greatest research [showcasing] whatever works for other people”⁶⁷¹ and

⁶⁶⁹ JF 424–433.

⁶⁷⁰ National Abortion Federation, “Continuing Education”.

⁶⁷¹ JB 457.

“new information [...] like a new way of doing this or a new way of doing that”⁶⁷² at those meetings. However, they repeatedly emphasized that their primary appreciation for the conferences rested not in the research or information gathered there but rather in the camaraderie they developed and experienced with their colleagues. Many nurses indicated that the opportunity to attend was as important as new clinical information. Jeanette B explained:

We get to go away to different cities. We get to see the city and we share a room with our colleagues and doctors and go out and have dinner. [...]. It's not just about going. It's about going with my 'homies!' That's important, right, as a nursing group. It is not only an educational opportunity, but it is an opportunity to sort of bond with our nursing colleagues.⁶⁷³

Sharon B remembered that attending the NAF conferences helped her feel like part of a 'family' or, as she put it, a 'secret society' with other abortion practitioners. She noted that in sharing common experiences (including of anti-abortionism) and perspectives, she felt closer to and supported by others. “Oh, yeah!” She said:

You feel like, 'Holy shit! Look at all these other people who go through the same stuff we go through every day.' And [you can] talk about protestors. You know it's hard to talk to your family

⁶⁷² SB 1910.

⁶⁷³ JF 884–990.

about climbing fences and [confronting] protestors. [They're] like, 'What!?' People can't understand it if they haven't - if you're not part of it [... or] if you're not really paying attention, you don't really know that this is happening. Like me - I didn't know either [before I worked at the clinic]. And so, you really feel a sense of family when you are with those people because there's like 600 of you!⁶⁷⁴

Outside of conferences, Sharon B felt that interacting with her colleagues in similar ways (i.e., socially) was also supportive. She reflected:

But the other part is you feel a sense of family when you're out for, you know, the Christmas party with Henry. Or when you all just sitting around having lunch. You've got a family happening there too. And you have that sense of humour and the sob stories and the sad stories that everybody else [in health care] does - but it's different [in abortion services]. It's different because you're a part of almost a secret society sometimes.⁶⁷⁵

⁶⁷⁴ SB 1714–1721.

⁶⁷⁵ SB 1727.

Jeanette B articulated that amongst other practitioners, she felt a similar sense of security. She explained, “You can actually say where you work! You don’t have to be afraid.”⁶⁷⁶

I suggest that building this sense of security and finding a sense of family through face-to-face interactions helped abortion clinic nurses construct and enact a professional identity that normalized and legitimized abortion work for them. In other words, nurses indicated that they had the opportunity to actively build and function in abortion-supportive physical and social environments rather than merely react to and manage anti-abortion efforts. Lisa R aptly summarized this perspective, claiming that she relished attending the interdisciplinary NAF conferences. She explained:

Just being able to go and learn and just interact with all these other women and men who were part of this. That, to me, was so important and so energizing when you go. Because you have your job, you do your thing, but just getting the big picture and then meeting your fellow abortion care providers and listening to their experiences [...]. I really loved going. [...]. It was amazing [...]. You really got the sense of being part of something bigger than yourself. [...]. [We realized] that we were this one little clinic doing our thing [...] in this whole other world of clinics.⁶⁷⁷

⁶⁷⁶ JB 894.

⁶⁷⁷ RW 1044–1049.

Rene W and Sharon B also indicated that the interdisciplinary networks they built at conferences were helpful in continuing to build abortion-supportive environments. Sharon B remembered, for example, that when her clinic could not serve particular women, she could personally phone physicians at other clinics to “squeeze in those patients.”⁶⁷⁸ For one physician in the USA in particular, she explained, “I’ll just phone him myself.”⁶⁷⁹ When I asked Sharon B if her willingness and ability to make those calls was because she had built a relationship with him, she exclaimed, “Yeah! Because you met them all at the Conferences twice a year!”⁶⁸⁰

Rene W remembered that she could not only phone clinics in the USA but, owing to the relationship she had fostered with a physician at the NAF conferences, she was also able to visit an abortion clinic in New York and one in Colorado. She recalled the story as follows:

It’s like ‘Wow!’ There are all kinds of little clinics all over the place and you’d see some of the same people. You’d only see them once a year or once every few years—hear what they were doing. And I remember [...] in the early '90's [...] I was going to New York on a holiday, and I mentioned it to [a physician at a conference] that I was going. And he's like, 'Oh! New York! Here, I'll write you a letter and you should go and visit this clinic in New York.' So, I went and visited this abortion clinic in New York, and

⁶⁷⁸ SB 1984.

⁶⁷⁹ SB 1985.

⁶⁸⁰ SB 1890.

they were like, 'You're here on vacation? And you're coming here to see us? And this is your vacation?' [...]. I'm like, 'Yeah...I'm here to collaborate.' And they showed me around and they were really nice.⁶⁸¹

She remembered a second visit to an abortion clinic in Colorado similarly.

And there was another time where I was going to Colorado and [the same physician who referred her to New York] said to me 'Oh...you're going there? You should go visit my friend.' [...]. And he gave me a letter of introduction. [...]. So, I phoned up [the Colorado physician, who] was like 'Great! Come and see what I do.' [...]. And he was really keen to show me how he did his thing and what he was doing. [...]. I stayed for the whole thing and I found that was really kind of great. It just was that sense of like 'Okay. This is how we do it.' I got to see what they did and how different it was than what we do. A different system. But there was just that sense of sort of a camaraderie that you're part of something bigger.⁶⁸²

⁶⁸¹ RW 1095–1105.

⁶⁸² RW 1105–1122.

These nurses' memories powerfully demonstrate that developing and relying on nurse-to-nurse and interdisciplinary relationships or collaborations was a valuable strategy for them. They strongly indicated that creating and engaging in 'underground nursing networks' and 'secret societies' helped them to take on and continue to do abortion work. By collaborating with each other and their interdisciplinary colleagues, I suggest, these abortion clinic nurses were able to construct and adopt the perception that abortion work for nurses was legitimate, professional, normal, and important. Rene W explained it well when she said, "It just sort of re-fired up my engines about how *important* this work was!"⁶⁸³ I suggest that in building these professional relationships, 'abortion clinic nurse,' then, was rendered a legitimate, if not exciting, professional nursing identity. Lisa E illustrated this point rather emphatically when she answered my interview question of "So, is there such a thing as an abortion nurse?" She exclaimed:

Yes, there is! ... But no, I don't refer to myself as an 'abortion nurse,' and I don't know why. [...]. But I would not walk away from the claim that I'm an abortion nurse [...]. Yeah. I'm an abortion nurse. And be proud of it! [...]. It's a specialty! [...]
Yeah, if you're going to own it, own it. Go be an abortion nurse!
We can say 'reproductive health care,' but when you say 'abortion' you know exactly what your specialty is. And you know exactly what you're good at. And that's what I'm good at.

⁶⁸³ RW 1091.

This analysis thus highlights some of the ways that abortion clinic nurses confronted and managed anti-abortion resistance to their work. Not only did they attempt to dismantle long-standing and intensifying physical and social environments that were designed to de-legitimize their work, abortion clinic nurses also actively built ones that normalized and supported it. Through multiple strategies—such as careful disclosure, seeking anonymity, securing and concealing the clinic, pushing back, engaging the law, and building collaborative relationships—these abortion clinic nurses, in many ways, constructed and enacted a professional identity of ‘abortion nurse.’ They implicitly and tangibly rejected the ‘traditional’ religious, largely anti-abortion underpinnings of nursing identity that prohibited abortion work for nurses.

CONCLUSIONS

In the following final chapter, I offer some concluding analysis, highlight areas to which this scholarship contributes, attend to some of the limitations of this study, and suggest several avenues for future inquiry. When taking on this research, I endeavoured to uncover and offer an interpretation of nurses' experiences in and perspectives of Canadian abortion services from the 1960s to the 1990s. In keeping with the brief glimpses that can be found of them in existing abortion historiography that is otherwise focused on politics, legislation, pro-choice and anti-abortion activism, and the experiences and perspectives of physicians and women-as-patients or would-be patients, this dissertation affirms that nurses were, indeed, *there*. Drawing from eight new oral histories of Registered Nurses who had worked in freestanding abortion clinics, hospital abortion services, and public health birth control clinics, a range of archival material, and key secondary sources, I traced nurses' work through criminalized, liberalized, and decriminalized eras of abortion provision (here, circa 1960-1968, 1969-1987, and 1988-1999, respectively). Notably, 'being there' emerged as a significant, dynamic, and complex undertaking that saw nurses engaging with a number of broad political, social, and professional elements of abortion provision while they carved out and adopted key roles in developing and doing the hands-on work of it. Specifically, it became clear that nurses' work in establishing, developing, and defending freestanding abortion clinics informed and was informed by considerations related to the state's regulation and de-regulation of abortion, shifting understandings of and approaches to women's health, the public cultural uptake of and resistance to abortion and its provision, and nurses' negotiation of professional identity (i.e., in part, the combination of nursing knowledge and practice). Ultimately, the evidence suggested that abortion clinic nurses created and undertook new abortion work (both in terms of knowledge and know-how), encountered and

managed multiple challenges while doing so, and continued to push forward with it owing to a fundamental professional commitment to promoting women’s bodily safety and emotional wellbeing. As abortion nurse Lisa E aptly explained: “the primary thing we [did was] help women have safe abortions.”⁶⁸⁴

In Chapter One, I highlighted the experiences and perspectives of nurses who listened to women seeking criminal abortions and attempted to care for those suffering from the complications of unsafe criminal procedures. I examined the work that nurses did in developing, operating, and trying to effectively navigate a restrictive and generally inequitable in-hospital Therapeutic Abortion Committee system with women. Finally, I analyzed nurses’ efforts in establishing, operating, and advocating for illegal freestanding clinics amid the state’s ongoing interruption of their work. My analysis revealed that nurses’ efforts to help women have safe abortions, particularly in the establishment and defence of illegal freestanding clinics, supported and were supported by the wider activism of non-nurse actors who were challenging the law in non-clinical ways. Their meticulous and indeed safe clinic work, for example, shored up the legal arguments made by physicians who formally brought the challenge to court. It strengthened the claims of pro-choice feminists, who called for the repeal of harmful legislation through public activism. Physicians and pro-choice activists relied on public perceptions of nursing as a noble and ‘morally good’ vocation, implicitly and explicitly articulating that if nurses were involved in abortion provision then it could not be fully wrong or criminal. Finally, nurses’ actions outside of the clinics, such as incurring arrest, incarceration, and court appearances, speaking out in the media, and joining political rallies, though they may not have been widely acknowledged as

⁶⁸⁴ LE 1283.

such, indicated their ongoing support for ‘the cause.’ In turn, the willingness of physicians and pro-choice activists to defend abortion clinic nurses supported their ability to do safe in-clinic, hands-on work, to help ensure that the clinics continued to operate beyond decriminalization, and, ultimately, to pave the way for more clinics to open across the country.

This chapter thus adds nurses and their work to the law-focused historiographical narrative that explains the long road to abortion’s decriminalization.⁶⁸⁵ It shows that, as key practitioners in abortion provision, nurses participated in challenging state regulation in a variety of ways. It adds, therefore, to important accounts of the social and legal maneuvering of practitioners, which have largely focused on physicians, while also bringing forward the previously underexamined hands-on clinical work that supported those activities. An underexplored related avenue of inquiry that I did not investigate was the participation of nursing’s provincial or national leadership and policy-making bodies in advocating for or perhaps resisting abortion law repeal. My review of the records of the Canadian Nurses’ Association, professional literature including in the *Canadian Nurse* and the *Registered Nurses Association of British Columbia Newsletter*, and informal conversations with nurses who worked at those organizations indicated that some source material is available but more is needed to undertake those analyses.⁶⁸⁶ A better

⁶⁸⁵ See, for example, Backhouse, “Involuntary Motherhood”; Gavigan, “Bringing on the Menses”; or Jenson, “Getting to Morgentaler”.

⁶⁸⁶ This material includes, for example, letters written on behalf of the Canadian Nurses Association and the New Brunswick Association of Registered Nurses to the Royal Commission on the Status of Women in the early 1970s in LAC RG 106 Vol 95 File 1230-C6-2. Additional

understanding of the leadership's engagement with abortion legislation would deepen existing understandings about the ways that professional bodies, in addition to the Canadian Medical Association and the Canadian Bar Association,⁶⁸⁷ impacted and were impacted by abortion legislation and state regulation more broadly.

Chapter One also begins to uncover connections between nursing and the pro-choice social movement,⁶⁸⁸ and perhaps, then, the early second-wave feminist movement at large. This avenue of inquiry bears further investigation given that the relationships between nursing and feminist activism are not well understood. Though further analysis of feminism and nursing and the liberalization and decriminalization of abortion is needed, related considerations were taken up in Chapter Two wherein I looked at nurses' work in freestanding clinics after 1988 (i.e., following decriminalization). There, I delved into the innerworkings of freestanding clinics and nurses' practices. I specifically traced the ways that freestanding clinic nurses helped build under-developed facilities and services from the ground up while negotiating their work with new and familiar colleagues. Significantly, they did so in the context of an enduring feminist women's health movement whose members had become increasingly involved in re-imagining

documents pertaining to CNA's liaising with Governmental commissions and committees, including the RCSW, are also held at LAC MG 28 I 248 vol 96 60-5-5.

⁶⁸⁷ Adding to the work done by Light in "Shifting Interests," for example.

⁶⁸⁸ The feminist pro-choice movement and its members' activism around abortion have been well studied in Palmer, "Choices and Compromises"; Sethna and Hewitt, "Clandestine Operations"; and Stettner, "Forced to Declare War," for example.

abortion clinic services and who worked towards de-medicalizing abortion practice from within the clinics.

I primarily learned about nurses' perspectives of their work and the ways that they believed that women experienced it, which is a new and important thread to illuminate. Just as they had done before decriminalization, after 1988 abortion clinic nurses generally articulated an overarching desire to help promote women's bodily safety and emotional wellbeing, and they aimed to help develop clinical spaces, procedures, and processes that supported them in doing so. One important discovery I made was that clinic nurses drew from a wide-ranging scope of knowledge and know-how that encompassed practitioner-driven (bio)medical approaches in addition to more contextualized and patient- or women-inclusive approaches to abortion and its provision (i.e., de-medicalizing perspectives and practices). Significantly, clinic nurses conceptualized this full range of knowledge and know-how as *nursing* knowledge and know-how. In doing so, they were not alone. At the same time that these practicing nurses considered the meaning and enactment of nursing from the 'ground up,' nursing scholars and theorists had also been examining and articulating nursing as a substantive health discipline that held its own theoretical underpinnings.⁶⁸⁹ Abortion clinic nurses recalled that they developed and enacted their ideas about the profession not merely as an academic pursuit or from a theoretical framework that was imposed or 'bestowed' upon them from above, but rather as an identity that emerged from and with practice. Notably, they articulated the perception that some of their colleagues who identified as feminist women's health advocates and who critiqued (bio)medical approaches to abortion as medicalizing had dismissed nurses' capacity to enact the contextual, inclusive or, as

⁶⁸⁹ See for example: Johnson, "Nursing Science".

they were framed in the chapter, de-medicalizing abortion practices. Some clinic nurses were deeply troubled by this characterization, which, they believed did not cohere with their conceptualizations and experiences of nursing. The evidence suggested that clinic nurses in fact meaningfully engaged with this specific feminist critique and, like nurses outside of abortion services did, similarly engaged with shifting public and professional perspectives about nursing, women's health, and health care more generally (which were not always considered through an explicitly feminist perspective but had certainly echoed it in the framework of de-medicalization and holistic nursing practice). Ultimately, it emerged that many abortion clinic nurses indicated that they valued multiple conceptualizations about abortion, health, and health service provision, and believed that a willingness and ability to hold and bridge ostensibly competing ones, both in theory and in practice, was not only imperative for the provision of safe abortion but also comprised a fundamental aspect of nursing itself.

Building from the findings from Chapter One, the conclusions from Chapter Two help to further position nurses and their abortion work within the large body of women's health history. More specifically, these findings add to current knowledge about the feminist women's self-help health movement⁶⁹⁰ by highlighting some of the ways that nurses engaged with it in freestanding abortion clinics. As such, new perspectives about nursing's ostensible silence around de-medicalization and women's medical autonomy in the context of abortion have been brought to light and carefully considered. This chapter elicits some conclusions and new questions about the multifaceted interconnections between broad social changes, diverse understandings of women's

⁶⁹⁰ For the Canadian perspective, *see* Morrow, "Our Bodies". For the USA context, *see* Nelson, "More Than".

health, multiple ideological and practical approaches to the provision of abortion, and the nature of nurses' clinical abortion work. In order to take this beginning analysis further, it would be helpful to learn more about counsellors' first-person perspectives and experiences of nurses and nursing work. Moreover, women's perspectives of the nursing care they received is also a crucial element to more fully consider. One place to begin to uncover this information, I found, is in abortion clinic records. The archival collection of the Everywoman's clinic, for example, includes a substantial report from a feedback survey conducted there in 1989, which includes women's responses about their experiences throughout their abortion appointments.⁶⁹¹ Finally, I suggest that more specific questions focused on the women's health movement could be asked of abortion clinic nurses themselves.

Chapter Three provides insight into an additional cultural or social response to abortion provision and nurses' freestanding clinic work. In my analysis I identified some of the ways that freestanding clinic nurses experienced and responded to anti-abortion resistance to their work leading up to and following decriminalization. I considered the anti-abortion activism that was targeted towards abortion clinic workers in general and at clinic nurses specifically. I also highlighted and interpreted the anti-abortion activism perpetrated by nurses who held anti-abortion perspectives, which were rooted in their self-identified professional commitments to Christian religion and health science. I discovered that some clinic nurses successfully managed the increasingly vocal and violent resistance to their work by developing multiple strategies that ultimately helped them to develop and enact the professional identity of abortion clinic nurse. They did so, I suggested, largely in response to anti-abortionist efforts to a) de-legitimize an

⁶⁹¹ Everywoman's, "Report to the BC Coalition".

abortion-supportive professional nursing identity while b) constructing, disseminating, and attempting to legitimize an anti-abortion one. Abortion clinic nurses indicated that they managed anti-abortionism through professional identity development in and around freestanding clinics and in their communities in both material and social realms. While doing so, they continued to articulate and demonstrate an overarching commitment to helping women have safe abortions, which, this chapter showed, was for them inextricable from helping their colleagues and themselves to be safe in providing them.

The analysis in Chapter Three thus positions nurses and their abortion work within the historiography of the wider North American anti-abortion movement.⁶⁹² First, it brings into focus abortion clinic nurses' specific experiences of anti-abortionism. Second, it uncovers nurses who took an anti-abortionist stance and were major players in the anti-abortion movement. Adding these nursing-specific elements, my analysis widens the historiography of the North American anti-abortion movement by bringing forward a nursing perspective on both sides of the proverbial fence. It adds to the literature that focuses on non-nursing coalitions and organizations and the theoretical underpinnings that have supported their perspectives and activism. I thus contribute new evidence and conclusions to the narrative that is focused primarily on the religious or moral groundings of anti-abortionism. More questions around nurses' less explicitly religious anti-abortion perspectives (e.g., those rooted in their beliefs about science, womanhood, motherhood, or nation-building, for example) have yet to be analyzed. There appears to be a wealth of existing sources that may prove fruitful for further inquiry into the range of anti-

⁶⁹² Key examples of this literature include Ackerman, "Defence of Reason" and Surette and Gordon, "Changing Voice".

abortion nurses' perspectives. These include professional nursing literature, anti-abortion literature, and nurses' collective and private letters to politicians and law makers.⁶⁹³ I have also conducted some preliminary analyses of anti-abortion nurses' strategies for resisting in-hospital abortion work, which ought to be brought forward further as well. Finally, nurses' explicitly 'pro-choice' perspectives and their discourse-making around them should also be investigated.

The findings put forward in these three substantive chapters locate nurses and their work within the domains of abortion and women's health history. They also position nurses' abortion work within the broader context of nursing history. The overall analysis, I suggest, contributes to current understandings about the development and enactment of professional nursing identity in general (i.e., not only in terms of the identity of *abortion clinic nurse*) in multiple ways. That is to say, the historical development of nursing in freestanding abortion clinics provides an additional context from which to consider nursing's professional engagement with questions around what nursing knowledge and practice are (or ought to be) and how they might differ from other health disciplines.⁶⁹⁴ A noticeable element that emerged from this project was nursing's longstanding struggle with the dual conceptualizations of nursing as a noble vocation or a

⁶⁹³ One such document is Registered Nurse Margaret Fitchie's 1984 letter to then-Minister of Health Jake Epp. See Fitchie, "Letter".

⁶⁹⁴ Nursing scholar June Kikuchi has argued that these considerations are vital to the self-determination of the profession. She wrote that "without a clear, coherent, and comprehensive conception of nursing to guide them [... the profession] stands in the great danger of losing itself and, in the process, not meeting its potential but rather that of other professions." See Kikuchi, "Thinking Philosophically": 8.

practical profession and the appropriate education, knowledge, and practices that ought to follow. Though abortion clinic nurses themselves did not explicitly dwell on these concepts in their interviews, pro-choice and anti-abortion supporters alike certainly did when they publicly invoked, reinforced, and relied on constructions of nurses as both ‘good’ (or inherently moral or even necessarily Christian) actors and as clinical experts. My analysis indicated that nurses’ abortion supportive and abortion resistant work could be legitimized and de-legitimized through both characterizations, which also shows multi-directional and reciprocal relationships between nurses’ actual clinic work and broader professional identity construction.

Relatedly, this investigation highlights enduring questions about nursing’s alignment with the medical establishment, and it thus contributes to the historical narrative in nursing that similarly interrogates this interdisciplinary relationship.⁶⁹⁵ Specifically, I provide a glimpse into some of the shifting relationships and negotiations of power that could and did take place in the new, under-developed, out-of-hospital setting of the freestanding abortion clinic. In developing clinical expertise (i.e., as professional practitioners rather than as vocational helpers or assistants), abortion clinic nurses indicated a belief that they were perceived of as part of the medical establishment or could be seen as reinforcers of the hierarchical, biomedical model of health service provision. In articulating the words and, as nurses perceived them, the beliefs of others about them as practitioners, clinic nurses were perhaps echoing and thinking about broader conceptualizations of nursing as subsumed within the physician-led, medicalized system of health care. Indeed, in the clinics they still worked within some of the non-negotiable hierarchical structures of health care in general, which included eliciting formal approval from

⁶⁹⁵ See Melosh, “Physician’s Hand” or Reverby, “Ordered to Care,” for key examples.

physicians (by way of physicians' orders) and adhering to overarching standards of practice developed by medicine's regulatory bodies. They also helped develop, take ownership of, and put to use (non-neutral) material medical processes and their related artifacts or equipment, such as ultrasound and intravenous therapies. They indeed applied, in part, a biomedical lens to abortion provision throughout women's appointments.

Abortion clinic nurses also indicated that in working closely with physicians and women, and while taking up multiple and increasingly expert roles in clinic development and operation, they also had the opportunity to disrupt the ostensible physician-nurse hierarchy as a result.

Significantly, clinic nurses saw this willingness and ability to take up authority in the clinics as essential to providing the safest care to women and as helping to disrupt not only the physician-nurse hierarchy but also the physician-patient hierarchy. They perceived that they could subsequently attend both to women's biomedical needs and emotional wellbeing. Their insight reflected a wider trend in nursing that had been developing since the 1960s in that nurses had begun to establish themselves as knowers with expertise in the larger field of health sciences and health knowledge. These abortion clinic nurses perceived the role of an abortion nurse as one that drew from multiple sources of knowledge. They perceived the ability to provide abortion as a safe procedure as a larger professional responsibility than conducting or assisting with a medical procedure alone.

They demonstrated that the scope of safe abortion was not limited to biological or traditional technical notions but also encompassed wider social and cultural implications of safety and wellbeing. Hence, they embodied a newer trend within the nursing profession that considered

nursing work as entailing both medical and social obligations. Abortion clinic nurses articulated that doing so was a professional obligation that facilitated the provision of the best nursing care. In this way, they perceived themselves as a separate discipline from the medical profession and as one that claimed distinct disciplinary knowledge, experiences, and professional commitments. Although it played out in the context and language of ‘feminism’ and de-medicalization in the abortion clinic after decriminalization, this kind of reflection about nursing’s unique and self-determined theoretical perspectives and approaches to practice (i.e., nursing’s professional identity) were not new to the profession and are not new to nursing history inquiry. Abortion provision, however, offers a unique field for exploring them.

This investigation additionally lends insight in terms of the broader understanding of what nursing is or can be with regard to nurses’ engagement in the context of activism and wider social movements. My analysis demonstrated that through individual and collective hands-on clinical practice, nurses added to and supported the political voices of others. It shows, then, that advocacy in nursing is not limited to upper-level policy making (e.g., devising policy statements that guide nursing practice and identity via the CNA or provincial associations), political lobbying (e.g., speaking out as a nursing organization in favour of or against social perspectives or public administration of health services, for example), or direct political engagement (e.g., taking up roles in governmental organizations). Moreover, it shows that nursing advocacy is not limited to advocating for the social and professional status of nursing. Rather, abortion clinic nurses’ commitment to and enactment of safe clinical hands-on practice emerged from this analysis as a form of activism undertaken on behalf of nurses *and* women-patients. This kind of analysis can inform new historical inquiries and thus future understandings about other

contested, stigmatized, or indeed politicized, fields of nursing practice. These could include nursing in opioid-related harm reduction programs, during the HIV/AIDS epidemic, or in the field of medical assistance in dying, for but a few examples.⁶⁹⁶

In terms of relatively uncontroversial specialty fields of practice, my analysis also adds to existing historiography of nursing work that sometimes is perceived of as ‘technological,’ such as in critical care areas.⁶⁹⁷ Incorporating an STS technological systems framework builds on a newer perspective of the way that technology has been considered in nursing history. Namely, I conceptualized nursing practice and its scientific artifacts (or instruments) that nurses have developed and used as *one* element or one thread of a broader sociological system.⁶⁹⁸ By this argument, technology in nursing not only comprises machines or other material elements but also theoretical knowledge and know-how, which comprise but another thread of the technological system.⁶⁹⁹ These ideologies and practices were also shown to intersect with additional shifting factors. In this study, other similarly overlapping elements of the technological system that were relevant to nursing included state regulation, anti-abortion and abortion-supportive social or cultural movements, and ever-developing approaches to women’s health and abortion.

⁶⁹⁶ For one study on the HIV/AIDS epidemic, *see* Perry. "From West End".

⁶⁹⁷ For key examples, *see* Fairman, “Alternative Visions” or Vanderspank “Social Construction”.

⁶⁹⁸ For nursing scholars who conceptualize similarly, *see*, for example, Fairman, “Economically Practical” or Boschma, “Electroconvulsive Therapy”.

⁶⁹⁹ Bijker et al., “Social Construction”.

Finally, this dissertation lays bare the actual hands-on provision of abortion. It thus contributes to knowledge about women's bodily abortion experiences in conjunction with nursing work. It is crucial to remember that abortion is, ultimately, a material phenomenon that happens to and within women's bodies and that nursing is, for many, a practice-focused discipline.⁷⁰⁰ It is known that women's assured access to safe abortion is essential to the lives, health and emotional wellbeing of women and that, as abortion provision is structured in Canada, nurses have played and continue to take up key roles in developing and delivering those services.⁷⁰¹ The deeper understanding of some of the social, professional, and cultural structures that have historically supported or constrained nurses in helping women to have safe abortions that I have provided here thus contributes to knowledge development in the domains of nursing, abortion, and women's health history.

I wish to leave readers with one particularly striking feature of nurses' reflections that emerged from this research, namely, their frequent and emphatic expressions of the pride they felt for the abortion work that they developed and enacted in freestanding clinics. Indeed, many nurses powerfully articulated that they felt "honoured" to do that work and that they considered themselves "lucky" to have been able to take on what was, for them, particularly meaningful nursing work. Rene W said, "It's an honour to do this work. This is an honour."⁷⁰² Lisa R

⁷⁰⁰ See Litchfield and Jónsdóttir, "A Practice Discipline" or Thorne, "Ideas and Action".

⁷⁰¹ I have argued this point in Haney, "Nursing Identity."

⁷⁰² RW 1446.

exclaimed, “Oh! My job’s awesome! It’s an honour. I get to bear witness to these acts of courage.”⁷⁰³ And Sharon B reflected:

What’s the word I want? It’s not [a] good enough [word], but [it was] such a ‘*great*’ job. That’s not what I mean—I mean it was such a rewarding place to be. I can tell you I was never so proud of my life than when I walked down the Sparks Street Mall [in Ottawa] with Henry after we had [opened a number of abortion clinics]. My head was as big as it could possibly be because *I had done that*.⁷⁰⁴

She added:

I think about those days and I think about the work that we did, and it was just terrific work and I’m very proud of those days. I’m really proud of the work that I did at the clinic. I have no complaints about the work that I did. I am proud of my nursing career, really.⁷⁰⁵

⁷⁰³ LR 993.

⁷⁰⁴ SB 864–865.

⁷⁰⁵ SB 1557–1561.

Finally, Joan W characteristically offered an especially striking and poignant reflection on her work, which makes for an appropriate closing for this dissertation. She concluded, as do I:

You worked like crazy. But it was so worth it. And you *knew* it was worth it. It was such an honour to be part of something that you knew was making such a difference in women's lives. Like, who gets that chance!?! [...]. For me to have spent my life working with that kind of an issue. I was so damn lucky. It's really all I ever wanted to do—to work on something that meant something.⁷⁰⁶

⁷⁰⁶ JW 2734–2743.

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APPENDIX: The Nurses

Oral History Participants

Jeanette B

After obtaining her Bachelor of Arts in Psychology, Jeanette B completed her nurses' training at the British Columbia Institute of Technology. There she earned her basic nursing diploma in the mid-1980s and a certification in the specialty of perinatal nursing in the mid-1990s. Prior to joining Vancouver's Elizabeth Bagshaw Clinic in 1990, she worked in a variety of high-acuity, in-hospital settings, including transplant services, oncology, cardiac surgery, and palliative care. The first nurse hired at the Elizabeth Bagshaw Clinic, Jeanette brought her acute care skills and experiences to the freestanding abortion clinic. She helped train incoming nurses, including long-time colleague Lisa E, and enjoyed fulfilling a variety of clinic roles. She was especially committed to promoting the efficient operation of the clinic, often searching for and personally negotiating the best 'deals' on medical equipment and supplies in an effort to maintain the clinic's financial solvency (and thus its continued existence) while simultaneously promoting safest clinical practices. She was close to retirement at the time of our interview.

Sharon B

Sharon B completed her formal nursing education via the in-hospital training program at Toronto's Hospital for Sick Children (also known as SickKids). Graduating with her diploma in 1971, she worked at SickKids in pediatric medicine and pediatric emergency until 1987. Having responded to a 'nurses wanted' classified ad in the city newspaper,⁷⁰⁷ she began working at the

⁷⁰⁷ "Morgentaler clinic requires full or part time RNs, experienced, compassionate and with a sense of humour": F10.

Toronto Morgentaler Clinic in 1986 (two years before abortion's decriminalization). She left her secure full-time position in emergency pediatric nursing to do so. She credited her extensive experience as the main reason that she was hired to nurse at the freestanding clinic. Sharon did not leave the abortion clinic setting for more than two decades until, that is, she fully retired from nursing in 2008. At the Toronto clinic, Sharon first worked as a bedside nurse and then, in addition to that work, took on a variety of central administrative roles, acting as Clinic Manager and head nurse from 1989 to 1991. Thereafter, she became the manager of all of the existing Morgentaler Clinics and was tasked with designing, opening, and developing additional ones in central and eastern Canada. Sharon noted that she developed a close professional relationship with Henry Morgentaler, who commonly referred to her as his "right-hand man" throughout their long partnership. She was retired at the time of our interview.

Lisa E

Lisa E earned her baccalaureate degree in Nursing from the University of Calgary in 1985. As with many of her colleagues, Lisa worked in a variety of high acuity settings in hospitals after graduation. For Lisa, these areas included general surgery, bone marrow transplant services, and palliative care, among others. Shifting away from hospital work to the freestanding abortion clinic, Lisa joined the team at the Elizabeth Bagshaw Clinic early in its operation in 1991. There, she most enjoyed working as a bedside nurse in the Procedure Room, supporting women throughout their abortion procedures. For a time, she also fulfilled an administrative nursing role and was instrumental in developing practice protocols that she perceived helped to promote women's physical and psychological safety before, during, and after their abortions. To that end, Lisa engaged in "guerilla research," as she put it, with other nurses and physicians by

concurrently and retrospectively tracking the experiences of women in order to develop protocols based on “good evidence.”⁷⁰⁸ During the interview, Lisa emphasized her activist-identity as contributing to her interest in abortion nursing, noting, “I was involved in the International Women’s Day Committees, I was an active feminist, an environmentalist, peace activist, and [...] gay rights activist.”⁷⁰⁹ She was practicing full time at the Elizabeth Bagshaw Clinic at the time of our interview.

Jackie F

Jackie F completed her nurses’ training at St. Joseph’s [Catholic] Hospital in New Brunswick in 1967—two years before the liberalization of abortion. She then completed a specialty training program in Operating Room nursing in New Brunswick in 1968. In the same year, Jackie moved to Vancouver, a city she associated with “freedom,” where she began working as a bedside and head nurse in multiple hospitals throughout the 1970s, 1980s and into the 1990s. Over the span of her career, Jackie worked in many fields of nursing, including neurology, respiratory care, oncology, intensive care, Operating Room, and surgical daycare, among others. Shortly after the liberalization of abortion, under the Therapeutic Abortion Committee system, Jackie played a central role in the development and the provision of in-hospital abortion services from hospital day-surgery clinics—where women underwent abortions in the hospital Operating Room but, barring major complications, went home the same day and were not admitted to the hospital-proper for overnight monitoring. In the mid-1990s, Jackie joined the two (by then legal) freestanding abortion clinics in Vancouver, fulfilling various roles there including bedside nurse,

⁷⁰⁸ LE 20.

⁷⁰⁹ LE 158.

head nurse, Executive Director, and member of the Board of Directors. She was retired at the time of the interview, working instead on her memoirs, which she planned to title “Life on the Edge.”

Christena M

Immediately following high school, Christena M attended Queen’s University in Kingston Ontario, earning her Bachelor of Nursing Science there in 1974. Shortly thereafter she moved to Vancouver, worked in a large hospital for a short time in orthopedics, and then transitioned into public health nursing in 1976. She worked in various public health clinics in the city, including at the Pine Free Clinic throughout the 1980s, which essentially functioned as a birth control and sexual health clinic at that time. In this role, she helped women access and prepare for in-hospital abortion services under the Therapeutic Abortion Committee system. Following abortion’s decriminalization, she worked at Everywoman’s Health Centre in the role of counsellor (but not formally as a Registered Nurse) beginning in 1989. She also worked as a nurse in the office of a physician who performed abortions there. Christena said that she preferred to help women prepare for their abortions rather than work with them in the Procedure Room. She emphasized that she had come of age in the midst of broader anti-Vietnam war messaging and declared that she had been, and remained, “pretty rabidly prochoice for my whole life.”⁷¹⁰ She was officially retired at the time of our interview yet continued to work casually for the BC Centre for Disease Control in the field of sexual health outreach.

⁷¹⁰ CM 124.

Lisa R

Lisa R shared that she grew up in a small town in British Columbia and had decided to become a nurse at around age five. In 1994, she earned her nursing diploma from Douglas College in Vancouver and then went on to complete a certificate in “cross-cultural counselling.” She initially worked in hospital orthopedics and on the sexual assault service. Prior to graduating from nursing school, she had worked in an administrative role at the office of her physician-aunt, Ellen Wiebe, helping to organize her in-office abortion practice. Lisa was later hired to work at both of the freestanding abortion clinics in Vancouver, starting with the Elizabeth Bagshaw Clinic in 1994 and Everywoman’s Health Centre in 1995. She spent most of her time at Everywoman’s. While fulfilling the temporary role of Acting Executive Director there, Lisa confronted an anti-abortion trespasser and was later called to court to testify in the ensuing case. Lisa reflected that she identified with the feminist label more and more as she worked in the clinic, reflecting that “it’s just been a kind of evolution for myself and my comfort with it, and growing up. I really feel that I grew up in Everywoman’s because I started there so young and now, I am [...] not so young anymore.”⁷¹¹ Lisa was still practising at the time of our interview.

Rene W

Rene W grew up in Toronto and moved to Vancouver in 1983. In 1987, having completed three years of classes in women’s studies, anthropology and sociology at Simon Fraser University, she switched to nursing school. She told me, “the whole reason I became a nurse was because I wanted to be a midwife. That was my calling. One day while I was still in University, I was in a health food store and I picked up a book—*Spiritual Midwifery* by [natural birth activist] Ina May

⁷¹¹ LR 625.

Gaskin—and it blew my mind. It was all about birthing, talking about it in a way that I never heard it described. [...]. I was so drawn to it.”⁷¹² Midwifery in British Columbia at the time, however, was not legitimized in the health care system: it was un-regulated and perceived of as *illegally practicing medicine without a licence*. Rene’s family encouraged her to become a physician, but she pursued a diploma in nursing from Douglas College as a stepping-stone towards midwifery instead. Early in her nursing career, Rene worked at BC’s women’s hospital where she attended to women undergoing later-term prostaglandin and saline instillation abortions ‘on the ward.’ In the early 1990s, she began working at the Elizabeth Bagshaw Clinic while also attending an “underground midwifery school” and apprenticing with a group of midwives. Although she completed the midwifery program, owing to “personal life circumstances” and the insecurity of that profession, Rene continued to work as a nurse at the abortion clinic on and off until the time of our interview. She explained to me that in helping women have abortions, “I am a midwife. But just a different kind.”⁷¹³

Joan W

Joan W provided the following biography prior to our interview. I have edited it here for length and included additional details from her curriculum vitae. “I am Joan W, Registered Nurse Diploma in 1967 and then Bachelor of Arts and Master of Education [from the University of Toronto in 1984 and 1989, respectively]. I did my master’s thesis on Women’s Moral and Ethical Decision Making, which was published in *Canadian Nurse*. I trained at St. Joseph’s [Catholic] Hospital in Toronto and witnessed the consequences of so called “illegal” abortions

⁷¹² RW 67.

⁷¹³ RW 1416.

during my three student years. Beginning in 1970, I worked at Women's College Hospital where we provided abortions. [Prior to that], I worked and travelled in a variety of countries. Areas of focus included general medicine, urology and general surgery, general ICU, and heart surgery ICU [among others]. In 1978/79 I joined the staff of The Bay Centre for Birth Control in Toronto. We provided counselling, physical assessments and referrals for abortion. After the Supreme Court decision [to decriminalize abortion], we received funding for a larger clinic called the Regional Women's Health Center at Bay and College in Toronto. I was the senior nurse counsellor and educator there until 1990 when I became co-coordinator. In October of 1994, I moved to Ottawa to manage the provincially funded Morgentaler Clinic, where I remained until my retirement late in 2009."⁷¹⁴ Joan also supervised nursing, social work, and medical students at the Bay Centre and helped "establish a woman-centered approach"⁷¹⁵ to practice with them there. She frequently gave lectures, presentations, and participated in public discussions (on the radio and television) about birth control, pregnancy, abortion, and women's health. As noted, she was retired at the time of our interview.

From the Archives: Nurses from the Illegal Morgentaler Clinics

I have compiled these biographies based on details provided in newspaper articles and Catherine Dunphy's Morgentaler biography.⁷¹⁶

⁷¹⁴ JW personal communication.

⁷¹⁵ JW personal communication.

⁷¹⁶ Dunphy, "Morgentaler".

Joanne Cornax

Joanne Cornax completed her nurses' training in 1944 in Germany. She began working with Henry Morgentaler in Montreal in 1958 and, despite her Catholic religious beliefs, helped transition the general medical office to a specialty abortion clinic. There she functioned as bedside and head nurse. Significantly, it was Joanne Cornax who retrieved the new-to-Canada vacuum aspiration machine from the customs agent at the airport. For her work, she was involved in many police raids, arrests (she was once arrested at her home), and lawsuits (including her own and as a Crown witness against her physician colleagues). According to Catherine Dunphy, these events eventually drove Cornax to leave the clinic and the country.

Lynn Crocker

Lynne Crocker, a former public health nurse, worked as the head nurse and as a bedside nurse at the illegal Morgentaler Clinic in Winnipeg. Following multiple police raids, she was twice arrested and once jailed for a weekend. Significantly, Crocker was not only charged with conspiring to provide abortions (multiple times) but also with actually procuring an abortion. The latter charge was usually levied against the physicians who performed the internal aspect of the operation. Crocker was particularly defiant against the state and engaged with the pro-choice activist movement. Frustrated by the ongoing interruption of abortion services and women's variable access to them, Crocker left the clinic before abortion was decriminalized.

Lynn Hilliard

Lynn Hilliard worked at the illegal Morgentaler Clinic in Winnipeg. Owing to her appearance in newspaper reports of clinic operations and police raids, in 1983 she faced public recognition and

ostracism that eventually resulted in threatened excommunication from the Roman Catholic Church. The institution called for her to renounce her abortion work and to seek reconciliation for it. According to the *Toronto Star* newspaper, she reportedly held “no malice” towards the Church but was instead concerned for the safety of her friends and family. She was barred from marrying in the Church. It remains unknown to me whether she was actually excommunicated. She is pictured in at least one newspaper article.⁷¹⁷

From the Archives: Anti-Abortion Nurses

I have compiled these biographies based on details provided in newspaper and newsletter articles and the book *Silhouettes Against the Snow*.⁷¹⁸

Helen, Rita, and Mary Burnie

Sisters Helen and Rita Burnie were public figures in the anti-abortion scene. Rita had worked as a nurse at Toronto’s St. Joseph’s Hospital, retiring after 32 years of service there in addition to eight years at other facilities. As a nurse, she claimed, she was committed to saving lives, which included fetal lives. Helen became an anti-abortion activist after she made a promise to, “do all I can for the unborn until the day I die” as she recovered from a decade-long illness.⁷¹⁹ As for their abortion activism, both sisters picketed the Toronto Morgentaler Clinic, beginning in approximately 1984. Both also spoke out publicly in national newspapers. They also joined the prominent anti-abortion organization *Campaign for Life Coalition*, an amalgamation of

⁷¹⁷ “Nurse barred”.

⁷¹⁸ Petrasek, “Silhouettes”.

⁷¹⁹ Petrasek, “Silhouettes”: 109.

previously established anti-abortion groups (including *Nurses for Life*) that formed in 1986. Members of this group were committed to “education, youth training, and political advocacy [including the organization of] the Annual March for Life on Parliament Hill.”⁷²⁰ Though it is unclear whether Rita became involved, Helen also joined *Operation Rescue*, a violent fundamentalist Christian-based group that also formed in 1986 (originally in the USA). Members of *Operation Rescue* were committed to ‘rescuing’ women from abortion clinics in an attempt to prevent their abortions. For her activities outside the Toronto Morgentaler clinic, Helen had been arrested and fined. Helen Burnie was pictured in a *Globe and Mail* in 1988.⁷²¹ A third Burnie sister, Mary, had also worked at St. Joseph’s Hospital in Toronto as a chemist. She shared Rita and Helen’s anti-abortion perspectives.

Ita Venner

Ita Venner was born in Ireland and completed her nurses’ training during the second World War. Reportedly while nursing soldiers, she then came to the belief that abortion and abortion nursing were morally untenable. She then moved to Canada and, after abortion’s liberalization in 1969, refused to participate in its provision in her hospital in Ajax, Ontario. Venner was one of the nurses who demonstrated on Parliament Hill in 1970. Significantly, she founded a pregnancy counselling telephone line via which she “counselled” women, steering them away from abortion. Similarly, she founded *Nurses for Life*, a nursing-specific anti-abortion coalition that grew across Canada. Like Helen and Rita Burnie, Ita Venner was involved with the broader anti-abortionist group *Campaign Life Coalition*.

⁷²⁰ Saurette and Gordon, “Changing Voice”: 374.

⁷²¹ “Picket’s credo”: A10.

Cecilia Von Dehn

A Roman Catholic, Cecilia Von Dehn completed her nurses' training in Montreal but moved to England to study midwifery in 1960. She then moved to Vancouver in 1963 and "used her midwifery skills in the early 1970s [to] prepare 'Kitsilano hippies' for home births."⁷²² This was at a time when midwives could not legally manage deliveries in communities or hospitals in British Columbia. It is unclear when she left midwifery. Eventually Von Dehn became the head of *Nurses for Life* in Vancouver and in 1988 she was also the spokeswoman for the *Vancouver Right to Life Society* (not a nursing focused organization). Her major contribution to the anti-abortion movement in Vancouver was buying and operating the anti-abortion clubhouse (*Gianna House*) located across the street from Everywoman's freestanding abortion clinic.

⁷²² "Crusaders": B1.