

De-politicization Through Medicalization: The Regulation of Abortion After Morgentaler

In 2012, anti-choice Conservative MP Stephen Woodworth introduced a private member's motion calling on the House to revisit the legal definition of when human life begins. His argument turned on the assertion that human life should be defined in scientific terms. The motion, which was overwhelmingly defeated in a vote of 203 to 91, called for the creation of a special committee to assess "what medical evidence exists to demonstrate that a child is or is not a human being before the moment of complete birth?" (Motion 312). The use of medical language to challenge the existing regulation of abortion in Canada is by no means a new tactic; anti-choice groups have been warning women about the alleged health risks of abortion since the procedure was decriminalized, asserting that abortion causes breast cancer and even assigning the term "post-abortion syndrome" to symptoms not causally linked to abortion.¹ While these claims have been found to have no substance, the use of medical language to reframe anti-choice arguments has successfully kept the debate open by shifting the focus of the discussion, presenting health as a kind of apolitical compromise that does not require a rehashing of the abortion debate and, perhaps most importantly, should not be interpreted as an attack on women's rights.² This chapter aims to demonstrate that sidestepping the socio-political issues at stake within the abortion debate by adopting a medical framework risks undermining both the significant gains in access to abortion achieved by Canadian women's movements, as well as the movement's success in moving towards a social and political climate in which women are, and see themselves as, equal citizens deserving of these services.

The medicalization of abortion has not been limited to groups opposing the procedure; the pro-choice movement has also embraced a medical rhetoric. The medicalization of abortion gained prominence with Dr. Henry Morgentaler and was the frame responsible for the eventual decriminalization of abortion in Canada.³ This framework thus underpins the watershed moment for the pro-choice movement in Canada. While calls for women's rights have not disappeared from the pro-choice agenda, just as the moral frame utilized by the anti-choice movement remains strong, many proponents have shifted the focus from one of equality to a right to healthcare. By

¹ Anti-choice groups liken "post-abortion syndrome" to posttraumatic stress disorder (PTSD), in which women who undergo abortions will experience "symptoms of trauma, such as flashbacks and denial, and symptoms such as depression, grief, anger, shame, survivor guilt, and substance abuse" (American Psychological Association 18). Talk of this alleged syndrome was so prevalent that it was the subject of an American Psychological Association task force report in 2008 that found these links to be based on studies with "often severe" methodological issues. The study concluded that "among adult women who have *unplanned pregnancy* the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy" (ibid. 5-6).

² The appropriation of pro-choice language extends beyond medicine to include issues of choice and even allegedly feminist arguments. See Gordon, Saurette, and Trevenen's *From Jezebel to Snowwhite: The Shifting Representations of Women in Canadian Anti-Abortion Discourse* (2013).

³ Brodie identifies a "medical rationale" as one of the dominant approaches to liberalizing abortion law in Canada. This approach "suggests that considerations of a woman's health sometimes make an abortion a medical necessity" (71). The recent appropriation of this frame argues for the need to discuss health in neutral, scientific terms that include the life and health of the fetus.

positioning abortion as a medically necessary service, they pressure governments to ensure that women's health care needs are being met through the provision of comprehensive abortion care. This focus is understandable in a political climate that is increasingly hostile to women's rights activism. In this context, pro-choice activists have dedicated their energies to holding their ground rather than pushing for improved access. This frame has led to great historical gains for the pro-choice movement and, after Morgentaler, the regulation of abortion as a medical issue has become the political status quo. Both groups have gained political leverage using these tactics; however, this approach to the abortion debate is not without serious shortcomings.

This chapter begins by looking at the medical frame of abortion, emphasizing how it has been used to women's advantage, but holds the potential to reverse these gains, since it predicates access to abortion solely on its value as a medical procedure. Medicalization has been presented as an apolitical solution to a contentious debate, but the realities of service delivery reveal the consequences of the politically charged views of practitioners and the public. The following section turns to the history of abortion politics in Canada, with particular attention paid to its intersections with medicine. In so doing, it showcases not only the gains provided by the medical frame for the pro-choice movement, but the beginnings of the co-optation of this frame by the anti-choice movement. This account will demonstrate how we have come to this position of tenuous access to abortion in Canada and illustrate the tension revolving around the medical framing of abortion in Canada, as both aiding and potentially threatening access. The final section goes on to explore the ways in which the medicalization of abortion in Canada has historically distracted from the relation between abortion and women's equality and the risks associated with a policy vacuum surrounding abortion. Emphasizing the actions of the federal government after Morgentaler, and revealing the changing tone of anti-choice arguments and pro-choice strategy, this section showcases a changing strategy centered on health. The chapter concludes by returning to the case of Woodworth's effort as it illustrates potential future developments in access to abortion in Canada.

Medicalization

Medicalization, broadly, refers to both the "process and outcome of human problems entering the jurisdiction of the medical profession" (Conrad 210). Increasingly, women's lives have entered this domain, as issues like "battering, gender deviance, obesity, anorexia and bulimia, and a host of reproductive issues including childbirth, birth control, infertility, abortion, menopause and PMS" have shifted to the medical sphere (Conrad 222). The consequences of this shift have been mixed: on the one hand, these issues seemingly gained legitimacy following their recognition as health care concerns, particularly in a country that prides itself on access to universal care, but on the other hand are reduced to medical, rather than socio-political concerns.

Despite Canada's universal health care program, variance in services and regulations across the country persists absent a commonly agreed upon definition of health. While terms like "health" and "medical necessity" are presently used to justify the provision of abortion, these terms remain undefined, leaving women's access to abortion entirely up to the discretion of individual physicians. Thus, instead of talking about the importance of women's equality and autonomy, abortion has been reduced to a healthcare

issue. Given the still stigmatized nature of abortion in much of Canada, the realities of this discretion continue to allow for uneven access to services for women.

New Brunswick, for example, has some of the most restrictive access in Canada and provides a cautionary tale about the shortcomings of medicalization. For a woman in the province to access an abortion covered under her provincial health insurance plan, she first has to negotiate a complex bureaucratic system, the realities of which likely completely unknown to her, without a clear sense of her rights as a patient. First, she must obtain written permission from two doctors stating that the procedure is “medically necessary”, a requirement for which there is no medical rationale. She must then secure an appointment with a specialist in the field of obstetrics and gynecology in an approved hospital to perform the abortion and the appointment must take place before she has reached her twelfth week of gestation.⁴ Given average wait times in the province it can be a near impossibility to get access to publicly funded care. After all, there is no guarantee that the doctors they do see will be willing to refer them, or that women encountering anti-choice physicians will be provided with a clear breakdown of their rights. In effect, the ability of these women to exercise their choices is often contingent on the belief systems of their doctors. One physician in the province explains that some physicians in the province have been known to simply shut the door on women, “leaving her out there on her own, unsure of where to go”.⁵

On the other side of the spectrum are provinces like Quebec. Abortion in Quebec is covered under provincial health insurance in both hospitals and clinics and does not require a referral. There are also a number of pioneering clinics that are attempting to change the way women experience terminating their pregnancies, from one of fear to one of understanding and respect. Anne Marie Messier is the clinic manager at the *Centre de santé des femmes de Montréal*, one of three clinics in Quebec offering services using a strictly feminist approach grounded in respect for women and their experiences (Messier, Interview.). Not only are women given some control over the setting during the procedure (whether they would like to listen to music or have someone to hold their hand and talk with them) but their knowledge of their own bodies is respect. If a woman is certain of her conception date, for example, she is not required to have an ultrasound.⁶

Quebec is a standout example, however, in large part because of the Quebec public’s recognition for the rights of Canadian women. In 2010 the National Assembly of Quebec put forward a motion stating:

THAT the National Assembly reaffirms the rights of women to freedom of choice and to free and accessible abortion services and asks the federal Government and

⁴ Regulation 84-20, which sets out these requirements, will not cover abortion under provincial health insurance “unless the abortion is performed by a specialist in the field of obstetrics and gynaecology in a hospital facility approved by the jurisdiction in which the hospital facility is located and two medical practitioners certify in writing that the abortion was medically required” (Government of New Brunswick 1984, 38).

⁵ Sean Moore [pseud.] (New Brunswick physician, more than ten years). Interview by author. 11 January 2011. Recorded and transcribed by author. Fredericton, New Brunswick.

⁶ Messier explained that the women were often more accurate in predicting their dates than their sonograms were, a reality which further demonstrates the importance of recognizing the authority of women in making decision over their own bodies; authority that can be distorted through medicalization.

the Prime Minister of Canada to put an end to the ambiguity that persists in relations to this question.⁷

Recognition of women's rights in politics and society in the province, not just as a health issue but also as a broader question of equality, has informed the treatment of abortion in the province. While access is still not uniform in the province, these declarations reflect public sentiment that has allowed medical practitioners room to attempt to improve services, and given women a sense of entitlement that helps to guide them through a system meant to help them realize their choices.

These examples represent extreme ends of the abortion access spectrum in Canada. While most provinces now provide some level of publicly funded care, barriers including distance, time, stigma, and fear continue to influence the reality of the way women experiences this access. Thus, while levels of access have dramatically improved across Canada since the procedure was decriminalized, the nature of access that women in different provinces experience is still markedly different. The medicalization of abortion has improved access, but rather than granting more power to women, the agency women are able to access continues to depend on a third party. While many physicians have treated women as the final arbiters of their reproductive decisions, absent formal protections women's rights remain vulnerable.

The above examples make it clear that the medicalization of abortion does not mean the relegation of the procedure to the medical sphere; government's continue to be active in its regulation both through formal restrictions and value-laden motions. As will become increasingly evident in the following section, locating abortion within medicine does not preclude political interference by various levels of Canadian government; it has merely provided a smokescreen for this political activity. The evolution of this strategy becomes apparent when the history of abortion in Canada is explored.

The Politics of Abortion Before Morgentaler

Canada's first abortion law, adopted in 1869, was designed to mimic an existing British law that prohibited abortion without exception (Keown 1988, 15). Canada's prohibition on abortion first began to take shape as *Lord Ellengorrough's Act* in Britain in 1803. The Act prohibited certain types of abortion around the second trimester, after the pregnant woman was first able to detect fetal movement (Keown 1988, 15). This law was created with the intent to protect women from unsafe medical practices (often attributed to midwives) and to safeguard the domain of physicians (Keown 1988, 18–19; Gleeson 2011, 217). This Act was later broadened to include abortion at all stages; a change intended largely to make the law more easily enforceable, though it is important to note that public sympathy for the plight of women facing unwanted pregnancy made the enforcement of this law difficult (Keown 1988, 16, 18–19). The complete prohibition on abortion, commonly known as Britain's *Offences Against the Person Act (1861)*, was later adopted into Canada's Criminal Code.

In 1939, Canadian physicians challenged the ban on abortion. On the heels of an influential British case, in which a woman's mental state was found to be grounds to deem an abortion a medical necessity, the barriers for physicians attempting to exercise their professional judgment on the state of women's reproductive health were relaxed

⁷. Hansard Parliamentary Debates. National Assembly of Quebec. (19 May 2010).

(Jenson 1992, 24). The law was liberalized to create protections for physicians sparing them from prosecution if they deemed abortion necessary to protect the life of a pregnant woman (Hausman 2002, 63). While this shift signaled some improvement, it was the first among many changes to women's reproductive health that followed a troubling pattern; even in instances where advancements have been made, they have often been framed in such a way as to dismiss the foundational socio-political issues women must address. Nonetheless, powerful social movement activists continued to push for change on their own terms, even if the results did not necessarily reflect their motivations.

The pro-choice movement gained tremendous strength in the years leading up to *R. v. Morgentaler* (1988). The consequences of illegal abortions were broadly understood and widely felt, and the urgency to improve women's reproductive rights was ever-present. Shifts in the *Criminal Code* liberalizing the abortion law in 1969 only fed concerns that treating abortion as a criminal issue was a health hazard for women, by partially legitimating its treatment as a medical necessity and drawing attention to the subjectivity of apparent health distinctions.⁸ The changes to the abortion law required women to plead their case before a Therapeutic Abortion Committee (TAC) in the hopes of being granted a legal abortion. Despite its shortcomings, legal scholar Carol White, identifies the advantages of this partial reclassification, explaining that medicalizing abortion removed a husband's formal vetoes over their wife's decision to terminate an unwanted pregnancy:

Yes medicalization of abortion put the decision making in the hands of the medical profession, on the other hand it took the decision formally away from husbands, kept them formally out of the picture, except in practice the Badgely committee found that even though the husband's consent wasn't required, husbands were routinely asked. (White, Interview.)⁹

When these changes first occurred the pro-choice movement had few clear tools in politics or law that they could utilize to challenge it; however, with the advent of the *Charter*, new opportunities for change were created. The *Charter* created individual rights protections in the constitution with which Dr. Henry Morgentaler, a growing figure in the pro-choice movement, was able to successfully take on the Courts.¹⁰

In 1988, utilizing a defense for "Life, Liberty, and Security of the Person" that had been successful in the United State in 1973, Morgentaler challenged the constitutionality of the 1969 abortion law (Department of Justice 1982). Using section 7 of the newly minted *Charter of Rights and Freedoms*, he argued that the existing law violated women's section 7 rights. This defense pivoted on the health risks associated with forcing women to either carry to term unwanted pregnancies or seek out illegal

⁸ In 1977 the Badgely Report, formally known as *Report of the Committee on the Operation of the Abortion Law*, found that "procedure provided in the Criminal Code for obtaining therapeutic abortion is illusory for many Canadian women" (Rebick 2005, 157).

⁹ Carol White, [pseud.] (Prominent feminist legal scholar and former social activist, more than ten years). Interview by author. 8 June 2010. Recorded and transcribed by author. Canada.

¹⁰ Morgentaler previously appeared in Quebec (1973, 1975, 1976) and Ontario (1983) provincial courts to challenge Canada's abortion law. His 1973 case was appealed as far as the Supreme Court where he famously challenged the constitutionality of the 1969 law using the defense of necessity. Without any formal individual protections, however, the Court focused on the jurisdictional element of the claim and found that the federal government appropriately regulated abortion.

abortion services. The consequences of attempting to endure or illegally terminate an unwanted pregnancy were widely understood at the time, despite not being openly discussed. By demonstrating the consequences of uneven and restricted access to abortion services, Morgentaler demonstrated the failure of the healthcare system to effectively protect the health of women under the existing law.

Ultimately the court ruled in Morgentaler's favour, with a majority decision of 5-2, finding that section 251, by requiring "a pregnant woman whose life or health is in danger to choose between, on the one hand, the commission of a crime to obtain effective and timely medical treatment and, on the other hand, inadequate treatment or no treatment at all", is a direct violation of her right to security of the person (p 34). By choosing to strike down section 251 of the *Criminal Code* rather than modifying it, the Court left room for Parliament to create new legislation to regulate abortion access, a move that Jenson argued undermined the treatment of abortion as a medical issue, freeing the terms of the debate and allowing "new positions to reorient the discussion" in the political sphere (Jenson 1992, 17). Attempts by the Mulroney government to create a new abortion law immediately following the decision revealed such a change in rhetoric, but did not signify the end of a medical frame of abortion.

The Mulroney government moved quickly in its attempts to create a new law, and Bill C-43 passed successfully through the House on May 29, 1990. The bill was originally meant to balance the sentiments of those both for and against abortion access in Canada, but it soon became apparent that there was no room for compromise. Ultimately, the bill did not go far enough for either side. Bill C-43 proposed to reintroduce a ban on abortion to the *Criminal Code*, but with exceptions to allow doctors to perform abortions at their discretion should they determine that the woman's health was compromised because of the pregnancy (Overby, Tatalovich, and Studlar 1988, 383). While the limitations on women's rights validated by this law supported the anti-choice movements moralistic attacks on women's autonomy, the exceptions provided for negative health consequences added an important escape clause. Mimicking previous restrictions on abortion in Canada, designed to protect physicians, this portrayal of abortion was meant to temper the otherwise polarizing debate without an overt challenge to the power structures on which abortion rights have historically been restricted. The right to veto a woman's choice to have an abortion still fell under a clear hierarchy preserving "scientific and male privilege" (Hausman 2002, 67).

Bill C-43 was passed by the House, but was met with a rare tie vote in the Senate on July 31st, 1991 that signaled its defeat.¹¹ No federal government has since attempted to create legislation restricting abortion and the procedure was formally reclassified as a healthcare issue; jurisdiction over it shifted to the provinces. Importantly, despite the fact that this law failed to pass, the use of a medicalized rhetoric in provincial legislatures and the House of Commons has persisted, alongside and often in addition to the pro- and anti-choice arguments that have come to dominate public discourse on abortion. Indeed, its reclassification as a health care issue following the Morgentaler decision has limited the ability of provincial governments to influence its regulation outside of this realm. Perhaps

¹¹ Brodie attributes this defeat largely to the actions of physicians who, unsure of the implications of the new law, began "voting with their feet"; that is, they stopped performing abortions en masse to pressure the government to reconsider the bill (1992, 112).

the best example of this phenomenon took place in Nova Scotia shortly after jurisdiction over the procedure shifted.

In 1989, the Government of Nova Scotia implemented a regulation prohibiting the performance of abortions “in any place other than a building, premises, or place approved by the Minister of Health and Fitness as a ‘hospital.’”¹² When Morgentaler set up an abortion clinic in the province later that year he was swiftly charged with “14 breaches of the *Medical Services Act*”.¹³ The case was appealed to the Supreme Court, who ruled in Morgentaler’s favour, finding the legislation to be an “an “indivisible attempt by the province to legislate in the area of criminal law.”¹⁴

This case demonstrates the new parameters in which the provinces must now work to change their own policies: they must adopt a medical rationale to justify restrictions to abortion access or risk legal action. In federal politics, however, abortion is still open to being reclassified through the creation of a new law, though a medical frame has begun to gain strength in the House as well. At both levels, despite shifts in language, adherence to the fundamental beliefs of both the pro- and anti-choice movements continue to inform the strategic use of the medical frame. As such, any analysis of the use of such a frame must first engage with the motivations and past approaches of these movements.

Abortion After Morgentaler

Anti-choice groups base their opposition to abortion on the belief that “life begins at conception, and therefore that abortion is tantamount to murder” (Nossiff 2007, 61). This belief system is also deeply tied to a desire to return to traditional gender roles, which prioritize women “first and foremost as wives and mothers” (ibid.). The goals of these groups vary, some “are concerned with abolishing abortion services [while] other groups are more concerned with the perceived legitimacy of the procedure, that is, so long as it is publicly demonized its availability is less of a concern” (Blanchard 1994, 36). While a change in the tone of these arguments is apparent in more recent tactics, the founding concerns remain unchanged.

The anti-choice movement in Canada started to mobilize as the law on abortion liberalized. White explains, “it is one of the paradoxical aspects of the Morgentaler victory that it unintentionally contributed to the development of the backlash that followed” (Interview.) The growing legitimacy of abortion in Canadian society spurred on the movement’s attempts to have the procedure recriminalized on moral grounds (Blanchard 1994, 36). While the movement has continued to mobilize, it has consistently lost ground in the public eye. The decriminalization of abortion resulted in improvements to women’s health and leaps forward in equality that was difficult to challenge. In response, the anti-choice advocates shifted their rhetorical approach to abortion politics, refocusing on aspects of the procedure already grounded in political discourse. This pattern is perhaps nowhere more apparent than in the numerous backbencher motions put forward in the House after 1988.

In 1996 and 1997 backbencher motions were put forward calling for a “binding national referendum on government funding for ‘medically unnecessary’ abortions”

¹². R. v Morgentaler. [1990] 99 NSR (2d) 293 (Can) at 55.

¹³. Ibid. at 2.

¹⁴. R. v Morgentaler. [1993] 3 SCR 463 (Can) at 24.

(ARCC 2010). In 2002 and 2003 two similar backbencher motions emerged, but with a perceptible shift in language. The motion required,

That the Standing Committee on Health should fully examine, study, and report to Parliament on a) whether or not abortions are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability; and b) the health risks for women undergoing abortions compared to women carrying their babies to full term.

Already, the language had changed from a clear reflection of the goal of recriminalizing the procedure to a more neutral, inquisitive tone that seems to suggest a desire to get at some universal *truth* about the healthcare implications of the procedure. This approach was also reflected in other bills. Overt attempts to reclassify abortion as homicide (1991, 1996) and secure fetal rights (1998, 1999, 2001) have been replaced with calls to prevent the coercion of medical professionals and women (2008, 2010), ensure informed consent from women seeking abortions (2003), and to create increased penalties for the murder of a pregnant woman (2004, 2007)(ARCC 2010). While the goals of these motions have remained the same – the eventual re-criminalization of abortion services – the language is demonstrative of an understanding that calling on the immorality of women or the rights of “unborn children” does not garner significant public support; particularly given the known consequences of illegal and restricted abortion. The more successful tactics have been to adopt the language of the pro-choice movement and position themselves as pro-woman.

The pro-choice movement and its focus on women’s equality, in contrast, has begun to fade from formal politics, focusing on countering anti-choice motions rather than pressing for better access. This approach is not just representative of the political climate, which has become increasingly resistant to women’s rights claims, but it also represents a decreased sense of urgency surrounding issues of abortion access. After the decriminalization of abortion in Canada, when it became apparent that a new law was not going to replace section 251 of the *Criminal Code*, many pro-choice groups slowed their mobilization, feeling that they had effectively won the war. While some continue to work diligently on the issue, recognizing the problems still present in realizing equal access to the procedure across the country, the desperate call for change lost its urgency. Since *R. v. Morgentaler* (1988) the pro-choice movement has treated the abortion debate as largely resolved. While numerous provincial court cases sought to ensure that provinces were providing reasonable access to abortion care, the desire to frame abortion as an equality right has often taken a backseat to the push to have abortion considered a health issue.¹⁵

In terms of litigation, the pro-choice movement’s focus on health makes a great deal of sense; abortion was decriminalized under a provision for “life, liberty, and security of the person” rather than the equality claims endorsed by the movement.¹⁶ The

¹⁵ Some of the more prominent provincial court cases aiming to improve abortion access in the provinces include: *Morgentaler v. PEI* (1994), *Morgentaler v. NB* (2004), *Nova Scotia (Attorney General) v. Morgentaler* (1990), and *R. v. Lewis* (1996). While equality rights were noted in most of these cases they did not provide the turning point for the central arguments. One notable exception to this trend was *Doe. et al. v. The Government of Manitoba* (2004) in which abortion laws were recognized as violating the equality provision in the Charter (this case was later overturned on appeal).

¹⁶ According to White, while the *Charter* was entrenched in 1982, section 15 “did not come into force until three years after that, 1985, so the only section of the *Charter* that was available at the time of the

power of a medical model has not only been successful historically, but in maintaining and improving provincial access. Joyce Arthur, Director of the Abortion Rights Coalition of Canada, explains that abortion is “a health treatment, it’s medically necessary under the Canada Health Act, and I think that’s helped a lot in terms of making abortion services more integrated into the healthcare system in general”.¹⁷ The reality that Canadians place such value on universal healthcare also makes this model appealing.

What is perhaps most notable about the current position of many pro-choice groups is their desire not to push too hard for recognition of abortion as an equality issue. Without the backing the movement once had, and facing constant threats of backlash from provincial and federal governments to place new limitations on abortion access, there is a constant struggle just to maintain existing services. Arthur explains that the fear of losing what services are already in place motivates a certain caution around the issue (Interview.). Michelle Robidoux, director of the Ontario Coalition for Abortion Clinics, echoed a similar sentiment when asked what kind of changes she would like to see to the regulation of abortion in Ontario: “It’s funny because you never get asked ‘what do you think would be a really good thing to have’. It’s just... it’s rear-guard actions all the time.”¹⁸

The trend of silencing the pro-choice movement has increased in recent years, particularly in federal politics. Robidoux explains that the anti-choice movement, “[has] access to this government [the Harper Government] in a way that they probably hadn’t had for sometime in previous governments” (Interview.). Pressure to maintain services rather than push for improved access has led the pro-choice movement to stress the letter of the law on this issue, defending abortion as a medical issue.

Examples of pro-choice activity in the political sphere are markedly less common than the anti-choice and tend to arise in opposition to anti-choice activity rather than originating from pro-choice activists. While these groups have worked diligently in opposition to the backbencher motions detailed above, they have not attempted to create their own legislation.¹⁹ The difficulties in advancing an equality agenda in federal politics were made apparent in 2010 when Canada hosted the annual G8 summit, in which leaders from the world’s eight leading global economies meet to discuss important economic and social issues. The agenda included the continuation of a project championed in previous summits designed to promote “Maternal, Newborn and Child Health” in developing countries, though what the government believed would fall under the header of “maternal health” was not made clear (Harper 2011). While arguing that they ““would not be ‘closing doors against any options, including contraception”” the pro-choice movement remained wary that these services would be excluded and rallied to press for guarantees of a comprehensive maternal health policy.²⁰ In response the group

Morgentaler case was section 7” (Interview.). The Court has not yet heard the case for abortion as an equality issue.

¹⁷ Joyce Arthur (Executive Director and founder of the Abortion Rights Coalition of Canada, 2005–Present). Interview by author. 30 September 2011. Recorded and transcribed by author. Kingston, Ontario.

¹⁸ Michelle Robidoux, (Manager Ontario Coalition of Abortion Clinics, years unknown). Interview by author. 30 March 2011. Recorded and transcribed by author. Toronto, Ontario.

¹⁹ One notable exception to this trend was a 2010 motion by the National Assembly of Quebec detailed on page 10.

²⁰. CBC News. “No Abortion in Canada’s G8 Maternal Health Plan.” April 26, 2010.

came up against strong opposition and were cautioned by Senator Nancy Ruth to “shut the fuck on” on abortion, saying “If you push it, there will be more backlash”.²¹

While different forces have shaped their strategies, both movements have converged on a medical rhetoric to address the issue of access to abortion care. In so doing, they have attempted to sidestep or de-emphasize the fundamental issues they believe to be at stake in the abortion debate. The anti-choice movement has done so in order to gain legitimacy; the pro-choice movement has done so to strategically hold their ground. The treatment of abortion as a medical issue may offer some protections for women, by legitimizing the health risks associated with a lack of reproductive choice, but it fundamentally fails to resolve the rights versus morality debate at the heart of the pro- and anti-choice movements respectively. The effect of positioning abortion as a medical issue has been to de-politicize the procedure, obscuring not only its connection with a range of social issues related to society’s treatment of women, but also rendering invisible the ongoing pro- and anti-choice debates in the institutions that regulate the procedure.

Conclusion

This chapter has attempted to demonstrate that treating a medical framing of abortion as an apolitical compromise has allowed issues of women’s rights to be pushed aside in the discussion of abortion. This framework currently acts as the political status quo and has provided substantive gains for the pro-choice movement, which has made it all the more difficult to challenge. Fear of losing existing services has stifled the pro-choice movement; absent clear and pressing policy targets the movement has resorted to holding its ground rather than pressing for more. While the rights rhetoric has not disappeared from the movement’s discussion of abortion, failing to push on the equality issues at stake implies that abortion is at least better off guided solely by health care than it might be if the debate were to be reopened. The patchwork of services now available in the provinces is treated as a marked improvement over the pre-1988 context; while it is clear that the decriminalization of abortion is a positive step, leaving abortion in the realm of medicine continues to leave the equality of Canadian women vulnerable.

Addressing abortion as strictly as medical question, without pushing for equality protections for women, places women’s individual agency at the mercy of medical gatekeepers. It is simply a matter of luck that many physicians attempt to guide women, rather than create barriers for them; however, without formal protections for women unlucky enough to encounter an anti-choice physician or medical staff, the ability to access abortion services becomes a question of good fortune rather than rights.

Woodworth’s 2012 motion to revisit the legal definition of human being demonstrates the problems inherent in this frame. Individuals on the fence about abortion may have questioned the apparent problems with revisiting the legal category of humanity through a scientific lens utilized by both pro- and anti-choice groups. While a brief reflection on this motion reveals its shortcomings, any hesitation in condemning it, I posit, is related to a similar trend in the pro-choice movement of stressing the value of medicine and health care, often at the expense of more fundamental equality arguments. The potential pitfalls of this frame are beginning to come to a head in federal politics, as

²¹. Susan Delacourt. “Aid groups advised to ‘shut the f--- up’ on abortion.” *The Star* [Toronto, ON], May 3, 2010.

the consequences of restricted abortion access have begun to fade from the collective memory. As a consequence, suggesting the recriminalization of abortion is not necessarily seen as a clear attack on women. The need to reinvigorate the rhetoric of women's equality in addition to calling for improved access to services is becoming increasingly apparent, but the pro-choice movement's focus on abortion rights may be too narrow for such a project, particularly absent clear and immediate threats to access to encourage mobilization. The reproductive justice movement's emphasis on expanding the definition of choice, to include a range of issues necessary to create real choice, such as public daycare, pay equity, and positive rights to reproduction, may provide a path to move forward.

While this chapter has positioned abortion as a political question rather than a medical issue in the abstract, legal recognition of a woman's right to choose is not sufficient for equality; women's reproductive freedom must be embraced by society as a whole so that women are able to exercise agency. If abortion remains stigmatized and women are unsure of their rights and safety in attempting to access a legal procedure, reproductive choice has not been realized. Moreover, recognition of women's equality as it relates to pregnancy necessitates a more complete understanding of choice that is not limited to a negative right to abortion. Reproductive justice, with its focus on a larger package of rights grounded in an understanding of existing barriers to reproductive freedom, may thus provide a productive new lens to explore a range of policies affecting women's health. Its expansive focus may also help to contribute a sense of urgency to issues surrounding reproduction that have not been the focus of previous debates on choice. Finally, it locates abortion issues in a social as well as legal and political context, demonstrating the need to recognize women's rights on all fronts before they can be realized.

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